Alberta Health Services

Conflict of Interest Bylaw

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1. Principles and Expectations

1.1 Alberta Health Services (AHS) is committed to promoting a standard of conduct that preserves and enhances public confidence in the integrity, objectivity, and impartiality of its clinical and business activities. AHS relies on AHS Representatives to uphold these standards by ensuring private interests do not interfere with or influence their decision-making processes. Recognizing that AHS Representatives have interests outside of AHS, they are expected to fulfill their responsibilities in a manner that avoids involvement in any conflict of interest situations, and to promptly disclose and address any conflicts should they arise.

1.2 This Bylaw supports the AHS value of accountability and is consistent with the expectation that all AHS Representatives act ethically.

1.3 AHS Representatives must act impartially in carrying out their duties.

1.4 AHS Representatives must not act in self-interest or further their private interests by virtue of their position or duties as an AHS Representative.

1.5 AHS Representatives must take steps to avoid real, apparent, and potential conflicts of interest, whenever possible.

1.6 AHS Representatives must disclose and manage all real, apparent, and potential conflicts of interests in accordance with this Bylaw.

2. Definitions

2.1 **AHS Representative** means:

a) members of the AHS Board;

b) AHS employees; and

c) any other person, other than a representative of the Government of Alberta, who:

(i) is acting on behalf of AHS or claims to be acting on behalf of AHS;

(ii) is authorized to bind AHS or purports to bind AHS; or

(iii) directly or indirectly controls AHS funds.

2.2 **Commercial value** means the fair market value that a good or service would have if it was offered for sale. For example, the commercial value of a travel via corporate

aircraft is the fair market value that travel would have if purchased from a commercial airline.

2.3 **Concern** means, in the context this Bylaw, a written complaint or concern from any individual or group of individuals alleging a breach of this Bylaw by a member of the AHS Medical Staff or the AHS Midwifery Staff.

2.4 **Consulting services** means organization leadership/management level advisory services. Such services typically involve situational analysis and the provision of advice, options, etc. to guide AHS decisions or in respect of which AHS can act. Consulting services do not include the implementation or execution of work based on the analysis or advice. Consulting services does not include services for the provision, administration, or management of clinical care or clinical support or medical administrative leadership roles.

2.5 **Cooling off period** means the minimum period of time following the termination of employment during which a former employee, who was formerly employed in a position allocated in the M4 career level and above, cannot engage in a contract with AHS for consulting or professional services.

2.6 **Frivolous or vexatious** means:

a) misuse or abuse of the process for reporting an alleged breach of this Bylaw;

b) a report of an alleged breach that is not reasonably purposeful with no possible outcome that would resolve the subject matter of the report of alleged breach; or

c) directed, unreasonable conduct by an individual who:

(i) attempts to re-open a matter that has been addressed and closed through the applicable reporting and resolution process and offers no new relevant information;

(ii) is unreasonably persistent in pursuing a report of a breach which leads to resources being absorbed disproportionately, and causes disruption, delay, or disadvantage to other individuals who are part of the reporting process or to AHS as an organization; or

(iii) is abusive or threatening.

2.7 **Manager** means the individual responsible for managing and overseeing an AHS Representative, or to whom the AHS Representative reports. For further clarity, the

Manager of the President and Chief Executive Officer and AHS Board members is the AHS Board Chair.

2.8 **Medical administrative leadership roles** mean roles that are appointed by AHS, potentially as outlined in the AHS *Medical Staff Bylaws* and *Rules*, but also as determined as necessary by AHS to support strategic and operational needs, to provide oversight, direction and/or management of clinical or clinical support portfolios.

2.9 **Medical Staff** means the collective group of physicians, dentists, oral & maxillofacial surgeons, podiatrists and scientific leaders who are appointed under the AHS *Medical Staff Bylaws*. Medical Staff appointment does not necessarily indicate an individual's employment status with AHS.

2.10 **Midwifery Staff** means the collective group of midwives who are appointed under the AHS *Midwifery Staff Bylaws*. Midwifery Staff appointment does not necessarily indicate an individual's employment status with AHS.

2.11 **Patient** means an adult or child who receives or who has received health care or services from AHS and its health care providers or individuals authorized to act on behalf of AHS. This term is inclusive of residents, clients, and outpatients.

2.12 **Person** means an individual, a partnership, a corporation, a company, a joint venture, a trust, and the heirs, executors, trustees, administrators or other legal representatives of a person.

2.13 **Political activity** means an action that supports or opposes a political party, candidate, or cause at any level of government, including but not limited to:

a) seeking nomination as, or being a candidate for election;

b) volunteering for a political party or candidate;

c) campaign visits, tours, or events from candidates and/or their representatives;

d) posting political party, candidate, or campaign signs or posters;

e) distributing political party, candidate or campaign literature;

f) wearing or distributing political party, candidate, or campaign attire including buttons;

g) soliciting political donations or fundraising; and

h) soliciting petition/nomination signatures.

2.14 **Political donations** means the contribution of funds (including, but not limited to, cash, cheques, purchase orders, purchase cards or "p-cards"/credit card purchases, and funding requests made to accounts payable), time, gifts (including door prizes and silent auction gifts), or resources to a political activity, political party, or candidate.

2.15 **Political party** means an organization, including associated constituency associations, established under the *Election Finances and Contributions Disclosure Act* (Alberta) or *Canada Elections Act* (Canada) and registered with Elections Alberta or Elections Canada to nominate candidates in an election.

2.16 **Private interest** means a financial, personal, or private affiliation, a relationship, or any other involvement or interest of an AHS Representative that is not of general application, that does not affect the AHS Representative as one of a broad class of the public, that does not concern the remuneration and benefits of the AHS Representative, and that is not trivial. For example, the following would not be considered a private interest: being an AHS patient, being a family member of an AHS patient, or being an Alberta taxpayer. The private interest could benefit:

a) the AHS Representative directly;

b) a corporation for which the AHS Representative owns, directly or indirectly, more than 10% of the voting rights;

c) a business partner;

d) a joint-venture;

e) a trust or estate which the AHS Representative has a substantial interest in, and/or where the AHS Representative serves as a trustee, or similar role;

f) an immediate family member (i.e. parent, spouse, sibling, or child);

g) an outside employer of the AHS Representative, including self-employment or acting as a paid advisor or consultant;

h) a political entity such as a political party or candidate;

i) a private sector, public sector, non-profit, charitable, or corporate organization or board the AHS Representative is involved with or volunteers for that has a connection to the health care sector; or

j) any other individual or organization that a reasonable person would believe the AHS Representative's actions may be affected.

2.17 **Professional services** means services involving the implementation or execution of work, or provision of deliverables that require professional expertise. Professional services may include services that are, in part, also classified as consulting services. Where the primary purpose of a particular procurement is for implementation or execution of certain work or deliverables, all of such services for such procurement will be considered Professional Services notwithstanding that an ancillary part of the procurement includes services that would otherwise be considered consulting services. The provision of reporting/information help lines is also classified as professional services. Professional services does not include services for the provision, administration, or management of clinical care or clinical support or to medical administrative leadership roles.

