Icon Cancer Centre By-Laws

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Contents

1. Preface

Integrated Clinical Oncology Network Pty Ltd, trading as Icon Cancer Centre (Icon) is governed by a Board of Directors with the Group Executive being responsible to the Group CEO through to the Board for the overall management of the organisation. Icon operates Australia's leading network of day only cancer care services.

These By-Laws have been created by Icon to assist accredited Medical Practitioners and Allied Health Professionals in understanding the important policies and processes of Icon and how these are implemented by Icon and in particular by the Group Executive.

These By-Laws apply to all day hospitals operated by Icon and have a number of purposes:

- assist in the selection and retention of Medical Practitioners and Allied Health Professionals who possess the qualifications and experience to deliver safe quality health care to patients and their families;
- maintain and improve the safety and quality of health services by ensuring the environment in which hospital and clinical services are delivered supports and facilitates safety and quality thereby protecting Icon and accredited Medical Practitioners and Allied Health Professionals;
- defines the relationship between Icon and its Medical Practitioners and Allied Health Professionals and serves to clarify the rights and obligations of those parties; and
- assist in compliance with Commonwealth and State laws, regulations and standards; and in particular the 'Governance for Safety and Quality in Health Service Organisations' disseminated by the Australian Commission for Safety and Quality in Health Care (2010)

2. Strategic Intent and Mission

To be the pre-eminent provider of cancer care services in Australia delivering evidence-based care that is accessible to all through an efficient and sustainable business model

The Mission is to provide exceptional care for everyone

3. Medical Practitioner and Allied Health Professionals Rights and Responsibilities

Icon aims to partner with its Medical Practitioners and Allied Health Professionals to provide exceptional care to cancer patients. Icon and its Medical Practitioners and Allied Health Professionals have an obligation to work together for the benefit of patients. To collaborate effectively and deliver optimal outcomes, both parties must fulfil certain requirements for the other. While Icon Medical Practitioners and Allied Health Professionals have certain rights in the clinical environment, they must also commit to upholding key responsibilities.

These rights and responsibilities are built around Icon's mission of providing exceptional personalised cancer care to patients and their families, and around the organisation's values:

- Innovate: Striving to find new and better ways of doing what we do
- Connect: Building and maintaining value adding relationships within our patients, corporate customers, and suppliers
- On-Purpose: Everything we do comes back to our focus on delivering exceptional cancer care
- Nurture: Caring for patients and their families during the challenging time of their cancer treatment
- Energy: Bringing a positive energy to everything we do

Icon expects its Medical Practitioners and Allied Health Professionals to accept a leadership role by nature of their professional status, the close working relationship they maintain with facility staff and their lead role in patient care and treatment.

Icon, therefore, has an expectation that the behaviour of Medical Practitioners and Allied Health Professionals, will reflect Icon's values and uphold the rights and responsibilities outlined below.

RIGHTS

Icon undertakes to deliver the following for Medical Practitioners and Allied Health Professionals working in conjunction with its day hospitals:

- Efficient patient management
- Exceptional patient care
- Clinical independence
- Professional collaboration and education
- Access to clinical research trials

Efficient patient management

Where Icon manages a Medical Practitioners practice, the Medical Management Unit will work with them to effectively manage patient scheduling and patient flow to maximise efficiencies and minimise wait times.

This is in addition to the full range of support services outlined in the *Icon Practice Management Agreement.*

Exceptional patient care

Icon's day hospitals will provide consistently exceptional care to patients in a safe, nurturing, and supportive environment and within a culture of respect and value.

Icon will ensure its clinical and pharmacy teams are well-trained in all processes and procedures relating to their responsibilities and that they participate regularly in professional learning programs to maintain and hone their specialised cancer care expertise. In addition, Icon staff will be supported to focus on a patient's best interests and to carry out their roles in line with Icon's values.

Clinical independence

Icon and its staff fully respect a Medical Practitioners clinical and professional independence. Icon doctors have the right to prescribe treatment that is in a patient's best interests, providing the treatment is safe, evidenced-based and adheres to medical ethics. Medical Practitioners, however, are required to inform Clinic Managers if they intend to prescribe high-cost treatments that are not covered under the Pharmaceutical Benefits Scheme and are outside of a clinical trial environment, so costs can be managed accordingly.

Professional collaboration and education

Icon encourages Medical Practitioners and Allied Health Professionals to collaborate and support one

another to drive better patient outcomes. Icon will provide structured opportunities to lead and participate in peer education and discussions via journal clubs, Icon-sponsored conferences/activities or pharma-sponsored events, such as research presentations by national and international leaders in the cancer care sector. Medical Practitioners and Allied Health Professionals maintain the right to accept or decline these opportunities.

Access to clinical research trials

Icon gives Medical Practitioners and their patients, access to a comprehensive program of clinical trials under the governance of the Icon Group Research Committees.

This includes a large cohort of clinical trials sponsored by the pharmaceutical industry, along with collaborative group as well as investigator initiated and outcome studies undertaken in partnership with various universities and collaborative groups such as ANZBCTG, ALLG, AGITG and ANZGOG.

The Research team in Icon includes a multidisciplinary team of nurses, clinical trial coordinators and data managers to oversee and support a patient's needs from the recruitment phase through to follow- up.

RESPONSIBILITIES

Icon expects Medical Practitioners and Allied Health Professionals working in conjunction with its day hospitals to uphold the following responsibilities:

- Respect for patients, Icon staff and peers
- Effective organisation and communication to support patient care
- A collegiate approach to patient care
- Professional leadership

Respect for patients, staff and peers

Patients – Icon asks Medical Practitioners and Allied Health Professionals to be mindful of the fact our patients have made a choice for private treatment, which comes with expectations of exceptional care and efficient delivery of treatment. It is important Medical Practitioners and Allied Health Professionals respect a patient's time by working to reduce wait times and manage expectations if delays are anticipated.

Staff – Icon places a high value on respect for others in the workplace, regardless of the role and years of experience, and asks Medical Practitioners and Allied Health Professionals to reflect this value in their communication with day hospital staff. Icon, as an employer, also has a legal obligation to provide employees a work environment that is free of bullying and harassment and requires Medical Practitioners and Allied Health Professionals to familiarise themselves with Icon's *Discrimination and Harassment Policy* and to act in accordance with this policy.

Peers – Icon expects Medical Practitioners and Allied Health Professionals to demonstrate professional respect for one another and to conduct themselves in a manner that reflects Icon's values. It is not acceptable for Medical Practitioners and Allied Health Professionals to undermine colleagues during patient consultations nor in forums with Icon staff and peers.

Effective organisation and communication to support patient care

Icon is committed to working with Medical Practitioners and Allied Health Professionals to minimise wait times for patients at its day hospitals. To support this, Icon requests:

- clinics to run on time, as practicably possible;
- communication with relevant staff around anticipated delays;
- completing treatment orders in advance; and
- being responsive to day hospital staff and medical secretaries around inquiries regarding patient care.

A collegiate approach to patient care

Medical Practitioners are expected to adopt a collegiate approach to patient care and support one another to cover holidays and weekend rosters. Covering Medical Practitioners are encouraged to respond to patient calls after hours in a timely manner and to write treatment orders for their colleague's first day back to reduce patient wait times.

Medical Practitioners respect the choice of patients that are referred for a second opinion or management of care, with those patients remaining in the care of the primary Medical Practitioners, unless otherwise agreed between practitioners.

Professional leadership

In addition to their critical leadership role in day hospital operations, Medical Practitioners are encouraged to mentor new practitioners around patient care and private practice development (if applicable) and to role model responsible behaviour, in line with Icon's values.

Part A – Definitions and Introduction

4. Definitions and Interpretation

4.1 Definitions

In these By-Laws, unless indicated to the contrary or the context otherwise requires:

Accreditation means the process provided for in these By-Laws by which a person is accredited. The two conditions for Accreditation are an explicit definition of quality (i.e., standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.

Accreditation Category means as part of Accreditation, the appointment of an Accredited Practitioner to one of more of the following categories: Allied Health Professional, Visiting Medical Officer, Employed Medical Officer, General Medical Practitioner, Medical Practitioner, Nurse Practitioner and Specialist Medical Practitioner. The Board may from time to time approve other Accreditation Categories.

Accreditation Type means as part of Accreditation, the appointment of an Accredited Practitioner with one or more of the following: admitting privileges, allied health privileges, anaesthetic privileges, assist privileges, consulting privileges, contract of employment privileges, diagnostic privileges and procedural privileges. The Board may from time to time approve other Accreditation Types.

Accredited means the status conferred on a Medical Practitioner or Allied Health Professional permitting them to provide services within an Icon Facility after having satisfied the Credentialing requirements provided in these By-Laws.

Accredited Practitioner means a Medical Practitioner, Allied Health Professional or other practitioner who has been accredited to provide services within an Icon Facility, and who may be an **Accredited Medical Practitioner** or **Accredited Allied Health Professional**, with Accreditation to perform services at an Icon Facility within the Accreditation Category, Accreditation Type and Scope of Practice notified in the appointment.

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to Icon, and is in an amount and on terms that Icon considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the Chief Executive Officer of Icon in accordance with the provisions of these By-Laws.

