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MEMORANDUM OF UNDERSTANDING – CLINICAL PRIVILEGES, CONDUCT AND GOVERNANCE IN WESTERN AUSTRALIAN GOVERNMENT HOSPITALS AND HEALTH SERVICES

The Memorandum of Understanding on Clinical Privileges, Conduct and Governance in Western Australian Government Hospitals and Health Services came into effect from 7 July 2015.

It replaces the previous 2012 Memorandum of Understanding on Clinical Privileges, Conduct and Governance in Western Australian Government Hospitals and Health Services.

Enquires relating to the Memoranda of Understanding may be directed to System-wide Industrial Relations, Department of Health.

MEMORANDUM OF UNDERSTANDING
BETWEEN

THE MINISTER FOR HEALTH,
THE DIRECTOR GENERAL OF HEALTH AND

BOARDS OF MANAGEMENT AND

THE AUSTRALIAN MEDICAL ASSOCIATION
(WESTERN AUSTRALIA) INCORPORATED

IN RESPECT OF

CLINICAL PRIVILEGES, CONDUCT AND
GOVERNANCE IN WESTERN AUSTRALIAN
GOVERNMENT HOSPITALS AND HEALTH
SERVICES

2015

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1. INTRODUCTION

(1) The Memorandum of Understanding details the undertakings given by individual Boards to Medical Practitioners and the AMA about how those Boards will oversee and organise the business of the Health Care Facility. It articulates matters of principle and best practice about which the Minister for Health, the Boards and the AMA agree.

(2) The Memorandum applies to all Western Australian Government Health Care Facilities except Fiona Stanley Hospital, Royal Perth, Sir Charles Gairdner, Fremantle, King Edward Memorial and Princess Margaret Hospital, Perth Childrens Hospital and Graylands Hospital Campus.

(3) This Memorandum does not of itself create legally binding obligations' and is not legally enforceable.

(4) The parties may agree that this Memorandum shall apply to any or all of the named exceptions in this Clause.

(5) The terms of this Memorandum may be varied by agreement of the parties and any such variation shall be set out in writing and signed by all parties.

(6) This Memorandum will nominally expire 3 years· after its commencement. After nominal expiry, the Memorandum will continue to apply until replaced by a new memorandum or agreement, or until the Memorandum is terminated by the Minister, a Board or the AMA giving 3 months written notice of termination to the others. Termination by one Board does not affect any other Board.

(7) The AMA, the Minister, the Director General of Health and Boards who are party to this Memorandum will meet by 30 June 2018 to commence negotiations on arrangements to apply after expiry of this Memorandum.

(8) During the life of this MoU the parties shall meet and review the content of this MoU and where necessary vary the MoU in accordance with 1.5 above.

(9) The parties will continue to consider the conversion of this Memorandum into a legally binding agreement.

(10) To the extent of any inconsistency with any obligation or duty imposed on a Board by any statute including, but not limited to the Hospitals and Health Services Act 1927, the Public Sector Management Act 1994 and the Industrial Relations Act 1979, and any obligation or duty imposed by subsidiary legislation, regulation, order, award or instruction (however titled), this MoU shall have no force or effect.

Each Board will, subject to the foregoing, ensure that it's policies and procedures, that apply to matters within the scope of this MoU, are consistent with the matters of principle and best practice about which the Board and the AMA have herein agreed.

To reflect their commitment to the MOU the parties will confer and engage with the relevant authority, to seek compliance with the MoU, if they become aware of any changes or prospective changes to any relevant obligation or duty imposed on a Board.

2. BOARDS AND MEDICAL PRACTITIONERS

(1) Boards are established under the Hospitals and Health Services Act 1927 (WA) to provide health services to the community and have responsibility for and control of all aspects of the management, and operation of Health Care Facilities. The Boards may from time to time be replaced by other entities responsible for those functions.

(2) Medical Practitioners may compete for access to the resources of a Health Care Facility. The level of access to Health Care Facilities depends on clinical need, the available human, financial and physical resources of the Health Care Facility and the role of the Health Care Facility. Access is subject to any applicable contract of employment or Medical Services Agreement for the provision of medical services, and

Clinical Privileges Conditions

(3) Subject to this Clause Medical Practitioners practicing in the local community who are qualified in the medical disciplines required at each local health care facility will be able to admit and treat patients at that facility.

(4) Subject to the Board's overriding duty of care to patients and Health Care Facility(ies) policies and any applicable contract of employment, Medical Services Agreement and Clinical Privileges Conditions, Boards will not control the clinical decisions of a Medical Practitioner in respect of admission, treatment, transfer or discharge of a patient.