2.18 **Senior Leader** means any employee with the following job classification: SL1, SL2, SL3, ML1, ML2, M5 who reports directly to a member of the Executive Leadership Team, and other individuals so designated by the President and Chief Executive Officer.

2.19 **Severance notice period** means the length of time for which an employee received payment in lieu of notice following their termination date. Such period is specified in the Release that is signed by the employee in consideration for their severance payment.

2.20 **Termination date** means the last day an employee was employed with AHS.

2.21 **Vendor** means an individual or company that supplies, or seeks to provide, goods and/or services to AHS and includes contractors and suppliers, but excludes AHS Representatives.

3. Applicability

3.1 Compliance with this Bylaw is required by all AHS Representatives.

4. Conflict of Interest (Participants in AHS Contracting and Procurement Initiatives)

4.1 The Chief Program Officer, Contracting, Procurement, and Supply Management (CPSM) (or designate) will establish administrative processes for the declaration, receipt, processing, and approval of conflict of interest disclosure forms for use in AHS contracting and procurement initiatives. Such processes will pertain to all individuals responsible for the development of a procurement initiative methodology, the assessment, evaluation and selection of proponents, or the negotiations with selected or preferred proponents.

4.2 Attached as **Schedule A** to this Bylaw is the AHS Conflict of Interest Procedure for Contracting and Procurement Initiatives. If there is any inconsistency between the terms of this Bylaw and Schedule A to this Bylaw, then Schedule A shall prevail.

5. Conflict of Interest (General): Identifying

5.1 A conflict of interest can be real, apparent, or potential. All references to conflicts of interests in this Bylaw include all three categories:

a) a real conflict of interest occurs when an AHS Representative performs an action, makes a decision, influences a decision, or seeks to influence a decision, which benefits a private interest;

b) an apparent conflict of interest occurs when a reasonably informed person could believe that an AHS representative's action, decision, influence on a decision, or attempt to influence a decision benefits a private interest; and

c) a potential conflict of interest occurs when an AHS Representative's action, decision, influence on a decision, or attempt to influence a decision may benefit a private interest.

5.2 The scenarios listed below are examples of real, apparent, and potential conflict of interest situations for an AHS Representative that must be disclosed pursuant to Part 6 of this Bylaw and approved pursuant to Part 7 of this Bylaw. This is not an exhaustive list and AHS Representatives are required to use reasonable judgement in determining whether an activity or arrangement poses a real, apparent, or potential conflict of interest:

a) using their position, power, or authority with AHS to influence, or seek to influence, a decision made by AHS that benefits a private interest;

b) granting preferential treatment or assistance through their position, power, or authority with AHS to benefit a private interest;

c) using knowledge or information not available to the public, and gained through their role with AHS, to benefit a private interest;

d) subject to section 5.3, participating in outside employment, self-employment, volunteer activity, or having an outside appointment (e.g. being a board member);

e) establishing or entering into a business arrangement or financial interest if the interest is something known to the AHS Representative because of their role with AHS; and

f) allowing the performance of their AHS duties to be influenced by offers of future employment.

5.3 Subject to section 5.5, the following scenarios are deemed to not present a conflict of interest for an AHS Representative that warrant declaration pursuant to Part 6 of this Bylaw and approval pursuant to Part 7 of this Bylaw:

a) having more than one position with AHS;

b) carrying out AHS duties at more than one AHS location;

c) being employed by or providing goods or services to:

(i) an AHS subsidiary;

(ii) Covenant Health;

(iii) Lamont Health Care Centre;

(iv) an organization that has no connection with the health care sector, AHS or AHS' subsidiaries;

d) self-employment that has no connection with the health care sector, AHS, or AHS' subsidiaries;

e) home-based direct selling – for example, being a sales representative or consultant for Avon, Mary Kay, Scentscy, PartyLite, etc. For clarity, this includes home-based direct selling of wellness products – for example, Watkins, Herbalife, etc.;

f) serving as an AHS-appointee board member for an organization or corporation;

g) volunteering with or serving as a board member for a not-for-profit, charitable, religious, professional association, or educational institution that has no connection with the health care sector, AHS, or AHS' subsidiaries;

h) serving as a board member for a for-profit corporation that has no connection with the health care sector, AHS, or AHS' subsidiaries;

i) having joint appointments as between AHS and an Alberta post-secondary educational institution; and

j) participating in union activity.

5.4 Any AHS Representative engaged in activity described in sections 5.3(a) – (i) must not use AHS resources to engage in the activity, including, but not limited to, AHS work time, equipment, supplies, facilities, staff, or communication platforms, unless otherwise authorized.

5.5 Despite section 5.3, using their reasonable judgment, a Manager or the Chief Ethics and Compliance Officer (or designate) may direct an AHS Representative to complete a Conflict of Interest Declaration Form (Declaration Form) for any of the scenarios listed in sections 5.3(a) – 5.3(i), identifying the activity as a conflict of interest and including a management plan for the activity.

6. Conflict of Interest (General): Disclosing

6.1 Self-disclosing of conflicts of interest is done through the Declaration Form. Management plans for addressing conflicts of interest are also set out in the Declaration Form.

6.2 If a conflict of interest has been identified, the Declaration Form must be completed every two years or whenever there are relevant changes to the information previously disclosed, whichever is more recent.

6.3 AHS Representatives do not have a positive duty to disclose that they have no conflict of interest unless:

a) their Manager directs them to make such a disclosure (see section 6.8); or

b) they are a Senior Leader (see section 6.4).

6.4 Despite section 6.2, all Senior Leaders and AHS Board members must submit a Declaration Form annually, or whenever there are relevant changes to the information previously disclosed, whichever is more recent. Despite section 6.3, this Declaration Form must be submitted regardless of whether or not the Senior Leader or AHS Board member actually has a conflict of interest.

6.5 Declaration Forms are submitted as follows:

a) AHS Representatives, excluding AHS Board members and the Chief Ethics and Compliance Officer, must submit their completed Declaration Form for approval to declarationcoi@ahs.ca;

b) The Chief Ethics and Compliance Officer must submit their completed Declaration Form for approval to the Chair of the Governance Committee of the AHS Board;

c) AHS Board members, excluding the AHS Board Chair, must submit their completed Declaration Form for approval to the AHS Board Chair and for information to AHS' General Counsel and the Chair of the Governance Committee of the AHS Board; and

d) The AHS Board Chair must submit their completed Declaration Form for approval to the Chief Ethics and Compliance Officer and for information to the Minister of Health, AHS' General Counsel, and the Chair of the Governance Committee of the AHS Board.