Allied Health Professional means a person registered under the applicable legislation to practice as an Allied Health Professional in the State in which an Icon Facility is located, or other categories of appropriately qualified health professionals as approved by the Group Executive.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety or organisational outcomes.

Board means the Board of Directors of the Integrated Clinical Oncology Network Pty Ltd.

By-Laws means these By-Laws.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Competence means, in respect of a person who applies for Accreditation, that the person is possessed of the necessary aptitude in the application of knowledge and skills in interpersonal relationships, decision making and performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Credentials means, in respect of a person who applies for Accreditation, the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to the person's Competence, Performance and professional suitability to provide safe, high quality health care services. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal regard are relevant to their Credentials.

Credentialing means, in respect of a person who applies for Accreditation, the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of the applicant for the purpose of forming a view about their Credentials, Competence, Performance and professional suitability to provide safe, competent, ethical and high-quality health care services within an Icon Facility.

Current Fitness is the current fitness required of an applicant for Accreditation to carry out the Scope of Practice sought or currently held. A person is not to be considered as having current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder (including habitual drunkenness or addiction to deleterious drugs) which detrimentally affects or is likely to detrimentally affect the person’s physical or mental capacity to practice medicine or allied health (as the case may be).

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Medical Practitioners, hospital personnel, health care professionals, patients, family members, or others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of Icon.

Emergency Accreditation means the process provided in these By-Laws whereby a Medical Practitioner or Allied Health Professional is accredited for a specified short period on short notice in an emergency situation.

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to Icon.

Facility means the day hospital or Icon facility to which an application for Accreditation is made.

Flying Minute (or vote outside a committee) applies when a motion must be passed in writing and given to all committee members. The motion must be passed be a simple majority.

Group Executive means the person appointed to the position of Group Executive of Icon or any person acting, or delegated to act, in that position.

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to Icon.

Medical Advisory Committee means the medical advisory committee of Icon referred to as MAC.

Medical Director means the person appointed to the position of Medical Director of Icon or any person acting, or delegated to act, in that position.

Medical Practitioner means, for the purposes of these By-Laws, a person registered under the applicable legislation to practice medicine in the State in which an Icon Facility is located.

New Clinical Services means clinical services, chemotherapy protocols, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of an Icon Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Medical Practitioners.

Organisational Capability means Icon's ability to provide the facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required. In some jurisdictions the approved level of service capability may be specified on the Icon Facility license to operate (for example in Queensland the licensed clinical services capability).
Organisational Capability may also be referred to as service capability.

Organisational Need means the extent to which Icon is required to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet consumer and community needs and aspirations.

Patient means a person admitted to, or treated as a patient, at Icon.

Performance means the extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known good Clinical Practice and results in expected patient benefits.

Re-accreditation means the process provided in these By-Laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

Salaried Medical Officer means a Medical Practitioner who is an employee of Icon, who has been granted Accreditation and Scope of Practice pursuant to these By-Laws.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within an Icon Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges.

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Compilation No.105. July 2016) and is registered under the applicable legislation to practice medicine in that specialty in the State in which an Icon Facility is located.

Temporary Accreditation means the process provided in the By-Laws whereby a Medical Practitioner or Allied Health Professional is accredited for a limited period.

Threshold Credentials means the minimum credentials for each clinical service, procedure or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials are to be approved by the Group Executive and may be incorporated into an Accreditation policy.

Visiting Allied Health Professional means an Allied Health Professional who is not an employee of Icon, and who has been granted Allied Health Accreditation and Scope of Practice pursuant to these By-Laws.

Visiting Medical Officer means a Medical Practitioner who is not an employee of Icon, who has been granted Accreditation and Scope of Practice pursuant to these By-Laws. Visiting Medical Officers include visiting Specialist Medical Practitioners.

4.2 Interpretation

Headings in these By-Laws are for convenience only and are not to be used as an aid in interpretation.

In these By-Laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender shall also include feminine gender, words importing the singular shall also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.

The Group Executive may delegate any of the responsibilities conferred upon him/her by the By-Laws in his/her complete discretion, but within any delegation parameters approved by the Board.

Any dispute or difference which may arise as to the meaning or interpretation or application of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Group Executive. There is no appeal from such a determination by the Group Executive.

4.3 Meetings

The Group Executive is responsible for the overall governance of Icon and to ensure effective governance the Group Executive, or delegate, will establish committees to undertake various governance functions of the Group Executive in relations to clinical review, clinical quality improvement, credentialing and strategic review.

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee. If there are no terms of reference, where there is an odd number of members a quorum will be a majority of the members, or where there is an even number of members a quorum will be half of the number of the members plus one. A Flying Minute will apply in circumstances approved by the Group Executive.

Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.

Voting, if not specified elsewhere, shall be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means). There shall be no proxy vote.

In the case of an equality of votes, the chairperson will have the casting vote.

A committee established pursuant to these By-Laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed beyond the purpose for which the information was made available, subject to the exceptions set out in these By-Laws

Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and subject to any agreed resolution on the matter shall take no part in any relevant discussion or resolution with respect to that particular matter. This will include a member the Medical Advisory Committee or Credentialing Committee whose application for Accreditation is being considered.

4.4 Indemnity for committee members

Icon will keep the members of its committees indemnified against claims (meaning any originating process or a legal proceeding or arbitration, cross-claim or counter-claim or similar notice claiming compensation) made against any of them in relation to the performance of their functions on a committee as set out in these By-Laws and any approved terms of reference, provided that:

- they have performed their functions in good faith and without demonstrated malice, and
- where the Icon insurance policy responds to the claim, the terms and conditions of the insurance policy will apply in respect of the indemnity, and the conduct of the claim and appointment of lawyers will be at the direction of Icon's insurer.

5. Introduction

5.1 Purpose of this document

(a) The By-Laws provide direction to the Group Executive in relation to the exercise of certain aspects of their managerial responsibility.

(b) Patient care is provided by Accredited Practitioners who have been granted access to use an Icon Facility in order to provide that care. The By-Laws define the relationship and obligations between Icon and its Accredited Practitioners.

(c) This document sets out certain terms and conditions upon which Medical Practitioners and Allied Health Professionals may apply to be Accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit patients and/or care and treat patients at an Icon Facility, and the terms and conditions for continued Accreditation.

(d) Every applicant for Accreditation will be given a copy of this document and Annexures before or at the time of making an application. It is expected that the By-Laws are read in their entirety by the applicant as part of the application process.

(e) Icon aims to maintain a high standard of patient care and to continuously improve the safety and quality of its services. The By-Laws implement measures aimed at maintenance and improvements in safety and quality.

Health care in Australia is subject to numerous legislation and standards. The By-Laws assist in compliance with certain aspects of this regulation but are not a substitute for review of the relevant legislation and standards.

Part B – Terms and Conditions of Accreditation

6. Compliance with By-Laws

6.1 Compliance obligations

(a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-Laws at all relevant times when admitting, caring for or treating patients, or otherwise providing services at Icon.

(b) Any non-compliance with the By-Laws may be grounds for suspension, termination, or imposition of conditions.

(c) Unless specifically determined otherwise by the Group Executive in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Group Executive, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-Laws and any terms, express or implied, in a contract or employment or engagement.

6.2 Compliance with policies and procedures

Accredited Practitioners must comply with all policies and procedures of Icon, and the Australian Charter of Healthcare Rights (2019).

6.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, aged care, privacy, coroners, criminal law, health practitioner registration, research, environmental protection, workplace health and safety, antidiscrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, fair trading and trade practices, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of Icon.

In addition, Accredited Practitioners must ensure compliance with, or assist Icon to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards.

6.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance. The insurance must be adequate for the defined Scope of Practice and level of clinical activity.

Accredited Practitioners must at all times maintain registration with their relevant health registration board (local and/or national) that regulates the provision of services in the State where an Icon Facility is located.

Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration with the relevant health professional registration board, and all other relevant licenses or registration requirements for the Scope of Practice

granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for Icon to obtain that information directly.

6.5 Standard of conduct and behaviour

(a) Icon expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves at all times in accordance with:

(i) the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;

(ii) the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;

(iii) the Values of Icon;

(iv) the Strategic Intent of Icon;

(v) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-Laws; and

(vi) all reasonable requests made with regard to personal conduct in facilities operated by Icon.

(b) Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behavior.

(c) Upon request by the Group Executive the Accredited Practitioner is required to meet with the Group Executive and any other person that the Group Executive may ask to attend the meeting, to discuss matters in a) or b) above, or any other matter arising out of these By-Laws.

6.6 Notifications

Accredited Practitioners must immediately advise the Group Executive, and follow up with written confirmation within 2 days, should:

(a) an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her patient (irrespective of whether this relates to a patient of an Icon Facility), by the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency;

(b) an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a patient of Icon;

(c) the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a patient of Icon and irrespective of whether this is noted on the public register or is privately agreed with a registration board;

(d) professional indemnity membership or insurance or Medicare provider number be made

conditional or not be renewed or terminated, or should limitations be placed on insurance or professional indemnity coverage or Medicare provider number;

(e) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;

(f) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practice or that would require any special assistance to enable him or her to practice safely and competently;

(g) the Accredited Practitioner be charged with having committed or is convicted of a sex, violence or other criminal offence. The Accredited Practitioner must provide Icon with an authority to conduct at any time a criminal history check with the appropriate authorities;

(h) the Accredited Practitioner believe that patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of Icon; or

(i) the Accredited Practitioner make a mandatory notification to a health practitioner registration board (for example Medical Board) in relation to another Accredited Practitioner of Icon.