(5) The parties recognise that, amongst other responsibilities, Medical Practitioners are personally responsible to their patients and responsible and accountable to:

(a) the Medical Board and other statutory authorities;

(b) the ethical codes and standards of relevant colleges and professional associations; and

(c) the Board.

(6) Health Care Facilities should be managed using a cooperative team approach in which management, Medical Practitioners and other medical, nursing and allied health staff work together to achieve the best possible result for patients and the community through best practice management, health care delivery and clinical practice.

(7) Medical Practitioners provide essential expertise and must be consulted about and participate in the:

(a) planning of clinical activities;

(b) maintenance of high clinical standards;

(c) introduction of new technology and new methods of patient care;

(d) efficient use of resources for the greatest benefit to the community; and

(e) safety and quality activities.

3. MEDICAL ADVISORY COMMITTEES

(1) Boards shall establish Medical Advisory Committees to:

(a) inform and advise the Board on:

(i) medical policy and matters affecting patient care;

(ii) medical workforce issues and medical requirements of the Health Care Facility(ies);

(iii) efficient and equitable use of hospital resources; and

(iv) other matters referred to it by the Board;

(b) liaise between the Board and Medical Practitioners at the relevant Health Care Facility;

(c) actively encourage and advance quality improvement and other activities aimed at better patient care and better use of resources; and

(d) consider medical/patient care issues raised by Medical Practitioners or the Board.

(2) A Medical Advisory Committee may be established for any number of Health Care Facilities within the responsibility of a Board or be nominated to advise a number of Boards. An individual Medical Advisory Committee will ordinarily be established for each Health Care Facility but these may be replaced or complemented by multi-facility Medical Advisory Committees in consultation with the AMA.

(3) The composition of a Medical Advisory Committee should reflect the main clinical services provided by the Health Care Facility. The Medical Advisory Committee will generally comprise of:

(a) a minimum of 4 elected members if there are 15 or less Medical Practitioners at the relevant Health Care Facility(ies) or a minimum of 6 elected members if there are more than 15 provided that nothing limits the Board from increasing the number after discussion with the Medical Advisory Committee;

(b) the Director of Medical Services and either the General Manager or Director of Nursing or equivalents appointed by the Board; and

(c) members co-opted by the Medical Advisory Committee from Medical Practitioners at health care facilities not otherwise represented on the Medical Advisory Committee or which are, in the opinion of the Medial Advisory Committee, inadequately represented. This may include, where appropriate, Mental Health, Community Health, Aboriginal Medical Services, RFDS and other medical representative services in the community;

(d) anyone co-opted by the Medical Advisory Committee to provide specialist advice, as required.

(4) Co-opted members and non-Medical Practitioners will not be entitled to vote at meetings of the Medical Advisory Committee.

(5) After each meeting of the Medical Advisory Committee, the minutes and recommendations will be forwarded to the Board for consideration.

(6) Boards should ensure adequate information is provided to Medical Advisory Committees to enable them to function and shall take account of the advice when making decisions.

(7) The Medical Advisory Committee will report annually on it activities to the Board and the Medical Practitioners at the Health Care Facility/ies. The Committee's report may include an assessment of its contribution to the effective operation of the Health Care Facility/ies. The Board may request a report on particular matters as required. The Committee may report to the Board and the Medical Practitioners at the Health Care Facility/ies at any time on particular matters.

(8) Any significant issue that is unable to be resolved between the Board and Medical Advisory Committee may be raised with the Minister after the relevant parties have taken all reasonable steps to resolve the matter. The party referring the matter to the Minister will advise the other party of this action.

Chairperson of the Medical Advisory Committee

(9) The Chairperson of the Medical Advisory Committee will:

(a) liaise between management and Medical Practitioners to ensure each is informed on significant issues;

(b) if no Director of Medical Services is appointed, serve as the medical coordinator for the Health Care Facility including participation in relevant management meetings as required;

(c) in conjunction with the General Manager or Director of Medical Services review the adequacy of the emergency service roster at the Health Care Facility and, in particular, endeavour to reconcile the Health Care Facility and community requirements having regard to relevant factors including, but not limited to the availability of Medical Practitioners and occupational health and safety considerations; and

(d) at the invitation of the General Manager or at the request of the Chairman of the Medical Advisory Committee, attend as an ex-officio member of the

executive committee of the Health Care Facility where such a body exists.