6.6 AHS Representatives have an ongoing duty to self-disclose a conflict of interest, in writing, to their Manager. Disclosures of a conflict of interest must take place in advance of any action that may lead to a conflict of interest, or, if the conflict of interest could not be foreseen, immediately upon being aware of the conflict of interest.

6.7 AHS Representatives have an ongoing duty to alert their Manager of any situations that may place another AHS Representative in a conflict of interest situation. Should the Manager fail to act, the AHS Representative may report the conflict of interest to the Ethics & Compliance Office or to the confidential AHS safe disclosure line at 1-800-661-9675.

6.8 The Manager of an AHS Representative and the Chief Ethics and Compliance Officer (or designate) have authority to direct an AHS Representative to complete a Declaration Form.

6.9 Declaration Forms must be retained for a period of five (5) years after they have been superseded or become obsolete.

6.10 Completed Declaration Forms must be kept confidential except where:

a) the disclosure is for assessing and managing a conflict of interest;

b) there is a legitimate need to inform an AHS Representative's new Manager of the Declaration Form following the AHS Representative taking a new role or a change in reporting structure;

c) the disclosure is related to investigative, disciplinary, administrative tribunal, quasi-judicial, or legal proceedings;

d) there is a legal or regulatory obligation to disclose the Declaration Form; or

e) the AHS Representative has given permission to disclose the Declaration Form.

6.11 When an AHS Representative participates in a meeting where any matter arises where the AHS Representative has a conflict of interest, the AHS Representative must verbally declare their conflict of interest as soon as they are aware of the conflict of interest and any meeting minutes should reflect their statement. The chair of the meeting has the discretion to:

a) ask the AHS Representative to not participate in the discussion or any decision related to the matter;

b) ask the AHS Representative to leave the meeting for the duration of the matter; or

c) indicate that the AHS Representative should not be presented with meeting materials related to the matter (assuming the AHS Representative has not previously received the materials)

6.12 The Chief Ethics and Compliance Officer (or designate) may establish administrative processes for the receipt, processing, and approval of Declaration Forms.

7. Conflict of Interest (General): Approving a Declaration Form and Management Plan

7.1 For any AHS Representative other than AHS Board members and the Chief Ethics and Compliance Officer, the Chief Ethics and Compliance Officer (or designate) may approve in writing the Declaration Form and any management plan for a declared conflict of interest.

7.2 For the Chief Ethics and Compliance Officer, the Chair of the Governance Committee of the AHS Board may approve in writing the Declaration Form and any management plan for a declared conflict of interest.

7.3 For any AHS Board members other than the AHS Board Chair, the AHS Board Chair may approve in writing the Declaration Form and any management plan for a declared conflict of interest.

7.4 For the AHS Board Chair, the Chief Ethics and Compliance Officer may approve in writing the Declaration Form and any management plan for a declared conflict of interest.

7.5 If an AHS Representative does not accept the decision of the Chief Ethics and Compliance Officer (or designate) regarding whether a conflict of interest exists and is being adequately managed, then the AHS Representative will have the right to appeal the decision to the Chair of the Governance Committee of the AHS Board.

7.6 Conflicts of interest that cannot be properly managed may require a change to the AHS Representative's position and role with AHS up to, and including, termination of employment, contract, or appointment.

8. Receipt of Gifts

8.1 AHS Representatives may not accept fees, gifts, or other benefits that are connected directly or indirectly with the performance of their AHS duties from any person, other than:

a) the normal exchange of hospitality between persons doing business together;

b) tokens exchanged as part of protocol, including but not limited to:

(i) gift from a patient; or

(ii) gift from the family or friends of a patient; or

c) the normal presentation of gifts to persons participating in public functions, awards, speeches, lectures, presentations, or seminars.

8.2 The maximum commercial value of any one-time gift, hospitality, or other benefit accepted by an AHS Representative under sections 8.1(a) – 8.1(c) must not exceed $100.00 and must not take the form of cash, cheque, or electronic money transfer.

8.3 The total maximum commercial value of any gifts, hospitality, or other benefits accepted by an AHS Representative under sections 8.1 (a) – 8.1(c) within a calendar year from one source must not exceed $200.00, where "one source" includes, without limitation:

a) collectively, a patient and their family or friends; or

b) collectively, related entities. "Related entities" means any people, corporations, partnerships, and/or trusts owned or controlled by the same entity or group (such as corporations in a parent/subsidiary relationship) and any entities carrying on business together (such as corporations in a franchisor/franchisee relationship, partnership, joint venture relationship, or beneficiaries of a trust who also own or control a separate partnership. For clarity, beneficiaries of a trust are deemed to own the trust).

8.4 Gift cards are an acceptable form of gift under sections 8.1(a) – 8.1(c), however, they are subject to the monetary limits set out in sections 8.2 and 8.3.

8.5 AHS Representatives must not seek out gifts, hospitality, or other benefits from any person. An exception to this is that AHS Representatives may solicit gifts, hospitality, or other benefits from persons other than patients or patients' families or friends for the purpose of AHS-sponsored charitable, club, or team activities (e.g. United Way, National Nursing Week) providing that the principles of this Bylaw are adhered to, including the monetary limits set out in sections 8.2 and 8.3, and the caution in section 8.6.

8.6 Despite sections 8.1 and 8.5, no AHS Representative shall accept any gift, hospitality, or other benefit at any time from a vendor if there is a competitive procurement process underway where that vendor has submitted a response to a request for proposals or other competitive procurement process. The onus is on the AHS Representative to determine whether such a competitive procurement process is underway and they may make that determination by contacting AHS Contracting, Procurement, and Supply Management at cpsm.customersupport@ahs.ca.

8.7 Despite section 8.1(b)(i) and 8.1(b)(ii), no AHS Representative may provide a patient with preferential priority of access to publicly-funded health services managed by AHS due to receipt of a gift, hospitality, or other benefit, from a patient or the patient's family or friends. No AHS Representative may influence, or seek to influence, a patient's priority of access to publicly-funded health services managed by AHS due to receipt of a gift, hospitality, or other benefit, from a patient or the patient's family or friends.

8.8 If an AHS Representative receives a gift, hospitality, or other benefit that exceeds the commercial value set out in section 8.2, and where that gift, hospitality, or other benefit cannot be returned, the AHS Representative may not keep the gift, hospitality, or other benefit but must redirect it to a foundation, trust, auxiliary, or other charitable organization registered and established in accordance with the laws and statutes of Alberta and Canada which has an affiliation with AHS, whether by legislation or by agreement.

9. Receipt of Education from a Vendor

9.1 Subject to section 9.5, AHS Representatives may receive education provided by a vendor, either directly or indirectly, and the commercial value of any gift, hospitality, or other benefit that accompanies that education must not exceed a total of $500.00 from one source (as defined in section 8.3) in a calendar year. Examples of gifts, hospitality, or other benefit that accompany vendor education and that would be subject to the $500.00 annual total are meal expenses, travel expenses, accommodation expenses, complimentary resource materials, and promotional items such as pens, mugs, etc.