In addition, Accredited Practitioners should inform themselves of their personal obligations in relation to external notifications and ensure compliance with these obligations, including for example as a member of a Medical Advisory Committee in New South Wales pursuant to the Private Health Facilities Act (NSW) or mandatory reporting to a Medical Board. Icon expects the Accredited Practitioner to comply with these obligations.

6.7 Continuous disclosure

(a) The Accredited Practitioner must keep the Group Executive continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon:

(i) the Accreditation of the Accredited Practitioner;

(ii) the Scope of Practice of the Accredited Practitioner;

(iii) the ability of the Accredited Practitioner to safely deliver health services to his/her patients within the Scope of Practice;

(iv) the Accredited Practitioner's registration or professional indemnity insurance arrangements or Medicare provider number;

(v) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a patient;

(vi) adverse outcomes, complications or complaints in relation to the Accredited Practitioner's patients (current or former) of Icon;

(vii) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and

(viii) the reputation of Icon

(b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Group Executive informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, patient

complaints, health complaints body complaints or investigations, or other inquiries involving patients of the Accredited Practitioner that were treated at an Icon Facility.

6.8 Representations and media

Unless an Accredited Practitioner has the prior written consent of the Group Executive, an Accredited Practitioner may not use Icon's (which for the purposes of this provision includes a corporate or business name of Icon, its parent companies or subsidiary companies) name, letterhead, or in any way suggest that the Accredited Practitioner represents these entities.

The Accredited Practitioner must obtain the Group Executive's prior approval before interaction with the media regarding any matter involving Icon or a patient.

6.9 Committees

Icon requires Accredited Practitioners, as reasonably requested by the Group Executive, to assist it in achieving its goals and Strategic Intent, and provision of high-level care and services, through membership of committees of Icon. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; participating in medical, nursing and other education programs; and attending meetings of Medical Practitioners and/or Allied Health Professionals.

6.10 Confidentiality

(a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Icon's policy, the 'Australian Privacy Principles' established by the *Privacy Act (Cth 1988),* and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring Icon into breach of these obligations.

(b) Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information.

(c) Accredited Practitioners will comply with common law duties of confidentiality.

(d) The following will also be kept confidential by Accredited Practitioners:

(i) commercial in confidence business information concerning Icon;

(ii) the particulars of these By-Laws;

(iii) information concerning Icon's insurance arrangements;

(iv) information concerning any patient or staff of Icon;

(v) information which comes to their knowledge concerning patients, clinical practice, quality improvement, peer review and other activities which relate to the assessment and evaluation of clinical services.

(e) In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:

(i) where disclosure is required to provide continuing care to the patient;

(ii) where disclosure is required by law;

(iii) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, or Icon;

(iv) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or

(v) where disclosure is required in order to perform some requirement of these By-Laws.

(f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

6.11 Communication

Accredited Practitioners are required to familiarise themselves with the organisational structure of Icon.

Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, Group Executive, Medical Director, Director of Nursing and Day Oncology, Icon Committees, staff of Icon and other Accredited Practitioners.

Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal or billing information, which may otherwise be restricted by the *Privacy Act*. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the *Privacy Act* and only for proper purposes and functions.

7. Safety and quality

7.1 Admission, availability, communication, and discharge

(a) All Accredited Practitioners shall admit or treat Patients at an Icon Facility on a regular basis and be an active provider of services at an Icon Facility.

(b) Accredited Practitioners will admit and treat Patients only within the Accreditation Category, Accreditation Type and Scope of Practice granted, including any terms or conditions attached to the approval of Accreditation.

(c) Accredited Practitioners will not provide services or practice outside of the defined service capability of Icon.

(d) Accredited Practitioners who admit Patients to Icon for treatment and care accept that they are at all times responsible for the care of their patient and must ensure that they are available to treat and care for those patients at all times, or failing that, that other arrangements as permitted by the By-Laws are put in place to ensure the continuity of treatment and care for those patients.

(e) Accredited Practitioners must visit all patients admitted for treatment as frequently as is required by the clinical circumstances of those patients and as would be judged appropriate by professional peers. An Accredited Practitioner will be contactable to review the patient in person or their on-call or locum cover is available as requested by nursing staff to review the patient in an Icon Facility. Accredited Practitioners must ensure that all reasonable requests by Icon staff are responded to in a timely manner and in particular patients are promptly attended to when reasonably requested by Icon staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner within an appropriate timeframe to provide the care and treatment and shall advise the staff of the Icon Facility of this arrangement.

(f) Accredited Practitioners must be available and attend upon patients of the Accredited Practitioner in a timely manner when requested by Icon Facility staff or be available by telephone in a timely manner to assist Icon staff in relation to the Accredited Practitioner's patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist and shall advise the staff of the Icon Facility of this arrangement.

(g) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Group Executive. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.

(h) A locum must be approved in accordance with these By-Laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Icon Facility and all relevant persons are aware of the locum cover and the dates of locum cover.

(i) Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Icon executive, patients and the patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(j) The Accredited Practitioner must appropriately direct the care that is provided by Icon staff and other practitioners. This includes providing adequate instructions to, and supervision of, Icon staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.

(k) Adequate instructions and clinical handover is required to be given to Icon staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered.

(l) If care is transferred to another Accredited Practitioner, this must be noted on the patient medical record and communicated to the Site Manager or Nurse Manager.

(m) Accredited Practitioners must participate in formal on call arrangements as reasonably required by Icon. Persons providing on-call or cover services must be Accredited at the Icon Facility.

(n) The Accredited Practitioner must ensure that their patients are not discharged without the approval of the Accredited Practitioner, complying with Icon's discharge policy/processes and completing all patient discharge documents required by Icon. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner.

7.2 Clinical Procedures

Accredited Practitioners acknowledge the importance of, and will participate in, various measures aimed at ensuring safety and quality, which includes but is not limited to participating in or allowing to occur procedures relating to correct site, team time out and infection control.

7.3 Icon, State Based and National Safety Programs, Initiatives and Standards

Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by Icon based upon its own patient safety and quality improvement program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care, a State based division of a Health Department, or a State based independent statutory body).

Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that Icon elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon Icon and require assistance from the Accredited Practitioner to ensure compliance.

Accredited Practitioners shall comply with and take all reasonable actions to assist Icon to comply with each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines or hospital accreditation processes.

7.4 Treatment and financial consent

Accredited Practitioners must obtain fully informed consent for treatment (except where it is not practical in cases of emergency) from the patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards (including applicable legislation) and in accordance with the policy and procedures of Icon.

For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.

The consent will be evidenced in writing and signed by the Accredited Practitioner and patient or their legal guardian or substituted decision maker.

It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the patient is admitted or treated, with this the sole legal responsibility of the Accredited Practitioner. The consent process will ordinarily include an explanation of the patient's condition and prognosis, treatment and alternatives, inform the patient of material risks associated with treatment and alternatives, following which consent to the treatment will be obtained. All associated informed consent documentation must be recorded within the Accredited Practitioner medical record or electronic record.

A procedural consent form/s will be required for each procedure.

A course of treatment consent will be required at commencement of treatment or change of treatment or every 12 months (whichever comes first).

The consent process must also satisfy Icon's requirements from time to time as set out in its policy and procedures, including in relation to the documentation to be provided to an Icon Facility.

Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their patients in accordance with the relevant legislation, health fund agreements, policy and procedures of Icon, including in relation to the use of high-cost drugs.

7.5 Patient Records

Accredited Practitioners must ensure that:

(a) Patient records held by Icon are adequately maintained for patients treated by the Accredited Practitioner;

(b) Patient records are maintained at Icon facilities and are not removed from the facility;

(c) Patient records maintained by Icon are accessible and include all relevant information and documents reasonably necessary to allow Icon nursing and allied health personnel and other Accredited Practitioners to care for patients, including provision of clinical information, pathology, radiology and other investigative reports in a timely manner;

(d) Patient records satisfy Icon's policy requirements, legislative requirements, State based standards, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, and health fund obligations;

(e) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the patient, with the entries dated, timed and signed;

(f) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs orders clearly and legibly in the medication chart maintained by Icon;

(g) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders;

(h) An anesthetic report is completed, as well as documentation of the pre-anesthetic evaluation, fully informed anesthetic consent and post-anesthetic evaluation (where required);

(i) Where appropriate a discharge summary or discharge letter is completed that includes all relevant information reasonably required by the referring practitioner, general practitioner, or other treating practitioner for ongoing care of the patient.

7.6 Financial information and statistics

(a) Accredited Practitioners must record all data required by Icon to meet health fund obligations, collect revenue and allow compilation of health care statistics.

(b) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Icon policy and regulatory requirements

7.7 Quality improvement, risk management and regulatory agencies

(a) Accredited Practitioners are required to attend and participate in Icon's safety, quality, risk management, education and training activities, including clinical practice review and peer review activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care).