4. CREDENTIALING AND CLINICAL PRIVILEGES ADVISORY COMMITTEES

(1) Boards shall establish advisory committees of Medical Practitioners to:

(a) advise the Board on applications for Credentialing and Clinical Privileges; and

(b) review the Credentials and Clinical Privileges of all or specific Medical Practitioners periodically or on request of the Board and advise the Board accordingly.

(2) A Credentialing and Clinical Privileges Advisory Committee may be specific to a particular Health Care Facility or serve a number of Health Care Facilities. Each Board will need to nominate the Credentialing and Clinical Privileges Advisory Committee which provides advice to a particular Health Care Facility(ies).

(3) Clauses 4.6, 4.7 and 4.17 do not apply to regions administered by the W A Country Health Service, where the process of credentialing and defining the scope of practice of medical practitioners are structured in accordance with the WA Country Health Service Policy (November 2007) "Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners" and associated guidelines and processes. All the other provisions of the *MoU* continue to apply. Where there is any inconsistency except in relation to the exclusions of Clauses 4.6, 4.7 and 4.17 this *MoU* shall prevail. Provided that the parties agree that the WA Country Health Service may make changes to the administration of the Policy and associated guidelines and processes during the currency of this agreement, which do not conflict with this *MoU,* but shall not change the rights or requirements of the medical practitioners or materially change the policy without agreement pursuant to Clause 1.5 with the AMA.

(4) At the discretion of the Board, a Credentialing and Clinical Privileges Advisory Committee may be asked to assess an application for Clinical Privileges whether or not a contract exists.

(5) The Director General of Health may, in consultation with the relevant Boards and the AMA, establish or dissolve Credentialing and Clinical Privileges Advisory Committees which advise more than one rural Board and add or remove rural boards to be advised by the Committee.

(6) The Credentialing and Clinical Privileges Advisory Committee will generally consist of:

(a) at least 3 medical practitioners reflecting the mix of clinical services provided at the Health Care Facility(ies), appointed by the Board after consulting the relevant Medical Advisory Committee(s);

(b) the Director(s) of Medical Services;

(c) 1 Medical Practitioner nominated by the AMA;

(d) anyone co-opted by the Credentialing and Clinical Privileges Advisory Committee to provide specialist advice where the Clinical Privileges applied for, or under review, relate to that specialty; and

(e) -if considered necessary a community representative to observe the process.

(7) Co-opted members and non-Medical Practitioners may not vote on Credentialing and Clinical Privileges applications or reviews.

(8) The Credentialing and Clinical Privileges Advisory Committee will ensure procedural fairness and act as quickly as is practical in all the circumstances of the case.

(9) The Credentialing and Clinical Privileges Advisory Committee will have regard to:

(a) the role delineation of the Health Care Facility;

(b) the Medical Practitioner's formal qualifications, relevant working experience

and clinical expertise and the opinion of professional referees where these are sought;

(c) the Medical Practitioner's previous compliance with conditions attached to the exercise of Clinical Privileges at the Health Care Facility or elsewhere;

(d) other matters as it thinks fit, including any relevant current or past matters or reviews, current or past litigation, unresolved disputes and any reports of Conduct Review Panels, in relation to the Medical Practitioner at the Health Care Facility or elsewhere

(e) the principles enunciated in this MoU and the Department of Health "The Policy for Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners. (2nd Edition) 2009". Provided that the parties agree that changes may be made to the administration of the Policy and associated guidelines and processes during the currency of this agreement, which do not conflict with this MoU, but shall not change the rights or requirements of medical practitioners or materially change the policy without agreement pursuant to Clause 1.5 with the AMA.

Clinical Privileges granted by the Board

(10) Credentialing and Clinical Privileges Advisory Committees must specify in their recommendations to the Board the Clinical Privileges recommended and any conditions attached thereto and the reasons for the Committee's recommendations. Clinical Privileges may be temporary, probationary, conditional or standard.

(11) The scope of Clinical Privileges to be exercised may not exceed the scope of the medical services to be provided under the relevant contract of employment or Medical Services Agreement, but this does not preclude the exercise of a wider scope of medical services in a medical emergency.

(12) If the Credentialing and Clinical Privileges Advisory Committee recommends substantial changes to the conditions applying to the Clinical Privileges of a Medical Practitioner or the scope of Clinical Privileges is less than applied for, the Medical Practitioner will be given a copy of the recommendation and be allowed the opportunity to make submissions and provide materials to the Board.

(13) The Board will take account of the advice of the Credentialing and Clinical Privileges Advisory Committee when considering applications for or reviewing Clinical Privileges.