9.2 The time that a vendor uses to travel to, prepare for, or deliver education to an AHS Representative will be considered to have no value when calculating the commercial value of any vendor-sponsored education.

9.3 Any registration fee or conference fee for education that is paid for or waived by a vendor for an AHS Representative must not exceed a total of $1,500.00 from one source (as defined in section 8.3) in a calendar year for that AHS Representative. Registration fees or conference fees for education that are paid for or waived by a vendor which exceed a total of $1,500.00 from one source (as defined in section 8.3) in a calendar year may be accepted only with prior written permission from the Chief Ethics & Compliance Officer (or designate), which permission only shall be granted reasonably, in accordance with the principles of this Bylaw, and if there is no real, apparent, or potential conflict of interest.

9.4 All reasonable steps must be taken to receive vendor-sponsored education at an AHS site rather than at a restaurant or similar venue.

9.5 Despite section 9.1, no AHS Representative shall accept any vendor-sponsored education at any time if there is a competitive procurement process underway where that vendor has submitted a response to a request for proposals or other competitive procurement process. The onus is on the AHS Representative to determine whether such a competitive procurement process is underway and they may make that determination by contacting AHS Contracting, Procurement, and Supply Management at cpsm.customersupport@ahs.ca.

9.6 This Bylaw does not limit the ability of an AHS Representative to receive vendor-sponsored education or training as expressly agreed to as "value adds" in contracts between AHS and its vendors. These contractual items are not subject to the monetary limits indicated in section 9.1 and shall not be considered to be gifts under this Bylaw.

9.7 This Bylaw does not limit the ability of an AHS Representative to apply for or receive scholarships or bursaries from industry-funded organizations or non-profit professional organizations for purposes of continuing education. These scholarships or bursaries are not subject to the monetary limits indicated in section 9.1 and shall not be considered to be gifts under this Bylaw.

10. Contracting with Current and Former AHS Board Members

10.1 Restrictions on contracting with current or former AHS Board members apply whether the AHS Board member is providing the goods or services directly to AHS or through a company that is owned, controlled, or managed by the AHS Board member or by an immediate family member of the employee.

10.2 AHS shall not enter into a contractual or business relationship with a current AHS Board member. This restriction does not apply to services for the provision, administration, or management of clinical care or clinical support or to medical administrative leadership roles

10.3 AHS shall not enter into a contractual or business relationship with a former AHS Board member for a period of twelve (12) months following the end of their term, unless otherwise explicitly approved by the AHS Board. This restriction does not apply to services for the provision, administration, or management of clinical care or clinical support or to medical administrative leadership roles

11. Contracting with Current and Former AHS Employees

11.1 Restrictions on contracting with current or former employees apply whether the employee is providing the goods or services directly to AHS or through a company that is owned, controlled, or managed by the employee or by an immediate family member of the employee.

11.2 AHS shall not enter into contracts for goods and/or services, including but not limited to consulting services or professional services, with current AHS employees outside of any terms of the individual's employment.

11.3 The current or former employment relationship must be disclosed by the current or former employee as part of the normal procurement process and/or during the negotiation of any contract.

11.4 Contracts for consulting or professional services with former employees who held positions allocated in the M4 career level and above are subject to the completion of a cooling off period as set out in sections 11.5 and 11.6.

11.5 A cooling off period must occur before a former AHS employee who held a position allocated in the M4 career level and above can enter into a contract with AHS for the provision of consulting or professional services. The cooling off period shall begin on the later of:

a) the date that the individual's employment with AHS has ended; or

b) in situations where a severance was provided, the end date of the severance notice period.

11.6 The cooling off period shall be twelve (12) months for all former employees who held positions allocated in the M4 career level and above as determined by the last position held by the employee prior to the termination date.

11.7 For positions below the M4 career level, there shall not be any required cooling off period.

11.8 All requests to waive the cooling off period in whole or in part shall be reviewed and approved by the President and Chief Executive Officer in consultation with the Vice President, Corporate Services & Chief Financial Officer and the Vice President, People, Legal & Privacy. The approved waiver must be appended to the contract documentation.

11.9 Contracts with former employees who were employed at the level of President and Chief Executive Officer or Vice President, irrespective of the cooling off period set out in Part 11 or in the *Conflicts of Interest Act* (Alberta), must be reviewed and approved by the President and Chief Executive Officer in consultation with the Vice President, Corporate Services & Chief Financial Officer, and the Vice President, People, Legal & Privacy.

11.10 Contracts with former employees, who were employed in positions allocated in the M4 career level and above, before the end of their cooling off period, must be reviewed and approved by the President and Chief Executive Officer in consultation with the Vice President, Corporate Services & Chief Financial Officer, and the Vice President, People, Legal & Privacy.

11.11 The approvals required in sections 11.9 and 11.10 are in addition to any approvals required in accordance with standard contracting provisions.

11.12 Contracts with former employees who were employed in positions allocated below the M4 career level must be reviewed and approved in accordance with standard contracting provisions.

12. Post-Termination Requirements

12.1 Upon termination of employment, contract, or other relationship with AHS, a former AHS Representative must abstain from the following activities for a period of twelve (12) months following the end of their relationship with AHS:

a) using their former position with AHS to influence, or seek to influence, a decision made, or to be made, on behalf of AHS that would benefit a private interest; and

b) using or communicating knowledge and information not available to the general public and gained through their involvement with AHS to benefit a private interest.

13. Political Activity: Donations

13.1 AHS Representatives may make political donations using their personal funds and/or attend political events, including fundraising events, in a personal capacity.

13.2 AHS funds or resources shall not be donated or otherwise used to support any political activity, political party, or candidate including attendance at or donations to fundraising events. Personal funds or resources shall not be donated to a political activity, political party, or candidate on behalf of AHS.

14. Political Activity: Use of AHS Facilities

14.1 AHS facilities shall not be used for any political activity, including, but not limited to use for the purposes of canvassing, campaigning, making political announcements, touring and other activities. During an election campaign, political parties are not permitted to use AHS facilities as a backdrop or host location for any campaign event or activity.

14.2 Elected officials may access AHS facilities for the purpose of carrying out their duties to the elected office provided they do not engage in any political activity and comply with applicable AHS policies and all standard access requirements in place at the facility.

14.3 In accordance with the *Election Act* (Alberta), *Canada Elections Act* (Alberta), and *Local Authorities Election Act (*Alberta), AHS facilities may be used for polling stations and for special/mobile polling provided the polling does not interfere with health care delivery and AHS business.

14.4 Any other political activity is not permitted in AHS facilities.

15. Political Activity: Candidates for Election

15.1 The following AHS Representatives must not be a candidate in a provincial election while serving in their position or appointment with AHS:

a) AHS Board members;

b) the President and Chief Executive Officer;

c) any executive that reports directly to the President and Chief Executive Officer; and

d) any other person so designated by the President and Chief Executive Officer.