(b) Accredited Practitioners will report to Icon incidents, complications, adverse events and complaints (including in relation to the Accredited Practitioner's Patients) in accordance with Icon

policy and procedures and where required by the Group Executive, or delegate, will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management, and open disclosure processes.

(c) Accredited Practitioners will participate in risk management activities and programs, including the implementation by Icon of risk management strategies and recommendations from system reviews.

(d) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where Icon requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, Coroner, Police, State Health Department and its agencies or departments, State Private Health Regulatory/Licensing Units, and Commonwealth Government and its agencies or departments.

7.8 Clinical specialty committees

The Group Executive may establish clinical specialty committees for the purpose of reviewing and advising the Group Executive on performance of the clinical specialty by reference to Icon's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.

Each clinical specialty committee, in consultation with the Group Executive, will establish terms of reference for the committee and will report annually, or as required by the Group Executive, on its activities to the Medical Advisory Committee, and make recommendations to the Medical Advisory Committee on issues relevant to the clinical specialty.

7.9 Participation in clinical teaching activities

Accredited Practitioners, if requested, are required to participate in Icon's clinical teaching program where reasonable.

7.10 Research

(a) Icon approves the conduct of research (including clinical trials) in Icon Facilities. However, no research activity will be undertaken without the prior approval of the relevant Icon Research Committee and accredited Human Research Ethics Committee approval, following written application by the Principle Investigator.

(b) The activities to be undertaken in the research protocol must fall within the Scope of Practice of the Accredited Practitioner.

(c) For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.

(d) Research will be conducted in accordance with National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research 2015 (as amended and updated from time to time), and other applicable legislation.

(e) An Accredited Practitioner has no power to bind Icon to a research project (including a clinical trial) by executing a research agreement.

There is no right of appeal from a decision to reject an application for research

7.11 Obtain written approval for New Clinical Services

(a) Before treating patients with New Clinical Services, an Accredited Practitioner is required to obtain the prior written approval of the Group Executive, Medical Director and the Medical Advisory Committee and what is proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained and must fall within the licensed service capability of the Icon facility.

(b) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.

(c) If research is involved, then By-law 7.10 dealing with research must be complied with.

(d) The Group Executive's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

7.12 Utilisation

Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Group Executive, of the expectations in relation to exercising Accreditation and utilisation of Icon facilities. Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise an Icon Facility in accordance with the specified expectations.

7.13 Continuing Professional Development and Peer Review

(a) Accredited Practitioners may be asked to provide evidence of Continuing Professional Development Upon appointment and thereafter when re-credentialing.

(b) The Group Executive and Medical Director will maintain responsibility for all peer review information and data, reporting to the Medical Advisory Committee and the Board.

(c) The Group Executive or Medical Director may request Accredited Practitioners to participate in annual peer review process to capture performance data relative to their peers.

(d) Accredited Practitioners must support peer review as a means of identifying improvement opportunities and to understand differences relative to expectations.

(e) The Group Executive, in conjunction with the Medical Advisory Committee will take final action on identified issues, negative outcomes or areas of non-conformance.

(f) The Group Executive's decision is final.

Part C – Accreditation of Medical Practitioners

8. Credentialing and Scope of Practice

8.1 Eligibility for Accreditation as a Medical Practitioner

Accreditation as a Medical Practitioner will only be granted if the Medical Practitioner demonstrates adequate Credentials, is professionally competent, satisfies the requirements of the By-Laws, and is prepared to comply with the By-Laws and Icon policies and procedures.

By the granting of Accreditation, the Medical Practitioner accepts compliance with the By-Laws and Icon policies and procedures.

Any Medical Practitioner who falls outside of Accreditation requirements and therefore is not subject to a Credentialing process, before being permitted to attend an Icon Facility and be involved in clinical care of patients, will be provided with and agree to 'terms of attendance' (however phrased) that will govern attendance at an Icon Facility, including appropriate supervision, and the terms of the By-Laws where applicable and appropriate will be incorporated into the terms of attendance.

8.2 Entitlement to treat Patients at Icon Facilities

(a) Medical Practitioners who have received Accreditation pursuant to the By-Laws are entitled to make a request for access to facilities for the treatment and care of their patients within the limits of the Accreditation Category, Accreditation Type and Scope of Practice attached to such Accreditation at an Icon Facility and to utilise services and equipment provided by the Icon Facility for that purpose, subject to the provisions of the By-Laws, Icon policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

(b) The decision to grant access to facilities for the treatment and care of a Medical Practitioner's patients is on each occasion within the sole discretion of the Group Executive and the grant of Accreditation contains no conferral of, or a general expectation of, a 'right of access'.

(c) A Medical Practitioner's use of Icon facilities for the treatment and care of patients is limited to the Scope of Practice granted by the Group Executive and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular patient is subject always to bunker/chair availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed.

8.3 Responsibility and basis for Accreditation and granting of Scope of Practice

The Group Executive, or delegate will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Group Executive will make independent and informed decisions and in so doing will have regard to the matters set out in these By-Laws and will have regard to the recommendations of the Medical Advisory Committee. The Group Executive may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

8.4 Principles of Credentialing and Accreditation

The following principles should be considered and guide those persons involved in making decisions in the Credentialing and Accreditation process:

(a) Credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of maintaining and improving the safety and quality of health care services.

(b) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community.

(c) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals.

(d) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals.

(e) Credentialing and Accreditation and any reviews should be a non-punitive process, with the objective of maintaining and improving the safety and quality of health care services.

(f) Processes for Credentialing and Accreditation depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies.

(g) Processes of Credentialing and Accreditation should be fair and transparent, although recognising the ultimate ability of the Board and Group Executive to make decisions that they consider to be in the best interests of the organisation, its current and future patients.

8.5 Medical Advisory Committee

The Group Executive shall convene a Medical Advisory Committee and it will function in accordance with the terms of reference established for the Medical Advisory Committee and pursuant to any requirements set out in these By-Laws. The Terms of Reference set out in Schedule 1 of these By-Laws will apply to the Medical Advisory Committee.

The Group Executive will approve all membership including elected members and appointed members. The Board will have final approval of all members including elected Chairperson and Deputy Chairperson.

The Medical Advisory Committee may establish a Credentialing Sub Committee.

The Credentialing Sub Committee will function in accordance with the terms of reference established for the Medical Advisory Committee. The primary role of a Credentialing Sub Committee will be to conduct aspects of the Credentialing requirements set out in these By-Laws and make recommendations to the Medical Advisory Committee. The responsibilities set out in these By-Laws in relation to Credentialing will still ultimately remain with the Medical Advisory Committee.

In the absence of a Credentialing Sub Committee, the role will be performed by the Medical Advisory Committee. If the jurisdiction in which the Facility is located requires a separate Credentialing Sub Committee to consider and make recommendations relating to Credentialing, but the role is performed by the Medical Advisory Committee, the terms of reference for the Credentialing Sub Committee will include a process that provides for closing the Medical Advisory Committee meeting and reconvening it as a Credentialing Sub Committee meeting, including recording of separate minutes.

In addition to the terms of reference established for the Medical Advisory Committee or Credentialing Sub Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to Icon and Committee members. For example, the obligations imposed pursuant to the relevant state or territory Private Health Facilities Act.

The Group Executive appointed members will include the Director of Nursing and Day Oncology, Director of Icon Research, Pharmacy Representative and National Quality Manager.

In making determinations about applications for Accreditation there will ordinarily be at least one member of the same specialty as the applicant on the Medical Advisory Committee, which may mean co-opting a committee member in order to assist with the determination. It is, however, recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the Medical Advisory Committee.

9. The process for appointment and re-appointment

9.1 Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners

(a) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at an Icon Facility) and Re-Accreditation (where the applicant currently holds Accreditation at an Icon Facility) as Medical Practitioners must be made in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the Group Executive at least six weeks prior to the Medical Practitioner seeking to commence at an Icon Facility or at least two months prior to expiration of the current Accreditation. Where this timeframe is unable to be achieved due to Organisational Need or patient needs, Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the Group Executive.

(b) Applications will include a declaration by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, that the Medical Practitioner will comply in every respect with the By-Laws in the event that the Medical Practitioner's application for Accreditation is approved.

(c) The Group Executive may interview Medical Practitioners and/or request further information from applicants that the Group Executive considers appropriate.

(d) The Group Executive will ensure that applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes from any interview conducted, to the Medical Advisory Committee for consideration.

9.2 Consideration by the Medical Advisory Committee and Credentialing Sub Committee

(a) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the Group Executive.

(b) Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence, Current Fitness, Organisational Capability and Organisational Need.

(c) The Medical Advisory Committee will make recommendations to the Group Executive as to whether the application should be approved and if so, on what terms, including the Accreditation Category, Accreditation Type and Scope of Practice to be granted.

(d) The Medical Advisory Committee will act and make recommendations in accordance with its terms of reference and any relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.

(e) In instances where the Medical Advisory Committee has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to the Group Executive to:

(i) initiate an Internal Review;

(ii) initiate an External Review;

(iii) grant Scope of Practice for a limited period of time followed by review;

(iv) apply conditions or limitations to Scope of Practice requested; and/or

(v) apply requirements for relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

(f) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice, the Medical Advisory Committee may recommend refusal of the application.