(14) The Board will inform the Health Care Facility management, the Credentialing and Clinical Privileges Advisory Committee and the Medical Practitioner in writing of its determination as soon as possible.

(15) A Medical Practitioner practicing in the local community aggrieved by a determination of the Board in respect of their application for Clinical Privileges under this Clause, or following a review of their Clinical Privileges under this Clause, may, within 7 days after receipt of notice of the determination, appeal to the Medical Appeals Panel.

(16) A Medical Practitioner aggrieved by a decision of the Board not to refer an application for Clinical Privileges under this Clause may, within 7 days after advice of that decision, appeal to the Medical Appeals Panel.

(17) The Director of Medical Services may, in exceptional circumstances, grant temporary Clinical Privileges for periods not exceeding 6 months. The Chairman of the Medical Advisory Committee with the concurrence of the General Manager may, in exceptional circumstances, grant temporary Clinical Privileges for periods not exceeding 1 month. Temporary training rotations may be authorised for the period of the rotation. All decisions to grant temporary Clinical Privileges will, with the exceptions of training rotations or locums of less than three months, be referred to the

Credentialing and Clinical Privileges Advisory Committee for review.

5. REVIEW OF CLINICAL CONDUCT

(1) Boards have a duty of care to patients and must be able to review the conduct of Medical Practitioners.

(2) Nothing in this section prevents a matter being resolved informally.

(3) Matters concerning the conduct of a Medical Practitioner will be directed to the Director of Medical Services for initial consideration with a nominee of the Medical Advisory Committee
appointed for such purpose and informal review. In the event the matter involves the nominee or the nominee has a conflict of interest the Medical Advisory Committee shall appoint a substitute nominee for the matter under consideration.The Director of Medical Services will advise the Medical Practitioner of the matter raised in writing and invite a written response.

(4) The Director of Medical Service will after consideration and review, if justified forward matters to the Board for confidential consideration.

(5) The Board, after due consideration of the seriousness and urgency of the issues arising from the matter:

(a) where the Board has satisfied itself that a matter is trivial in nature, will dismiss the matter and provide written advice to the parties concerned;

(b) where the Board has satisfied itself that a matter has been resolved to the satisfaction of all parties following consideration and review by the Director of Medical Services, will confirm the resolution and provide written advice to the parties concerned; or

(c) where the Board has satisfied itself that a matter is prima facie serious, will initiate a Review by written request including reasons and constitute a Conduct Review Panel. A copy of this request including reasons will be sent at the same time to the Medical Practitioner the subject of the request for Review and the Chairman and the nominee of the Medical Advisory Committee, subject to the consent of the Medical Practitioner concerned.

Conduct Review Panel

(6) A Conduct Review Panel will comprise of:

(a) a Director of Medical Services;

(b) a person nominated by the Director General of Health; and

(c) an independent Medical Practitioner nominated by the AMA.

(7) Appointees to the Conduct Review Panel are to be independent of the people or issues, which are the subject of the Review,

(8) The members of the Conduct Review Panel will elect, from amongst themselves, a Chairperson.

(9) A quorum is 3 members.

(10) The Conduct Review Panel will:

(a) consider within 7 days, or as soon as reasonably practicable, any request for Review by the Board, and form an opinion whether the subject matter of the requested Review is:

(i) prima facie serious, and if so:

(A) report to the Board its finding and recommendations; or

(B) advise the Board that further consideration by the Panel is required; or

(C) recommend to the Board that the practitioners conduct warrants immediate restricting, making conditional, varying or suspending the Clinical Privileges of the Medical Practitioner pending further consideration by the Panel.

(ii) not prima facie serious, and if so, report to the Board its findings.

(b) consider within 3 days, or as soon as reasonably practicable, any decision of the Board at any time to restrict, make conditional, vary or suspend Clinical Privileges and immediately report to the Board, its opinion whether:

(i) the decision should stand;

(ii) the decision should be amended;

(iii) the decision should be rescinded; or

(iv) any other action is considered necessary.

(11) The Conduct Review Panel may at any time during its consideration of the matter, recommend that the Board:

(a) appoint an Investigator;

(b) appoint a Mediator.

(12) When appointing an Investigator the Board will consult with the AMA and the Medical Practitioner the subject of the Review. The Investigator will report to the Conduct Review Panel.

(13) The Conduct Review Panel, and any Investigator appointed by the Board, may consider such matters as it thinks fit, including:

(a) whether the alleged conduct departs or appears to depart from generally accepted standards of medical practice and if so, to what extent;

(b) whether the alleged conduct is or appears to be an isolated occurrence; and

(c) if applicable, any adverse health outcomes for the patient or patients concerned.