15.2 All other AHS Representatives must disclose their candidacy using a Declaration Form in order to manage any real, potential, or apparent conflicts of interest that may arise from being a candidate in an election or serving in an elected office. Upon disclosure, the candidate's Manager, in consultation with the Chief Ethics and Compliance Officer, will determine whether a real, potential, or apparent conflict of interest exists and if so, the appropriate management plan to mitigate or remove the conflict position.

15.3 AHS Representatives who are:

a) elected to the Legislative Assembly of Alberta, the Parliament of Canada, or a municipal office (including school trustee) are required to disclose the elected position using a Declaration Form and to comply with the decision of the Chief Ethics and Compliance Officer to remove or mitigate a real, potential, or apparent conflict position; or

b) not elected, and are on an approved leave of absence from AHS, may return to their position or similar position with AHS effective the first day after the election.

15.4 AHS Representatives requesting time off to assist in another individual's campaign are required to follow the standard processes for processing and approving paid or unpaid time off (e.g. vacation request, unpaid leave of absence).

16. Alleged Breach of this Bylaw: Reporting

16.1 There are three avenues to report an alleged breach of this Bylaw:

a) **Manager** – Unless their Manager is believed to be involved in the alleged breach, an AHS Representative should report any alleged breach to their Manager. Such a report may be made in a manner which maintains the confidentially of AHS Representatives but must be in accordance with sections 16.2, 16.3, and 16.4. The Manager must ensure that a written submission of the report is submitted by either the Manager or the AHS Representative to the AHS Chief Ethics and Compliance Officer for consultation or to direct follow-up and/or investigation. If the alleged breach pertains to the Manager, the report should be made to the next highest level of management, human resources contact, Chief Medical Officer or Zone Medical Director, or to the professional practice leader.

b) **Chief Ethics and Compliance Officer** – If an AHS Representative is unable to report an alleged breach of this Bylaw to his or her Manager (as described above) or to the next highest level of management, the reporter can report the alleged breach to the Chief Ethics and Compliance Officer. Such a report may be made in a manner which maintains the confidentially

of AHS Representatives but must be in accordance with sections 16.2, 16.3, and 16.4. The Chief Ethics and Compliance Officer can be contacted at complianceofficer@albertahealthservices.ca.

c) **External Confidential Reporting and Disclosure Service** – If reporting to the Manager or the Chief Ethics and Compliance Officer is not appropriate, the reporter can report the alleged breach through the AHS safe disclosure line at 1-800-661-9675. The information contained in the report is submitted by the safe disclosure line to the Chief Ethics and Compliance Officer for follow-up and/or investigation unless the alleged breach involves the Chief Ethics and Compliance Officer, in which case the report must be submitted to the Chair of the Governance Committee of the AHS Board.

16.2 All initial reports of an alleged breach of this Bylaw can be made confidentially; however, subsequent to the initial report the maintenance of absolute confidentiality may be limited in order to conduct an appropriate and fair investigation.

16.3 Reports of alleged breaches of this Bylaw made pursuant to section 16.1(a), (b) and (c), may require follow-up contact with the reporter in order to conduct an effective investigation of an alleged breach.

16.4 Reports of alleged breaches of this Bylaw should be factual rather than speculative and contain as much specific information as possible. Lack of detail and/or anonymous reports may limit AHS' ability to conduct a thorough investigation.

16.5 An allegation of a breach of this Bylaw that occurred more than two (2) years prior to the date of the report will generally not be open for review.

16.6 AHS retains the authority to review any allegation of an alleged breach that has surpassed the limitation period in section 16.5 if the matter represents a continued or future risk to AHS personnel, the public, patient safety, the integrity and reputation of AHS, and/or to the clinical or business operations of AHS.

16.7 All reports received by the Chief Ethics & Compliance Officer (or designate) must be reviewed to determine if they fall under the *Public Interest Disclosure (Whistleblower Protection) Act* (Alberta) prior to any investigation or response taking place.

17. Alleged Breach of this Bylaw: Reporting that is Frivolous or Vexatious

17.1 AHS Representatives are prohibited from making reports of alleged breaches of this Bylaw which are frivolous or vexatious in nature.

17.2 AHS will take all necessary steps to appropriately manage frivolous or vexatious reports of alleged breaches, regardless of whether the report is from an AHS Representative or another person. The Chief Ethics and Compliance Officer may refuse to accept a report if it is deemed frivolous or vexatious as per section 17.3.

17.3 The determination of whether a report of an alleged breach is frivolous or vexatious is made by a three (3) member group consisting of the Chief Ethics and Compliance Officer, General Counsel, and the Vice President of People, Legal & Privacy. If any one of these individuals is not available or if their presence in the group constitutes a conflict of interest or is otherwise not appropriate then the membership will consist of one other Senior Leader. A consensus on the determination is required.

17.4 If a report of an alleged breach of this Bylaw is deemed frivolous or vexatious, the Chief Ethics and Compliance Officer is required to promptly notify in writing the individual who made the report and members of AHS' Executive Leadership Team.

17.5 The Chief Ethics and Compliance Officer must maintain a record of all reports of alleged breaches made under this Bylaw that are deemed frivolous or vexatious. The record shall indicate:

a) the name of the individual making the report;

b) the names and positions of individuals who participated in the determination;

c) the rationale for the determination; and

d) a copy of the notification to the individual who made the report.

18. Alleged Breach of this Bylaw: Investigating an AHS Board Member

18.1 The AHS Board Chair has authority to investigate an alleged breach of this Bylaw by another AHS Board member and any such investigation will be consistent with the principles indicated in sections 21.3 to 21.10 of this Bylaw.

18.2 The Chief Ethics and Compliance Officer has authority to investigate an alleged breach of this Bylaw by the AHS Board Chair and any such investigation will be consistent with the principles indicated in sections 21.3 to 21.10 of this Bylaw. An exception to this is that any alleged breach by the AHS Board Chair of their statutory obligations outlined in Part 26 will be investigated by the Ethics Commissioner for Alberta pursuant to the *Conflicts of Interest Act* (Alberta).

18.3 The Chief Ethics and Compliance Officer will notify the Minister of Health of any allegation received by AHS of an alleged breach of this Bylaw by the AHS Board Chair and the outcome of any investigation in response to such an allegation.

19. Alleged Breach of this Bylaw: Investigating the President and Chief Executive Officer

19.1 The AHS Board Chair has authority to investigate an alleged breach of this Bylaw by the President and Chief Executive Officer and any such investigation will be consistent with the principles indicated in sections 21.3 to 21.10 of this Bylaw. An exception to this is that any alleged breach by the President and Chief Executive Officer of their statutory obligations outlined in Part 26 shall be investigated by the Ethics Commissioner for Alberta pursuant to the *Conflicts of Interest Act* (Alberta).