9.3 Consideration of applications for Initial Accreditation by the Group Executive

(a) The Group Executive will consider applications for initial Accreditation as Medical Practitioners referred to the Group Executive by the Medical Advisory Committee and will decide whether the applications should be rejected or approved and, if approved, whether any conditions should apply.

(b) In considering applications, the Group Executive will give due consideration to any other information relevant to the application as determined by the Group Executive, but the final decision is that of the Group Executive and the Group Executive is not bound by the recommendation of the Medical Advisory Committee. In addition to considering the recommendations of the Medical Advisory Committee, including Organisational Capability and Organisational Need, the Group Executive may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.

(c) The Group Executive may defer consideration of an application in order to obtain further information from the Medical Advisory Committee, the Medical Practitioner or any other person or organisation.

(d) If the Group Executive requires further information from the Medical Practitioner before making a determination, they will forward a letter to the Medical Practitioner:

(i) informing the Medical Practitioner that the Group Executive requires further information from the Medical Practitioner before deciding the application;

(ii) identifying the information required. This may include, but is not limited to, information from third parties such as other hospitals relating to current or past Accreditation, Scope of Practice and other issues relating to or impacting upon the Accreditation with that other hospital; and

(iii) requesting that the Medical Practitioner provide the information in writing or consent to contacting a third party for information or documents, together with any further information the Medical Practitioner considers relevant within fourteen (14) days from the date of receipt of the letter.

(e) In the event that the information or documents requested by the Group Executive is not supplied in the time set out in the letter, the Group Executive may, at their discretion, reject the application or proceed to consider the application without such additional information.

(f) The Group Executive will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Accreditation Category, Accreditation Type and Scope of Practice granted.

(g) The Group Executive will ensure that information relating to Accreditation Category, Accreditation Type and Scope of Practice is accessible to those providing clinical services within the Icon Facility.

(h) There is no right of appeal from a decision to reject an application for initial Accreditation, or any terms or conditions that may be attached to approval of an application for initial Accreditation.

9.4 Initial Accreditation tenure

(a) Initial Accreditation as a Medical Practitioner at an Icon Facility will be for a probationary period of one year.

(b) Prior to the end of the probationary period, a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Group Executive. The Group Executive will seek assistance with the review from the relevant Medical Advisory Committee or Specialty Committee where established. The Group Executive may also initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.

(c) In circumstances where, in respect of a Medical Practitioner:

(i) a review conducted by the Group Executive at the end of the probationary period, or

(ii) a review conducted by the Group Executive at any time during the probationary period, causes the Group Executive to consider the Medical Practitioner's Scope of Practice should be amended for any subsequent Accreditation granted, or

(iii) the probationary period should be terminated, or

(iv) the probationary period should be extended, or

(v) the Medical Practitioner should not be offered further Accreditation; the Medical Practitioner will be:

(vi) notified of the circumstances which have given rise to the relevant concerns, and

(vii) be given an opportunity to be heard and present his/her case.

(d) Should the probationary review outcome, including information obtained in paragraph 9.4(c) above, be unacceptable or insufficient to the Group Executive, they may:

(i) amend the Scope of Practice that will granted for any subsequent Accreditation; or

(ii) reject the continuation of Accreditation.

(e) Should the Medical Practitioner have an acceptable probationary review outcome, the Group Executive may grant an additional Accreditation period of up to three years, on receipt of a signed

declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-Laws.

(f) The Group Executive will make the final determination on Accreditation for all Medical Practitioners at the end of the probationary period. There will be no right of appeal at the end of the probationary period for a determination that Accreditation will not be granted following conclusion of the probationary period, or to any terms or conditions that may be attached to the grant of any Accreditation following the probationary period. All Medical Practitioners shall agree with this as a condition of initial Accreditation.

9.5 Re-Accreditation

(a) The Group Executive will, at least three months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.

(b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the Group Executive at least two months prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(c) The Group Executive and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for initial Accreditation as Medical Practitioners.

(d) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners (excepting applications for Accreditation after the probationary period) are set out in these By-Laws.

9.6 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to the probationary period will be for a term of up to three years as determined by the Group Executive.

9.7 Nature of appointment

(a) Accreditation does not of itself constitute an employment contract nor does it establish of itself a contractual relationship between the Medical Practitioner and Icon.

(b) Accreditation is personal and cannot be transferred to, or exercised by, any other person.

10. Extraordinary Accreditation

10.1 Temporary Accreditation

(a) The Group Executive may grant Medical Practitioners Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the Group Executive. Temporary Accreditation will only be granted on the basis of patient need, Organisational Capability and Organisational Need. The Group Executive may consider Emergency Accreditation for short notice requests.

(b) Applications for Temporary Accreditation as Medical Practitioners must be made in writing on the prescribed form as for initial applications for Accreditation. All questions on the prescribed form must be fully completed and required information and documents submitted before an application will be considered.

(c) Temporary Accreditation may be terminated by the Group Executive for failure by the

Medical Practitioner to comply with the requirements of the By-Laws or failure to comply with Temporary Accreditation requirements.

(d) Temporary Accreditation will automatically cease upon a determination by the Group Executive of the Medical Practitioner's application for Accreditation or at such other time as the Group Executive decides.

(e) The period of Temporary Accreditation shall be determined by the Group Executive, which will be for a period of no longer than ninety (90) days.

(f) There can be no expectation that a grant of Temporary Accreditation will result in a subsequent granting of Accreditation.

(g) The Medical Advisory Committee will be informed of all Temporary Accreditations granted.

(h) There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

10.2 Emergency Accreditation

(a) In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to Patients. Emergency Accreditation may be considered by the Group Executive for short notice requests, to ensure continuity and safety of care for patients and/or to meet Organisational Need.

(b) As a minimum, the following is required:

(i) verification of identity through inspection of relevant documents (e.g. driver's licence with photograph);

(ii) contact as soon as practicable with a member of senior management of an organisation nominated by the Medical Practitioner as their most recent place of Accreditation to verify employment or appointment history;

(iii) verification of professional registration and insurance as soon as practicable;

(iv) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing;

(v) verification will be undertaken by the Group Executive and will be fully documented.

(c) Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or initial Accreditation processes, if required.

(d) Emergency Accreditation will be approved for a limited period as identified by the Group Executive, for the safety of patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the Group Executive.

(e) The Medical Advisory Committee will be informed of all Emergency Accreditation granted.

(f) There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

10.3 Locum Tenens

(a) Locums must be approved by the Group Executive before they are permitted to arrange the admission of and/or to treat patients on behalf of Medical Practitioners.

(b) Temporary Accreditation requirements must be met before approval of locums is granted.

(c) There will be no right of appeal from decisions in relation to locum appointments.

11. Variation of Accreditation or Scope of Practice

11.1 Practitioner may request amendment of Accreditation or Scope of Practice

(a) An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By- laws.

(b) The process for amendment or variation is the same for an application for Re-Accreditation, except the Medical Practitioner will be required to complete a Request for Amendment of Accreditation or Scope of Practice Form and provide relevant documentation and references in support of the amendment or variation.

(c) The process to adopt in consideration of the application for amendment or variation will be as set out in By-Laws 8.1 to 8.3.

(d) The rights of appeal conferred upon Medical Practitioners who apply for amendment or variation are set out in these By-Laws, except an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, Emergency Accreditation, or locum tenens.

(e) Practitioner Special Leave: A Practitioner may request the Medical Director of the facility to furlough accreditation for a stated period for good cause such as study leave so as to preserve the practitioner's right to automatically resume exercising privileges at the end of the period without having to re-apply for accreditation or without threat of termination for non-use of privileges.

12. Review of Accreditation or Scope of Practice

12.1 Group Executive may initiate review of Accreditation or Scope of Practice

(i) The Group Executive may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following: Patient health or safety could potentially be compromised;

(ii) the rights or interests of a patient, personnel or someone engaged in or at an Icon Facility has been adversely affected or could be infringed upon;

(iii) the Medical Practitioner's level of Competence;

(iv) the Medical Practitioner's Current Fitness;

(v) the Medical Practitioner's Performance;

(vi) compatibility with Organisational Capability or Organisational Need;

(vii) the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;

(viii) confidence held in the Medical Practitioner;

(ix) compliance with these By-Laws, including terms and conditions, or a possible ground for suspension or termination of Accreditation may have occurred;

(x) the efficient operation of an Icon Facility could be threatened or disrupted, the potential loss of the Icon Facility's license or accreditation, or the potential to bring Icon into disrepute;

(xi) a breach of a legislative or legal obligation of Icon or imposed upon the Accredited Practitioner may have occurred; or

(xii) as elsewhere defined in these By-Laws.

(b) A review may be requested by any other person or organisation, including parties external to Icon, however the commencement of a review remains within the sole discretion of the Group Executive or as directed by the Board.

(c) The Group Executive will determine whether the process to be adopted is an;

(i) Internal Review; or

(ii) External Review.