(14) The Conduct Review Panel, and any Investigator appointed by the Board, must:

(a) act according to equity, good conscience and the substantial merits of the case without being constrained by legal technicalities or forms;

(b) not be bound by the rules of evidence, but may inform itself on any matter it thinks just and obtain legal advice to assist in its processes and deliberations;

(c) afford procedural fairness to all persons, but may proceed with a Review if documents or information are not provided within time limits specified;

(d) act as rapidly as practicable;

(e) whenever informing, reporting or referring matters to the Board, prepare a written report setting out:

(i) conclusions arrived at including any dissenting view of a Panel member;

(ii) reasons for arriving at those conclusions; and

(iii) materials:

(A) referred or provided to the Conduct Review Panel; and

(B) relied upon in arriving at the conclusions;

(f) inform the Medical Practitioner the subject of the Review of the substance

of the material relating to the Review, and details of the Review process;

(g) give the Medical Practitioner the subject of the Review an adequate opportunity to put materials and submissions before preparing the report;

(h) provide a copy of the report to the Medical Practitioner the subject of the Review;

(i) with the prior consent of the Board, take legal advice if it considers necessary concerning the subject matter and conduct of the Review and may in its discretion keep this advice confidential to itself and the Board, and

U) otherwise determine the manner in which the Review is to be conducted.

(15) The Conduct Review Panel will keep informed the Board and the Medical Practitioner, the subject of the Review, of all progress relating to the Review and any proposed course of action throughout or findings and or recommendations from the Review.

(16) Persons affected by a Review may be represented by a lawyer or other representative.

(17) Subject to the ordinary obligations of confidentiality, a Medical Practitioner subject to a Review will be entitled to full access to the clinical records of the Health Care Facility, which deal with the subject matter of the Review and must co-operate fully in the conduct and resolution of the Review.

Resolution Proposals and Mediation

(18) A Review may be resolved by the approval by the Board of a Resolution Proposal. A Resolution Proposal may be formulated:

(a) by any person involved in the Review;

(b) with the agreement of all parties as a result of a mediation process

(19) A Resolution Proposal may be expressed to be without prejudice to the rights of the persons involved in putting forward the proposal.

(20) A Resolution Proposal may include (but is not limited to) undertakings as to:

(a) the types of work which the Medical Practitioner will perform in the future,

(b) re-education or further education programs;

(c) attendance at drug or alcohol rehabilitation programs; and

(d) modification of Health Care Facility practices or procedures.

(21) Persons concerned with the Review may agree to participate in mediation. The Board will appoint a representative to participate in the mediation process. The mediation will be conducted by a trained or experienced mediator. The purpose of mediation will be to formulate a Resolution Proposal acceptable to all parties.

(22) The terms on which the mediation is to be conducted will be agreed between the parties involved in the mediation prior to the commencement of the mediation. It is anticipated that ordinarily it would be agreed that:

(a) the cost of the mediation will be borne by the parties;

(b) the mediation process will be without prejudice to the legal rights of the parties;

(c) statements made during the course of the mediation will be confidential, without prejudice to the legal rights of the parties and will not be admitted or tendered into evidence by the parties; and

(d) the period for which the Review is deferred for the purpose of conducting the mediation, which shall normally be for a maximum of 21 days unless the parties agree otherwise.

(23) The Conduct Review Panel will consider the report of any Investigator, Resolution Proposal and/or outcome of mediation and immediately inform the Board and the

Medical Practitioner of its findings and recommend what action, if any, it considers necessary.

(24) A Resolution Proposal will be considered by the Board and may be accepted by the Board as a resolution of the matter. The Board may take into account:

(a) the stage at which the offer or proposal is put;

(b) whether the proposal is put on a 'without prejudice' basis; and

(c) the views of any person involved in the process concerning the proposal.

(25) The fact that a Resolution Proposal has been put to the Board and considered by it will not prejudice or impair the ability of the Board to consider and determine the Review.

Board Determinations

(26) The Board must:

(a) consider and determine all Reviews;

(b) have regard for the recommendations and findings of any Conduct Review Panel;

(c) afford procedural fairness to all persons who might be adversely affected by its decision;

(d) take such action as it considers appropriate in the circumstances of the case; and

(e) notify such persons as it thinks fit of its decision.