20. Alleged Breach of this Bylaw: Investigating the Chief Ethics and Compliance Officer

20.1 The Chair of the Governance Committee of the AHS Board has authority to investigate an alleged breach of this Bylaw by the Chief Ethics and Compliance Officer and any such investigation will be consistent with the principles indicated in sections 21.3 to 21.10 of this Bylaw.

21. Alleged Breach of this Bylaw: Investigating an Employee

21.1 Investigations are conducted by personnel from stakeholder departments. The composition of an investigation team is dependent on the nature of the allegation.

21.2 Allegations that are serious, complex or high risk or could potentially have a significant impact on AHS, are referred to the senior designated group within AHS that acts as a steering committee for workplace investigations.

21.3 As part of the investigation, and in accordance with applicable laws, legislation, and AHS policies, procedures, and directives, investigators have authority to:

a) access AHS-owned or operated premises and AHS records; and/or

b) examine, copy, and/or remove all or any portion of the contents of files, desks, cabinets, equipment, or other storage facilities used for AHS-related activities on AHS-owned or operated facilities. The examination, copying, and/or removal does not require the consent of the individual who might use or have custody of the items or facilities.

21.4 AHS Representatives shall cooperate fully with investigators.

21.5 At the conclusion of an investigation, an allegation may be forwarded, as required or permitted by applicable law or legislation, to external agencies including, but not limited to, the police, a professional body, and/or a government department.

21.6 All investigations under this Bylaw shall be carried out in a timely manner which is consistent with the principles of due diligence, procedural fairness and the requirements of this Bylaw. The principles of procedural fairness for an investigation under this Bylaw include:

a) investigator(s) will be free of bias;

b) respondents will receive reasonable notice of any investigation against them;

c) respondents will be provided with a reasonable opportunity to respond to the allegations against them;

d) subject to privacy legislation and policy, respondents and the persons alleging breach of this Bylaw will receive written notification of the outcome of the investigation and any systemic recommendations for corrective action that may flow from the investigation and may receive, upon request, written reasons for the outcome; and

e) respondents and the persons alleging breach of this Bylaw will have a right of review regarding the outcome any investigation pursuant to Part 25 of this Bylaw.

21.7 In the event of a conflict between the timelines of an investigation conducted pursuant to this Bylaw and the timelines of another applicable process, the shorter timeline shall be used.

21.8 Information collected during an investigation shall be kept confidential to the extent possible, subject to applicable legislation and AHS policies and procedures. Unauthorized breaches of confidentiality of an investigation may result in disciplinary action up to and including termination of employment, appointment/privileges, contractual, or other relationship with AHS.

21.9 Follow-up contact must be conducted in a manner which maintains the confidentiality and anonymity of the reporter, where possible.

21.10 Investigation or other actions related to a report of an alleged breach may not be pursued where insufficient information prevents due process, or where the identity of the individual disclosing the alleged breach cannot be confirmed and is required by law in order to proceed.

22. Alleged Breach of this Bylaw: Investigating a Member of the AHS Medical Staff

22.1 Part 22 applies to any AHS Representative who is a member of the AHS Medical Staff, regardless of whether they are also an AHS employee, subject to the following:

a) if the AHS Representative is a member of the AHS Medical Staff and is also an AHS Board member, any investigation of an alleged breach of this Bylaw by the AHS Representative will be conducted pursuant to Part 18 of this Bylaw; or

b) if the AHS Representative is a member of the AHS Medical Staff and is also the President and Chief Executive Officer, any investigation of an alleged breach of this Bylaw by the AHS Representative will be conducted pursuant to Part 19 of this Bylaw.

22.2 Subject to section 22.3, any investigation of an alleged breach of this Bylaw under Part 22 will be subject to Part 6 of the *Medical Staff Bylaws* which are attached as **Schedule B** to this Bylaw and section 2.12 of the *Medical Staff Rules* which are attached as **Schedule C** to this Bylaw.

22.3 Any alleged breach of this Bylaw by an AHS medical administrative leader that pertains to his/her role, responsibilities, and duties as an AHS medical administrative leader will be investigated pursuant to sections 22.4 to 22.10.

22.4 The Concern shall be referred to an Associate Chief Medical Officer who shall confirm that the matter is most appropriately addressed through the internal AHS processes outlined in this Bylaw, taking into consideration the AHS medical administrative leader's contractual or employment arrangement with AHS.

22.5 Investigation and review of a Concern or other information/complaint about an AHS medical administrative leader shall be directed and conducted by a more senior AHS medical administrative leader(s).

a) In general, the investigation and review of a Concern or other information/complaint about a Zone-based AHS medical administrative leader shall be directed by the relevant Zone Medical Director who may delegate specified tasks, including conducting the investigation and review, to his/her designate(s).

b) In general, the investigation and review of a Concern or other information/complaint about a Zone Medical Director or a provincial AHS medical administrative leader shall be directed by an Associate Chief Medical Officer who may delegate specified tasks, including conducting the investigation and review, to his/her designate(s), a relevant Senior Medical

Director (if applicable) or other appropriate AHS medical administrative leader(s).

c) If a Concern or other information/complaint pertains to an Associate Chief Medical Officer, the investigation and review will be performed by the Chief Medical Officer.

d) If a Concern or other information/complaint pertains to Chief Medical Officer, the matter will be referred directly to the AHS President and Chief Executive Officer.

22.6 Reviews and investigations undertaken pursuant to section 22.5 shall include the following minimum steps:

a) Written confirmation of the other information/complaints from the complainant and/or other independent confirmation of the other information/complaint from sources other than the complainant shall be obtained. If deemed appropriate, formulation of a Concern will be undertaken.

b) The complainant shall be informed that an investigation will be undertaken (including an explanation of the process to be followed) and shall be periodically updated as to the progress of the investigation, and of its conclusion.

c) An investigation of a Concern shall be conducted and may include, but not be limited to, interviews with all relevant persons involved, review of all relevant documentation, solicitation of internal / AHS or external expert opinion and / or establishment of an independent external review if, and as, required.

d) Consensual resolution will be undertaken wherever feasible and reasonable, and when mutually agreed to by the complainant and the AHS medical administrative leader who is the subject of the Concern. Consensual resolution will involve the AHS medical administrative leader conducting the investigation and review, and, if deemed appropriate, an independent internal/AHS or external facilitator.

e) A report including the findings of the investigation, recommendations for resolution, and the outcome of consensual resolution (if undertaken), will be prepared by the AHS medical administrative leader conducting the investigation and review of the Concern. The report will be reviewed by the AHS medical administrative leader directing the investigation and review who shall then forward it to the Chief Medical Officer for final decision.