(d) Prior to determining whether an Internal Review or External Review will be conducted, the Group Executive may in his or her absolute discretion meet with the Medical Practitioner, along with any other persons the Group Executive considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the Group Executive) before the Group Executive makes a determination whether a review will proceed, and if so, the type of review.

(e) The review may have wider terms of reference then a review of the Medical Practitioner's Accreditation or Scope of Practice.

(f) The Group Executive must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review.

(g) In addition or as an alternative to conducting an internal or external review, the Group Executive will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Group Executive may elect to notify if the Group Executive considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, or it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body the Group Executive may elect to take action under these By-Laws.

12.2 Internal Review of Accreditation and Scope of Practice

(a) The Group Executive will establish the terms of reference of the Internal Review, and may seek assistance from the Medical Advisory Committee or co-opted Medical Practitioners or personnel from within an Icon Facility who bring specific expertise to the Internal Review as determined by

the Group Executive.

(b) The terms of reference, process, and reviewers will be as determined by the Group Executive. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

(c) The Group Executive will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.

(d) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Group Executive.

(e) Following consideration of the report, the Group Executive is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner's Accreditation in accordance with these By-Laws.

(f) The Group Executive must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(g) The Medical Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Group Executive if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

(h) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Group Executive will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Group Executive may elect to notify if the Group Executive considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of Icon.

12.3 External Review of Accreditation and scope of practice

(a) The Group Executive will make a determination about whether an External Review will be undertaken.

(b) An External Review will be undertaken by a person(s) external to Icon and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Group Executive at his/her discretion.

(c) The terms of reference, process, and reviewers will be as determined by the Group Executive. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

(d) The Group Executive will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.

(e) The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Group Executive.

(f) The Group Executive will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical

Practitioner's Accreditation or Scope of Practice in accordance with these By-Laws.

(g) The Group Executive must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(h) The Medical Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Group Executive if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

(i) In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the Group Executive will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Group Executive may elect to notify them if the Group Executive considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of Icon.

13. Suspension, termination, imposition of conditions, resignation, and expiry of Accreditation

13.1 Suspension of Accreditation

(a) The Group Executive may immediately suspend a Medical Practitioner's Accreditation should the Group Executive believe, or have a sufficient concern:

(i) it is in the interests of patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another facility not operated by Icon;

(ii) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;

(iii) it is in the interests of personnel welfare or safety;

(iv) serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient or patients of another facility not operated by Icon, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body;

(v) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;

(vi) the behaviour or conduct is in breach of a direction or an undertaking, or Icon By-Laws, policies and procedures;

(vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Icon Facility at any time, or is bringing the Icon Facility into disrepute;

(viii) the behaviour or conduct is considered disruptive or a Behavioural Sentinel Event;

(ix) the behaviour or conduct of the Medical Practitioner is inconsistent with the values of Icon;

(x) the Medical Practitioner has been suspended by their registration board;

(xi) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Medical Practitioner;

(xii) the Medical Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of Icon;

(xiii) the Medical Practitioner has made a false declaration or provided false or inaccurate information to Icon, either through omission of important information or inclusion of false or inaccurate information;

(xiv) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-Laws or based upon the information contained in a notification suspension is considered appropriate;

(xv) the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

(xvi) the Medical Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

(xvii) the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

(xviii) based upon a finalised Internal Review or External Review pursuant to these By-Laws any of the above criteria for suspension are considered to apply;

(xix) an Internal Review or External Review has been initiated pursuant to these By-Laws and the Group Executive considers that an interim suspension is appropriate pending the outcome of the review; or

(xx) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension.

(b) The Group Executive shall notify the Medical Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

(iv) if the Group Executive considers it applicable and appropriate in the circumstances to invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider the suspension should be lifted;

(v) if Group Executive considers it applicable and appropriate in the circumstances, any

actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and

(vi) the right of appeal, the appeal process and the time frame for an appeal.

(c) As an alternative to an immediate suspension, the Group Executive may elect to deliver a show cause notice to the Medical Practitioner advising of:

(i) the facts and circumstances forming the basis for possible suspension;

(ii) the grounds under the By-Laws upon which suspension may occur;

(iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;

(iv) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and

(v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Group Executive will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with paragraph 13.1(b). Otherwise the Medical Practitioner will be advised that suspension will not occur, however this will not prevent the Group Executive from taking other action at this time, including imposition of conditions, and will not prevent the Group Executive from relying upon these matters as a ground for suspension or termination in the future.

(d) Ordinarily suspension will be suspension of Accreditation in its entirety, however the Group Executive may determine for a particular case that the suspension will be a specified part of the Scope of Practice previously granted and these By-Laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.

(e) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Group Executive.

(f) The affected Medical Practitioner shall have the rights of appeal established by these By-Laws.

(g) The Group Executive will notify the Board and Medical Advisory Committee of any suspension of Accreditation.

(h) If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Medical Practitioner including but not limited to patients outside of Icon, it is in the interests of patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is required by legislation, or for other reasonable grounds, the Group Executive will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

13.2 Termination of Accreditation

(a) Accreditation shall be immediately terminated by the Group Executive if the following has occurred, or if it appears based upon the information available to the Group Executive the

following has occurred:

(i) the Medical Practitioner ceases to be registered with their relevant registration board;

(ii) the Medical Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Practice;

(iii) a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding; or

(iv) a contract of employment or to provide services is terminated or ends, and is not renewed.

(b) Accreditation may be terminated by the Group Executive, if the following has occurred, or if it appears based upon the information available to the Group Executive the following has occurred:

(i) based upon any of the matters in By-Law 12.1(a) and it is considered suspension is an insufficient response in the circumstances;

(ii) based upon a finalised Internal Review or External Review pursuant to these By-Laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Group Executive does not have confidence in the continued appointment of the Medical Practitioner;

(iii) the Medical Practitioner is not regarded by the Group Executive as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Group Executive does not have confidence in the continued appointment of the Medical Practitioner;

(iv) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and Icon does not consider that it has the capacity to accommodate the conditions imposed;

(v) the Medical Practitioner has not exercised Accreditation or utilised the facilities at an Icon Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Group Executive;

(vi) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;

(vii) the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-Laws be a continuous period of six months' incapacity; or

(viii) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.

(c) The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-Laws.

(d) The Group Executive shall notify the Medical Practitioner of:

(i) the fact of the termination;

(ii) the reasons for the termination;

(iii) if the Group Executive considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner why they may consider a termination should not have occurred; and

(iv) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

(e) As an alternative to an immediate termination, the Group Executive may elect to deliver a show cause notice to the Medical Practitioner advising of:

(i) the facts and circumstances forming the basis for possible termination;

(ii) the grounds under the By-Laws upon which termination may occur;

(iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;

(iv) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and

a timeframe in which a response is required from the Medical Practitioner to the show cause notice

Following receipt of the response the Group Executive will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph 13.2(d). Otherwise the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Group Executive from taking other action at this time, including imposition of conditions, and will not prevent the Group Executive from relying upon these matters as a ground for suspension or termination in the future.

(f) All terminations must be notified to the Board and Medical Advisory Committee.

(g) For a termination of Accreditation pursuant to By-law 12.2(a), there shall be no right of appeal.

(h) For a termination of Accreditation pursuant to By-law 12.2(b), the Medical Practitioner shall have the rights of appeal established by these By-Laws.

(i) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Group Executive to the Medical Practitioner's registration board and/or other relevant regulatory agency.

13.3 Imposition of conditions

(a) At the conclusion of or pending finalisation of an Internal or External Review, or in lieu of a suspension, or in lieu of a termination, the Group Executive may elect to impose conditions on the Accreditation or Scope of Practice.

(b) The Group Executive must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(c) If the Group Executive considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.

(d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Group Executive.

(e) The affected Medical Practitioner shall have the rights of appeal established by these By-Laws.

(f) If there is held, in good faith, a belief that the continuation of the unconditional right to practice in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the Group Executive will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

13.4 Resignation and expiry of Accreditation

(a) A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Group Executive, unless a shorter notice period is otherwise agreed by the Group Executive.

(b) A Medical Practitioner who intends to cease treating patients either indefinitely or for an extended period must notify his/her intention to the Group Executive, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Group Executive decides a shorter notice period is appropriate in the circumstances.

(c) If an application for Re-Accreditation is not received within the timeframe provided for in these By-Laws, unless determined otherwise by the Group Executive, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at an Icon Facility after the expiration of Accreditation, an application for Accreditation must be made as an application for initial Accreditation.

(d) If the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need, if the Medical Practitioner will no longer be able to meet the terms and conditions of Accreditation, or where admission of Patients or utilisation of services at an Icon Facility is regarded by the Group Executive to be insufficient, the Group Executive will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss. Following the meeting the Group Executive and Accredited Practitioner may agree that Accreditation will expire, and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Medical Practitioner wishes to admit or treat patients at an Icon Facility, an application for Accreditation must be made as an application for initial Accreditation.

(e) The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Group Executive to take action pursuant to other provisions of these By-Laws, including by way of suspension or termination of Accreditation

14. Appeal rights and procedure

14.1 Rights of appeal against decisions affecting Accreditation

(a) There shall be no right of appeal against a decision to not approve initial Accreditation, Temporary Accreditation, Emergency Accreditation, a locum appointment, or continued Accreditation at the end of a probationary period or Temporary Accreditation, Emergency Accreditation or locum period.