(27) The Board may at any time decide the conduct of a Medical Practitioner warrants restricting, making conditional, varying or suspending the Clinical Privileges of that Medical Practitioner pending a Review. In such a case, the Board must:

(a) immediately notify the Medical Practitioner of its decision; and

(b) whether or not a Review has already been initiated, within 7 days refer its decision to the Conduct Review Panel for further consideration. Such a reference will initiate a Review if a Review had not already been initiated.

(28) The Board may, notwithstanding any recommendation of the Conduct Review Panel, exercise one or more of the following powers:

(a) dismiss the matter;

(b) return the matter to the Conduct Review Panel to further investigate or consider;

(c) reprimand the person the subject of the Review;

(d) give formal directions to the management or staff of the Health Care Facility;

(e) restrict, make conditional, vary, suspend, terminate or reinstate Clinical Privileges of a Medical Practitioner, whether in whole or in part, at any or all Health Care Facilities within its responsibility, or confirm its decision to do so;

(f) suspend or terminate the engagement of a Medical Practitioner;

(g) refer the matter to the Medical Board or other appropriate professional body;

(h) refer the matter to the Credentialing and Clinical Privileges Advisory Committee; and

(i) make such other recommendations or determinations as it considers just.

(29) The Board shall immediately notify the Medical Practitioner, subject of the Review, and the members of the Conduct Review panel of its determination.

(30) A Medical Practitioner aggrieved by a determination of a Board may, within 7 days after receipt of notice of the determination, appeal to the Medical Appeals Panel.

(31) If the Board has exercised a power to:

(a) reprimand the person the subject of the Review;

(b) suspend or terminate the engagement of a Medical Practitioner; or

(c) refer the matter to the Medical Board or other appropriate professional body

it will report the matter to the Director General of Health, who may refer the matter to a State-wide review panel to determine whether it should recommend that Clinical Privileges be restricted, made conditional, varied, suspended, terminated or reinstated at other Health Care Facilities throughout the State.

(32) Any State-wide review panel will comprise:

(a) a Medical Practitioner nominated by the AMA;

(b) a Medical Practitioner nominated by the Director General of Health; and

(c) an independent Medical Practitioner agreed by the AMA and the Director General of Health who will be the Chairperson.

(33) The determination of a Review will not affect the rights of:

(a) a patient against the Board or a Medical Practitioner

(b) the Board and the Medical Practitioner against each other arising out of or in relation to any proceedings brought by a patient, or against a complainant; or

(c) the Board or any other person to refer any matter to the Coroner or Medical Board established under their respective Acts.

Timetable for Resolution

(34) The parties will try to complete the Review as quickly as possible. With the exception of the time limit imposed for the Conduct Review Panel to consider a decision of the Board at any time to restrict, make conditional, vary or suspend Clinical Privileges and the 7 day limit for appeals to the Medical Appeals Panel, time limits in this Clause are indicative only, and failure to comply with a time limit will not in any circumstances invalidate any step or action.

Days [calculated from the date of commencement of the Review process]	STEP IN **THE** PROCEDURE
0	Written request to Conduct Review Panel for Review. Copy to Medical Practitioner concerned.
7	Conduct Review Panel determines whether matter is serious and informs Board.
35	Conduct Review Panel completes Review and reports to Board.
63	Board determines Review.
70	Board notifies Medical Practitioner of determination of Review.
7 days from receipt of Board determination	Time limit for lodging an appeal to the Medical Appeals Panel.

6. MEDICAL APPEALS PANEL

(1) Boards will establish a Medical Appeals Panel, as required, comprising of:

(a) a Medical Practitioner nominated by the AMA;

(b) a Medical Practitioner nominated by the Board; and

(c) an independent Medical Practitioner agreed by the AMA and the Board who

will be the Chairperson.

(2) Appointments to the Medical Appeals Panel may be on an ad hoc basis to consider particular appeals and will not involve persons previously concerned with the subject of the appeal.

(3) Persons appearing before the Medical Appeals Panel may be represented by a lawyer or other representative.

(4) The Medical Appeals Panel will:

(a) in the absence of exceptional circumstances, hear and determine the appeal on the evidence and matters raised before the Board;

(b) not be bound by the rules of evidence, but may inform itself on any matter it thinks just and obtain legal advice to assist in its processes and deliberations;

(c) determine the matter according to equity, good conscience and the substantial merits of the case without being constrained by legal technicalities or legal forms;

(d) afford procedural fairness to all persons, but may proceed to hear an appeal if documents or information are not provided within time limits specified by the panel;

(e) act as rapidly as practicable;

(f) prepare a written report setting out:

(i) conclusions arrived at including any dissenting view of a panel member;

(ii) reasons for arriving at those conclusions; and

(iii) materials:

(A) referred or provided to the panel; and

(B) relied upon in arriving at the conclusions;

(g) give the Medical Practitioner the subject of the Review an adequate opportunity to put submissions before preparing the report;

(h) with the consent of the Board, take legal advice if it considers necessary concerning the appeal and may in its discretion keep this advice confidential to itself and the Board; and

(i) otherwise determine the manner in which the appeal is to be conducted.