22.7 Recommendations for resolution may include, but are not limited to, one or more of the following:

a) dismissal of the Concern or other information/complaints as unfounded;

b) no further action;

c) mutually agreed upon means to resolve the Concern to avoid future recurrences of the issue(s) that triggered the Concern;

d) an apology from the AHS medical administrative leader to the complainant

e) remedial leadership training/mentoring for the AHS medical administrative leader and/or the arrangement of further leadership development opportunities related to the matter triggering the Concern

f) professional counselling and treatment for the AHS medical administrative leader;

g) remedial measures to address inappropriate workplace behaviour demonstrated by the AHS medical administrative leader;

h) temporary suspension or permanent termination from the AHS medical administrative leadership role; and/or

i) referral to the relevant College and/or other external agencies if deemed appropriate or required by law.

22.8 The terms and conditions within the contract between the AHS medical administrative leader and AHS, including those with respect to expectations, responsibilities and duties, deliverables and termination, shall be considered and honoured during the investigation and resolution of any Concern.

22.9 At the conclusion of the investigation and review of a Concern:

a) a final report shall be placed in the AHS medical administrative leader's file along with a written response (if any) from the AHS medical administrative leader; and

b) the complainant will be notified that the investigation and review have been completed and shall only be informed as to whether the Concern was dismissed as unfounded or that the Concern and/or specific issues within it were determined to be well founded. The complainant will also be informed as to whether any actions/sanctions have been agreed upon or

imposed but the nature or details of such actions/sanctions will not be disclosed.

c) If the AHS medical administrative leader (who is the subject of a Concern) is dissatisfied with the final decision of the Chief Medical Officer, he/she may pursue any legal remedies available to him/her.

22.10 Notwithstanding the need to be thorough and thoughtful in the investigation and review of a Concern about an AHS medical administrative leader, AHS will strive to complete such investigations and reviews, whenever possible, within sixty (60) days of receipt of a Concern.

23. Alleged Breach of this Bylaw: Investigating a Member of the AHS Midwifery Staff

23.1 Part 23 applies to any AHS Representative who is a member of the AHS Midwifery Staff, regardless of whether they are also an AHS employee, subject to the following:

a) If the AHS Representative is a member of the AHS Midwifery Staff and is also an AHS Board member, any investigation of an alleged breach of this Bylaw by the AHS Representative will be conducted pursuant to Part 18 of this Bylaw; or

b) If the AHS Representative is a member of the AHS Midwifery Staff and is also the President and Chief Executive Officer, any investigation of an alleged breach of this Bylaw by the AHS Representative will be conducted pursuant to Part 19 of this Bylaw.

23.2 Any investigation of an alleged breach of this Bylaw under Part 23 shall be subject to Part 6 of the *Midwifery Staff Bylaws* which are attached as **Schedule D** to this Bylaw and sections 2.5 to 2.6 of the *Midwifery Staff Rules* which are attached as **Schedule E** to this Bylaw.

23.3 If there is any inconsistency between the terms of this Bylaw and the *Midwifery Staff Bylaws* and *Rules*, the *Midwifery Staff Bylaws* and *Rules* shall prevail.

24. Finding of a Breach of this Bylaw

24.1 AHS Representatives found to have committed a breach of this Bylaw may be subject to disciplinary action up to and including termination of employment, appointment, privileges, contractual, or other relationship with AHS.

25. Review of Investigation Findings

25.1 Where the respondent to an investigation under Part 18 of this Bylaw is an AHS Board Member (other than the AHS Board Chair), the findings of the investigation may be appealed to an *ad hoc* committee of members of the AHS Board appointed by the Chair of Governance Committee of the AHS Board. The *ad hoc* committee will not include the AHS Board Chair or any AHS Board member who is a respondent to the investigation.

25.2 Where the respondent to an investigation under Part 18 this Bylaw is the AHS Board Chair, the findings of the investigation may be appealed to an *ad hoc* committee of members of the AHS Board appointed by the Chair of the Governance Committee of the AHS Board. The *ad hoc* committee will not include the AHS Board Chair.

25.3 Where the respondent to an investigation under Part 19 of this Bylaw is the President and Chief Executive Officer, the findings of the investigation may be appealed to an *ad hoc* committee of members of the AHS Board appointed by the Chair of Governance Committee of the AHS Board. The *ad hoc* committee will not include the AHS Board Chair.

25.4 Where the respondent to an investigation under Part 20 of this Bylaw is the Chief Ethics & Compliance Officer, the findings of the investigation may be appealed to an *ad hoc* committee of members of the AHS Board appointed by the AHS Board Chair. The *ad hoc* committee will not include the Chair of the AHS Board Governance Committee.

25.5 Where the respondent to an investigation under Part 21 of this Bylaw is an AHS employee, the findings of the investigation may be appealed to an *ad hoc* committee appointed by the AHS Board and must include members from the AHS Board and/or AHS Senior Leadership.

25.6 Members of the AHS Medical Staff and Midwifery Staff may appeal the decision/recommendation through the appropriate process as set out by the *Medical Staff Bylaws* and *Rules* or the *Midwifery Staff Bylaws* and *Rules*.

26. Statutory Provisions Applicable to AHS Board Chair and President and Chief Executive Officer

26.1 Part 26 sets out provisions of the *Conflicts of Interest Act* (Alberta) that apply only to the AHS Board Chair or President and Chief Executive Officer of AHS.

26.2 The *Conflicts of Interest Act* (Alberta) imposes statutory obligations on both the AHS Board Chair and President & Chief Executive Officer regarding:

a) Restrictions on furthering private interests
[*Conflicts of Interest Act* (Alberta), section 23.925(1)];

b) Restrictions on using influence
[*Conflicts of Interest Act* (Alberta), section 23.925(2)];

c) Restrictions on using insider information
[*Conflicts of Interest Act* (Alberta), section 23.925(3)]; and

d) Disclosure of real and apparent conflicts of interest
[*Conflicts of Interest Act* (Alberta), section 23.925(4)];

26.3 The *Conflicts of Interest Act* (Alberta) imposes statutory obligations on only the President & Chief Executive Officer regarding:

a) Restrictions on concurrent employment/other offices
[*Conflicts of Interest Act* (Alberta), section 23.926];

b) Restrictions on publicly traded securities
[*Conflicts of Interest Act* (Alberta), section 23.93)];

c) Required disclosures to the Ethics Commissioner for Alberta, including financial disclosures and disclosures of direct associates
[*Conflicts of Interest Act* (Alberta), section 23.931 and 23.932)]; and

d) Post-employment restrictions (12-month restriction on certain activities)
[*Conflicts of Interest Act* (Alberta), section 23.937)].

26.4 Any person to whom Part 26 pertains may contact the Ethics Commissioner for Alberta at disclosure@ethicscommissioner.gov.ab.ca for advice regarding their disclosure obligations under the *Conflicts of Interest Act* (Alberta).

26.5 If there is any inconsistency between the terms of this Bylaw and the *Conflicts of Interest Act* (Alberta), the *Conflicts of Interest Act* (Alberta) shall prevail.

26.6 All section numbers and headings that follow in the remainder of Part 26 are taken directly from the *Conflicts of Interest Act* (Alberta). Any terms used in the balance of Part 26 have the meaning given to them in the *Conflicts of Interest Act* (Alberta).