(b) Subject to paragraph 14.1(a) above, a Medical Practitioner shall have the rights of appeal as set out in these By-Laws.

14.2 Appeal process

(a) A Medical Practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal in these By-Laws to lodge an appeal against the decision.

(b) An appeal must be in writing to the Group Executive and received by the Group Executive within the fourteen (14) day appeal period or else the right to appeal is lost.

(c) Unless decided otherwise by the Group Executive in the circumstances of the particular case, which will only be in exceptional circumstances, lodgment of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

(d) Upon receipt of an appeal notice the Group Executive will immediately forward the appeal request to the chairperson of the Board

(e) The chairperson of the Board will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the chairperson of the Appeal Committee.

(f) The Appeal Committee shall comprise at least three (3) persons and will include:

(i) a nominee of the chairperson of the Board, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;

(ii) a nominee of the Group Executive, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;

(iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Board, who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The chairperson of the Board in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above) but is not bound to follow the suggestions or comments.

(g) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the chairperson of the Board will notify the appellant of the members of the Appeal Committee.

(h) Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days' notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee.

(i) The appellant will be given the opportunity to make a submission to the Appeal Committee. The

Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

(j) If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.

(k) The Group Executive (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

(l) If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.

(m) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.

(n) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

(o) The Appeal Committee will make a written recommendation regarding the appeal to the chairperson of the Board, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members reach opposing recommendations, then the chairperson of the Appeal Committee has the deciding vote. A copy of the recommendation will be provided to the appellant.

(p) The Board will consider the recommendation of the Appeal Committee and make a decision about the appeal.

(q) The decision of the Board will be notified in writing to the appellant.

(r) The decision of the Board is final and binding, and there is no further appeal allowed under these By-Laws from this decision.

(s) If a notification has already been given to an external agency, such as a registration Board, then the Board will notify that external agency of the appeal decision. If a notification has not already been given, the Board will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-Laws relating to the decision under appeal.

Part D– Accreditation of Visiting Allied Health Professionals

15. Accreditation and Scope of Practice of Visiting Allied Health Professionals

(a) By-Laws 7 to 13 are hereby repeated in full substituting where applicable Allied Health Professional for Medical Practitioner.

(b) By-law 14 may also be utilised for other health practitioners who do not fall into the category of Medical Practitioner or Allied Health Professional, with the process as modified by the Group Executive to suit the particular circumstances of the case.

(c) Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Group Executive.

Part E – Amending By-Laws, annexures, and associated policies and procedures, and other matters

16. Amendments to, and instruments created pursuant to, the By-Laws

(a) The By-Laws and associated policies and procedures will be reviewed at least every three (3) years.

(b) Amendments to these By-Laws can only be made by approval of the Group CEO or COO after endorsement by Cancer Care Group Executive and Group Medical Director.

(c) All Accredited Practitioners will be bound by amendments to the By-Laws from the date of approval of the amendments by the Group CEO or COO, even if Accreditation was obtained prior to the amendments being made.

(d) The Group CEO or COO may approve any annexures that accompany these By-Laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Group CEO or COO are integrated with and form part of the By-Laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.

(e) The Group CEO or COO may approve forms, terms of reference and policies and procedures that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation and Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.

17. Audit and Compliance

(a) The Group Executive will establish a regular audit process, at intervals determined to be appropriate by the Group Executive or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-Laws relating to Credentialing and Accreditation, any associated policies and procedures, and Accredited Practitioners are practicing within the approved Scope of Practice and any associated conditions.

(b) The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be managed and reported by the electronic credentialing system.

(d) Audit reports will be presented to the Medical Advisory Committee and as requested to the Board by the Group Executive.

Schedule 1 – Medical Advisory Committee Terms of Reference

1. Purpose of Committee

The Icon Group Board "the Board" establishes the Medical Advisory Committee (MAC) in Australia as a part of the Clinical Governance Framework. The purpose of the MAC is to lead and facilitate a culture of clinical safety and quality in medical practice and provide advice to the Board on any clinical matter or health service matter. The MAC has a lead role in credentialing medical and allied health personnel for practice within Icon's services. The Executive authorises the MAC to investigate any activity within this Terms of Reference. The MAC perform obligations according to the By-Laws. The Chairperson of the MAC will consult with the Chief Executive Officer (CEO) before any committee deliberations that may materially adversely affect any Icon medical practitioner or the operational or financial performance.

2. Scope of Committee

The MAC has clinical governance accountability for medicine and medical practice across all clinical sites in Australia. The MAC may establish sub-committees, working groups, and task forces to undertake specific works.

3. Membership

The CEO will endorse all members to the Board, including elected members and appointed members. The Board has final approval, including the Chairperson and Deputy Chairperson. Members' responsibilities include:

1. Representing the medical practitioners within their site or region on all matters
2. Review all reports, minutes, and agenda items before meetings to facilitate robust discussions and shared participation
3. Contribute constructively to discussions within the meeting
4. Following meeting attendance, disseminate documentation and communication of agreed actions and outcomes within their represented site.

<u>Elections</u>

- The MAC members will be elected according to State locations and facility sites to ensure the distribution of scope of practice and specialty
- Three (3) Haematology representatives must be from different Icon sites that provide Haematology services
- Three (3) Medical Oncology representatives must be from different Icon sites that provide Medical Oncology services
- Three (3) Radiation Oncology representatives must have one representative from each of the following three regions:

  New South Wales and Australian Capital Territory

  Queensland

  Western Australia, Victoria, South Australia and Tasmania

Nominations will either be the Medical Practitioners themselves representing their principal place of practice or a Medical Practitioner nominating another practitioner.

MEMBER	DESCRIPTION
Chief Executive Officer	
Medical Director	The Medical Director is required to be a credentialed Medical Oncologist, Haematologist or Radiation Oncologist and will be in addition to the totals of Medical Practitioners listed below The Medical Director will also be a member of the Board
Director of Radiation Oncology	The Director of Radiation Oncology will be a credentialed Radiation Oncologist and will be in addition to the totals of Medical Practitioners listed below:
Three (3) Medical Practitioners with the credentialed scope of Medical Oncology	Elected members
Three (3) Medical Practitioners with credentialed scope of Haematology	Elected members
Three (3) Medical Practitioners with credentialed scope of Radiation Oncology	Elected members
Director of Icon Research	CEO appointed member
Representative of the Quality Unit	CEO appointed member
Pharmacy Clinical Lead	CEO appointed member

Elected Members will include:

- Chairperson elected from and by the members of the MAC
- Deputy Chairperson who will be elected from and by the members of the MAC
- Where there are two or more applicants from one region, a ballot will be conducted
- The Chairperson, with the agreement of the CEO, may authorise the appointment from time to time of experts to assist with specific topics or to sit on specific subcommittees. Such appointees will act on a pro bono basis unless otherwise agreed by the CEO
- Attendees are invited
- Other attendees may be invited by the Chairperson and CEO as required by the agenda.

4. Term of Appointment

Elected members will have term of up to three years with a limit of two continuous terms in office (i.e., no more than six years continuous representation). At the end of the 2 continuous terms of service, an elected member may be appointed for a further 3-year term on a majority vote of MAC members and the CEO.

The Committee's Secretariat will confirm the willingness to serve a second term with the elected member. Towards the end of an elected member's first term, the Committee Secretariat will seek that member's consideration of a second term's representation on the Committee.

All members must disclose their membership and scope of practice to the relevant health jurisdiction as required by legislation.

5. Termination of Membership

Any member of the MAC may resign by giving notice of their intention to resign to the CEO. The CEO may terminate membership or Chairperson of the MAC where the member:

- Fails to attend the majority of meetings over 12 months
- Fails to attend three (3) consecutive meetings
- Has clinical privileges reviewed, suspended, or terminated.

6. Confidentiality

Information provided to any committee or person provided in confidence shall be regarded as confidential and not be disclosed to any third party or beyond the forum purpose for which such information is made available.

7. Code of Conduct

The MAC and any sub-committee convened for the specific activities of the MAC must comply at all times with all legal requirements, including the common law and relevant State / Territory and Commonwealth legislation. Specifically, the committee must conduct itself according to the rules of natural justice, without conflicts of interest or bias and in a manner which does not breach relevant legislation including privacy, trade practices, whistle-blower, equal opportunity, and defamation legislation.

Conflict of interest may arise if:

- The member has a financial, pecuniary, personal or other interest in the application for Clinical Privileges; or
- The member is related to or is in a personal relationship with the Medical Practitioner or Allied Health Professional.

The member must declare the conflict and shall not be involved in considering applications for or requests to review such applications.

For the By-laws, membership of the same college or professional association by any member of the MAC shall not be regarded as a conflict of interest.