(5) The Medical Appeals Panel will report and provide its recommendations to the Board and may make such recommendations concerning the appeal as it considers appropriate to best protect the interests of all parties and members of the public.

(6) After consideration of the report and recommendations of the Medical Appeals Panel, the Board may exercise any of its powers and such determination will be final and binding.

(7) The administrative costs of the Medical Appeals Panel including any fees for members of the Medical Appeals Panel will ordinarily be borne by the Board. However, the Medical Appeals Panel may recommend an apportionment of costs if, in its view, it is fair and equitable to do so. The legal costs of each party will be borne by that party.

(8) The Director General of Health may establish regional, State-wide or specialist Medical Appeals Panels. These Medical Appeals Panels will comprise:

(a) a Medical Practitioner nominated by the AMA;

(b) a Medical Practitioner nominated by the Director General of Health; and

(c) an independent Medical Practitioner agreed by the AMA and the Director

General of Health who will be the Chairperson.

7. COMMITTEES GENERALLY

(1) This Clause applies to Medical Advisory Committees and Credentialing and Clinical Privileges Advisory Committees ("Committees"), provided that any reference to election of members or chairs have no application to the Credentialing and Clinical Advisory Committees.

(2) Subject to the agreement of the parties to this memorandum, this Clause may be varied to accommodate local requirements. Details of any such variations will be made available to all Medical Practitioners at the Health Care Facilities for which the Committees provide advice.

Elections

(3) Elections for Committees will generally be held in June. Elections to fill casual vacancies will be held at such time as the Committee may determine. The Board may determine whether the elections will be biennial elections of the whole of the Committee or annual elections of half the Committee.

(4) Generally, Committee members will take office from 1 July. Committee members elected to fill casual vacancies will take office from the date of their election with their term expiring at the same time as the committee member they replace.

(5) The Chairperson of the outgoing Committee will nominate a returning officer. The nominee must not be a person seeking election to the Committee.

Transitional Arrangement

(6) Existing members of committees established under the Memorandum of Understanding in respect of Clinical Privileges, Conduct and Governance in Western Australian Hospitals dated 2005 shall from the date of implementation of this MoU continue as the newly constituted committees until the next scheduled elections. Half of the members elected will be appointed for one year and the other half for two years (based on the number of votes received).

(7) Elections shall be held annually with members being elected for two years.

Nominations and Voting

(8) Nominations for election to Committees must be in writing signed by the proposer, seconder and nominee.

(9) Nominations must be in the hands of the returning officer one calendar month before the date fixed for the election. If no one is nominated from a particular Health Care Facility in respect of which a Committee provides advice, the returning officer may accept oral nominations of persons from that Health Care Facility up to 72 hours before the date advertised for election papers to be sent out.

(10) Medical Practitioners engaged at the Health Care Facility for a term greater than 12 months will be eligible to:

(a) stand for election;

(b) nominate and second candidates; and

(c) vote at elections for those Committees in respect of the Health Care Facilities at which they are engaged.

(11) Voting in elections for Committees will be by non-preferential secret ballot submitted to the returning officer by the due date. Postal votes will be accepted, provided that they are in the hands of the returning officer by noon on the day before the day fixed for

the poll to be declared.

Election of Chairperson and Voting

(12) The Chairperson of each Committee will be elected by the elected members of the Committee for a one year term and will be eligible for re-election.

(13) The Chairperson will have a deliberative as well as a casting vote.

Appointment of Deputy Chairperson

(14) Each Committee will appoint a Deputy Chairperson to act as chairperson at meetings of the Committee and perform the other functions of the Chairperson when the Chairperson is unavailable or unable to perform his or her functions.

Rules of Debate

(15) The Chairperson will determine the appropriate rules of debate to apply.

Absences

(16) Any elected member who misses three consecutive meetings of a Committee without good cause being shown will be deemed to have resigned.

Quorum and Proxies

(17) A quorum will comprise two thirds of the elected members of the Committees.

(18) Subject to the agreement of the Chairperson a member may nominate in writing another Medical Practitioner able to represent the same constituency as proxy to attend particular meetings in their place when they are unable to attend. Where a member is called to an emergency, or where a member has received less than 48 hours notice of the meeting, the Chairperson may accept an oral proxy.