8. Responsibilities

In respect of medical practice:

Domains	Responsibilities
Clinical Governance and leading a culture of quality	• Plans and conducts meetings according to the Terms of Reference, assuring proper frequency and attendance. • Performs the obligations conferred upon the Medical Advisory Committee according to the By-laws • Receives advice and notes changes to relevant medical legislation, regulation and standards and ensures compliance • Formulate, approve and maintain the currency of medical and other pertinent clinical standards, policy, procedures, and clinical systems and assure adherence • Receive, review and comment on reports and minutes of the sub-committees and provide direction if required • Escalates significant matters to the Group Clinical Governance Committee and the Executive.
Clinical workforce	• Defines requirements for clinical privileges, credentialing and competencies of medical personnel and assures that all medical personnel have compliance with these and the By-laws • Advises the CEO on the information that should be requested and provided by Medical Practitioners for the provision of specific clinical privileges • At the request of the CEO, undertake an internal review regarding the credentials and clinical privileges of a Medical Practitioner or Allied Health Professional • When made aware of matters between a Medical Practitioner and any professional/regulatory bodies, act appropriately to mitigate the risks to Icon.
Clinical practice	• Resolve matters of clinical debate/dispute or a sensitive nature through the appointment of an independent sub-committee with the agreement of the CEO.
	• Reviews, monitors, evaluates and makes recommendations regarding new clinical services procedures as requested by a Medical Practitioner and any professional or the CEO.
	• Receives reports on trends in audits and incidents.
	• Receives reports on medical/clinical research and development.

9. Agenda

- Opening
- Apologies and Leaves of Absence
- Confirmation of Previous Minutes
- Previous Business
- Announcements
- Reports (Sub-Committees or other)
- New Business
- Closure of Meeting

The full agenda may not be required to be covered at each meeting, depending on the key issues and requests from the CEO and Medical Director.

The Credentialing Officer will prepare the agenda for consideration before the meeting by the CEO and the Chair. This report will then be distributed to all members at least three (3) working days before the meeting, which will need to be read before the Committee.

The meetings will be minuted. The CEO will prepare a summary report of proceedings and the key items and submit it to the ICC Board for consideration at the Board meeting. The CEO may present matters of an important nature directly to the ICC Board.

10. Frequency

The MAC will meet each February, April, June, August, October, and December.

11. Quorum

At least fifty per cent of members plus one will constitute a quorum
The group may decide without a quorum to hold a Flying Minute.
Members based outside of Brisbane may physically attend the meetings, and the company will bear the cost of that travel and accommodation to attend the meeting.

12. Committee Performance Plan

The Committee will evaluate and report against an annual performance plan in Appendix 2.

Appendix 1

Facilities covered by the Icon Group Medical Advisory Committee

Icon Cancer Centre – Adelaide
Suite 10, 1st Floor
Tennyson Centre, 520 South Road
KURRALTA PARK SA 5037

Icon Cancer Centre – Cairns
Liz Plummer Cancer Care Centre
Block E, Ground Floor
Corner Lake and Grove Streets
CAIRNS QLD 4870

Icon Cancer Centre – Cairns Private
203 Lake Street
CAIRNS QLD 4870

Icon Cancer Centre – Canberra
5 Allawoona Street
BRUCE ACT 2617

Icon Cancer Centre – Chermside
Level 1, 956 Gympie Road
CHERMSIDE QLD 4032

Icon Cancer Centre – Concord
Building 60 Concord Repatriation General Hospital
Hospital Road
CONCORD NSW 2139

Icon Cancer Centre – Epworth Richmond
Level 4,
Epworth Centre,
32 Erin St,
Richmond VIC 3121

Icon Cancer Centre – Epworth Freemasons
Basement,
166 Clarendon St,
East Melbourne VIC 3121

Icon Cancer Centre – Geelong
Epworth Geelong
Epworth Place
WAURN PONDS VIC 3216

Icon Cancer Centre - Gold Coast Private Hospital
Gold Coast Private Hospital
Lower Ground 3, 14 Hill Street
SOUTPORT QLD 4215

Icon Cancer Centre - Gold Coast University Hospital
Gold Coast University Hospital
Block C, Lower Ground, 1 Hospital Blvd
SOUTHPORT QLD 4215

Icon Cancer Centre - Gosford
41 William Street
GOSFORD NSW 2250

Icon Cancer Centre - Greenslopes
Greenslopes Private Hospital
Newdegate Street
GREENSLOPES QLD 4120

Icon Cancer Centre – Hobart
2 Melville Street
HOBART TAS 7000

Icon Cancer Centre – Holmesglen
Holmesglen Private Hospital
490 South Road
MOORABBIN VIC 3189

Icon Cancer Centre – Mackay
148 Sams Road
NORTH MACKAY QLD 4740

Icon Cancer Centre – Maitland
Maitland Private Hospital
175 Chisholm Road
ASHTONFIELD NSW 2323

Icon Cancer Centre - Maroochydore
60 Wises Road
MAROOCHYDORE QLD 4558

Icon Cancer Centre – Midland
6 Centennial Place
MIDLAND WA 6056

Icon Cancer Centre – Mildura
Mildura Health Private Hospital
3-4 Healthscope Court
MILDURA VIC 3500

Icon Cancer Centre – Moreland
John Fawkner Private Hospital
275 Moreland Road
COBURG VIC 3058

Icon Cancer Centre Mulgrave
535 – 539 Police Road
MULGRAVE VIC 3170

Icon Cancer Centre – Noarlunga
10 Morton Road
CHRISTIE DOWNS SA 5164

Icon Cancer Centre – North Lakes
9 McLennan Court
NORTH LAKES QLD 4509

Icon Cancer Centre – Norwest
Norwest Private Hospital
11 Norbirk Drive
BELLA VISTA NSW

Icon Cancer Centre - Redland
Bayside Business Park
16-24 Weippin Street
CLEVELAND QLD 4163

Icon Cancer Centre – Revesby
3 MacArthur Avenue
REVESBY NSW 2212

Icon Cancer Centre - Rockingham
2 Civic Boulevard,
ROCKINGHAM WA 6168

Icon Cancer Centre - South Brisbane
Mater Medical Centre
Level 4, 293 Vulture Street
SOUTH BRISBANE QLD 4101

Icon Cancer Centre - Southport
Premion Place
Level 9, 39 White Street
SOUTHPORT QLD 4215

Icon Cancer Centre - Springfield
Level 1, Cancer Care Centre
Mater Private Hospital
30 Health Care Drive
SPRINGFIELD QLD 4300

Icon Cancer Centre - Toowoomba
Cancer Care Centre
St Andrew's Hospital
280 North Street
TOOWOOMBA QLD 4350

Icon Cancer Centre – Townsville
9-13 Bayswater Road
HYDE PARK QLD 4812

Icon Cancer Centre - Wahroonga
Sydney Adventist Hospital
Level 2 Clark Tower
185 Fox Valley Road
WAHROONGA NSW 2076

Icon Cancer Centre - Warrnambool
South West Regional Cancer Centre,
26-30 Ryot St,
WARRNAMBOOL VIC 3280

Icon Cancer Centre - Wesley
Wesley Medical Centre
Level 1 – 40 Chasely Street
AUCHENFLOWER QLD 4066

Icon Cancer Centre - Windsor Gardens
Level 1,
480 North East Road,
WINDSOR GARDENS SA 5087

Appendix 2: Committee Performance Plan

Domains	Indicator/Element	Definition	Metric	Benchmark	Verification	Evaluation Frequency	Responsible	Reporting
Domain 1: Clinical Governance and leading a culture of quality	1. Meeting frequency and quorum	Plans and conducts meetings according to the Terms of Reference, assuring proper frequency and attendance	Meetings per schedule with =>50%+1.	100%	Meeting minutes	Quarterly	Chairperson	Minutes
	2. Legislation, regulation policies, and standards	Not measured	Not measured					
Domain 2: Clinical workforce	3. Credentialing and competencies	The Committee maintains evidence of a credentialing process for each new medical specialist and allied health professional, documented in the minutes.	A register is kept listing the credentialing of medical and allied health personnel by name, date, and approval mechanism. This register is current for the previous quarter (Y/N)	100%	Minutes	Quarterly	Chairperson	Minutes
Domain 3: Clinical environment, equipment, and resources	4. Clinical environment, equipment, and resources	Not measured.	Not measured.					
	5. Audit and review	No measured.	Not measured.					
Domain 4: Clinical practice	6. Peer review, openness, and reflective practice (Culture of Quality Studies)	Not measured.	Not measured.					

Domains	Indicator/Element	Definition	Metric	Benchmark	Verification	Evaluation Frequency	Responsible	Reporting
	7. Clinical Systems[1]	Not measured.	Not measured.					
	8. Quality and patient safety systems	Not measured.	Not measured.					
Domain 5: Clinical service partnerships	9. Partnerships in services delivery	Not measured.	Not measured.					
Domain 6: Patient-centred care	10. Patient-centred care	The Committee reviews and comments on the minutes of the Consumer Partnership Group, which is documented in the minutes.	Not measured.					
Domain 7: Clinical effectiveness	11. Clinical effectiveness and healthcare systems performance	The Committee reviews and comments on the clinical performance report. This is documented in the minutes.	Not measured.					
	12. Management of incidents and risks	The Committee reviews, receives, reviews and comments on the clinical incidents report, and this is documented in the minutes.	Not measured.					
	13. Research and development	The Committee reviews and comments on current research activity, documented in the minutes.	Not measured.					

[1] Procedures, guidelines, protocols, or clinical algorithms.