(19) The Health Care Facility will ensure necessary resources including secretarial support is provided and minutes are maintained of all formal meetings of the Committee.

Conflict of Interest

(20) A member of a Committee who, whether directly or indirectly, has duties or interests in conflict with his or her duties or interests on that Committee, must declare a possible conflict of interest to the Chairperson. The member will withdraw from the Committee for the duration of the deliberations in question, prior to any discussions or decisions on the matter being taken, unless the Committee determines the conflict is trivial or unlikely to affect the outcome.

(21) Subject to the approval of the Chairperson where a member has withdrawn from the Committee for a particular matter, that member may nominate in writing another Medical Practitioner as proxy for the purpose and duration of the period during which such matter is under consideration.

Confidentiality

(22) Subject to this Memorandum, discussions, deliberations and recommendations of Committees will be kept confidential unless the Committee or the Board (after consultation with the Committee concerned) decides otherwise or as required by law.

8. DEFINITIONS AND INTERPRETATION

(1) In this Memorandum, the following definitions apply:

(a) **Clinical Privileges** means the range and scope of clinical practice that a Medical Practitioner may exercise in the facility;

(b) **Clinical Privileges Conditions** means the terms and conditions attached to the granting of Clinical Privileges;

(c) **Credentials** means the formal qualifications and evidence of training, experience and clinical competence of the Medical Practitioner;

(d) **Credentialing** means the process of assessing and recognising a Medical Practitioner's formal qualifications, training, experience and clinical competence;

(e) **Director of Medical Services** means a Medical Practitioner(s) appointed by the Board to manage the provision of medical services at the Health Care Facility(ies) under that title or a Medical Practitioner(s) appointed by the Board for a specific purpose under this Memorandum;

(f) **General Manager** means person or persons appointed to managing the Health Care Facility(ies) under the title of General Manager, Regional Director or otherwise and includes each person acting in that capacity from time to time;

(g) **Health Care Facility** means a public hospital or public health care institution, including approved associated community clinics or a multi-purpose services, where medical practitioners provide services;

(h) **Investigator** means an investigator appointed by the Board in accordance with Clause 5 of this Memorandum;

(i) **Medical Practitioner** means a medical practitioner registered under the Health Practitioner Regulation National Law (WA) Act 2010 (as amended from time to time) including an employee of a Board;

U) **Metropolitan Health Services** means the Board of all the hospitals formerly comprised in the Metropolitan Health Service Board pursuant to section 7 of the Hospitals and Health Services Act 1927 (WA) however constituted;

(k) **Medical Services Agreement** means an agreement between a Board and an independent contractor for the provision of medical and other services;

(l) **Region** means a geographic area within the jurisdiction of a Regional Director who holds a delegation from one or more boards;

(m) **Review** means a review of the conduct of a Medical Practitioner in accordance with Clause 5 of this Memorandum;

(n) **Resolution Proposal** means an agreement between the parties of a Review.

(2) The Minister and the AMA may act through their officers and representatives.

(3) A Board may act through its authorised agents and employees.

9. BOARDS PARTY TO THIS MEMORANDUM

(1) The Minister for Health in his incorporated capacity as the Board of all of the hospitals formerly comprised in the Metropolitan Health Service Board pursuant to section 7 of the Hospitals and Health Services Act 1927 (WA);

(2) The Minister for Health in his incorporated capacity as the Board of all of the hospitals formerly comprised in the Peel Health Service pursuant to section 7 of the Hospitals and Health Services Act 1927 (WA); and

(3) WA Country Health Service of which the Minister for Health is incorporated as the Board thereof under section 7 of the Hospitals and Health Services Act 1927 (WA).

10. SIGNATURES OF PARTIES

7/7/2015

THE HON. KIM HAMES, MLA
DEPUTY PREMIER
MINISTER FOR HEALTH, IN THE CAPACITY AS BOARD OF ALL HOSPITALS

7/7/15

DR MICHAEL GANNON
PRESIDENT
AUSTRALIAN MEDICAL ASSOCIATION (WA) INCORPORATED

7/7/2015

PAUL BOYATZIS
EXECUTIVE DIRECTOR
AUSTRALIAN MEDICAL ASSOCIATION (WA) INCORPORATED

7/7/15

PROF BRYANT STOKES
ACTING DIRECTOR GENERAL OF HEALTH
IN HIS CAPACITY AS DELEGATE OF THE MINISTER FOR HEALTH AS THE BOARD