Excerpts from the *Conflicts of Interest Act* (Alberta)

The entire *Conflicts of Interest Act* (Alberta) is available to the public at www.qp.alberta.ca/Laws_Online.cfm

Decisions furthering private interests

[Section 23.925 applies to both the AHS Board Chair and the AHS President and Chief Executive Officer.]

[Section 23.925 came into effect for the incumbent AHS Board Chair and the incumbent AHS President and Chief Executive Officer on December 15, 2017]

[Section 23.925 will come into effect for any new AHS Board Chair or new AHS President and Chief Executive Officer immediately upon their appointment]

23.925(1) A senior official breaches this Part if he or she takes part in a decision in the course of carrying out his or her office or powers knowing that the decision might further a private interest of the senior official, a person directly associated with the senior official or the senior official's minor or adult child.

(2) A senior official breaches this Part if the senior official uses his or her office or powers to influence or to seek to influence a decision to be made by or on behalf of the Crown or a public agency to further a private interest of the senior official, a person directly associated with the senior official or the senior official's minor child or to improperly further any other person's private interest.

(3) A senior official breaches this Part if he or she uses or communicates information not available to the general public that was gained by the senior official in the course of carrying out his or her office or powers to further or seek to further a private interest of the senior official or any other person's private interest.

(4) A senior official breaches this Part if the senior official fails to appropriately or adequately disclose a real or apparent conflict of interest.

Concurrent employment

[Section 23.926 applies only to the AHS President and Chief Executive Officer.]

[Section 23.926 will come into effect for the incumbent AHS President and Chief Executive Officer when they are reappointed, when their contract is extended or renewed, or on December 15, 2019, whichever comes first]

[Section 23.926 will come into effect for any new AHS President and Chief Executive Officer immediately upon their appointment]

23.926(1) If any of the following senior officials is involved in any appointment, business, undertaking or employment, including self-employment, other than the appointment, business, undertaking or employment that is subject to this Act, that senior official breaches this Part:

(a) a chief executive officer;

(b) a chair whose position has been designated for the purposes of section 23.921(4)(b);

(c) a person holding a position identified under section 23.921(3)(c), if that position has been designated for the purposes of section 23.921(4)(b).

(2) A person referred to in subsection (1) may apply to the Ethics Commissioner for approval in writing to engage in an appointment, business, undertaking or employment, including self-employment, other than the appointment or employment that is subject to this Act.

(3) The Ethics Commissioner may provide approval in writing on any conditions that the Ethics Commissioner considers to be appropriate if the Ethics Commissioner is satisfied that the appointment, business, undertaking or employment proposed in an application under subsection (2) will not constitute a real or apparent conflict of interest.

(4) Subsection (1) does not apply if the Ethics Commissioner approves the application referred to in subsection (2) in writing and the person referred to in subsection (1) complies with the conditions, if any, that the Ethics Commissioner has included in the approval.

Restriction on holdings

[Section 23.93 applies to only the AHS President and Chief Executive Officer.]

[Section 23.93 will come into effect for the incumbent AHS President and Chief Executive Officer when they are reappointed, when their contract is extended or renewed, or on April 4, 2020, whichever comes first.]

[Section 23.93 will come into effect for any new AHS President and Chief Executive Officer immediately upon their appointment.]

23.93(1) A designated senior official breaches this Part if he or she, after the expiration of the relevant period referred to in subsection (7), owns or has a beneficial interest in publicly-traded securities.

(2) Subsection (1) does not apply if

(a) the publicly-traded securities are held in a blind trust approved under subsection (4) or in an investment arrangement approved under subsection (5),

(b) prior to the expiration of the relevant period referred to in subsection (7), the designated senior official applies to the Ethics Commissioner for approval to retain ownership of or a beneficial interest in the publicly-traded securities and either obtains the Ethics Commissioner's approval or, if the approval is refused, takes any steps that the Ethics Commissioner directs with respect to the disposition of the ownership or beneficial interest, or

(c) after the expiration of the relevant period referred to in subsection (7), the designated senior official acquires ownership of or a beneficial interest in publicly-traded securities with the prior approval of the Ethics Commissioner.

(3) The Ethics Commissioner may give an approval

(a) under subsection (2)(b) or (c) if the Ethics Commissioner is of the opinion that the publicly-traded securities are securities of a corporation the interests of which are not likely to be affected by decisions of the public agency or by decisions of the Government within the scope of advice, advocacy, activity or influence of the public agency, or

(b) under subsection (2)(b) if the Ethics Commissioner is of the opinion that the designated senior official will sustain a financial loss if the publicly-traded securities are disposed of and the public interest does not require disposition of the publicly-traded securities.

(4) The Ethics Commissioner may approve the retention of publicly-traded securities to be held in a blind trust if the blind trust will meet the criteria set out in section 20(4).

(5) The Ethics Commissioner may approve the retention of publicly-traded securities to be held in an investment arrangement if the investment arrangement will meet the criteria set out in section 20(5).

(6) An approval or direction given by the Ethics Commissioner under this section may be given subject to any conditions determined by the Ethics Commissioner.

(7) For the purposes of subsections (1) and (2),

(a) the relevant period is

(i) in the case of a person who becomes a designated senior official after the coming into force of this section, 60 days after becoming a designated senior official or any longer period that the Ethics Commissioner directs, or

(ii) in the case of a person who is a designated senior official when this section comes into force, 60 days after the coming into force of this section or any longer period that the Ethics Commissioner directs,

or

(b) with respect to a designated senior official who acquires ownership of or a beneficial interest in publicly-traded securities by gift or inheritance, the relevant period is 60 days after receiving the gift or inheritance or any longer period that the Ethics Commissioner directs.

(8) For greater certainty, the Ethics Commissioner may, during the Ethics Commissioner's first review of disclosure statements, returns and holdings under this Part, direct that a relevant period set out in subsection (7) be extended for administrative reasons.

Disclosure statements

[Section 23.931 applies to only the AHS President and Chief Executive Officer.]

[Section 23.931 will come into effect for the incumbent AHS President and Chief Executive Officer when they are reappointed, when their contract is extended or renewed, or on April 4, 2020, whichever comes first.]

[Section 23.931 will come into effect for any new AHS President and Chief Executive Officer immediately upon their appointment.]

23.931(1) Every designated senior official shall file with the Ethics Commissioner a disclosure statement in the form and manner determined by the Ethics Commissioner

(a) within 60 days after

(i) becoming a designated senior official, in the case of a person who becomes a designated senior official after the coming into force of this section, or

(ii) the coming into force of this section, in the case of a person who is a designated senior official when this section comes into force,

and

(b) in each subsequent year at the time specified by the Ethics Commissioner.

(2) A designated senior official shall, within 30 days after the occurrence of any material changes to the information contained in a current disclosure statement, file with the Ethics Commissioner an amending disclosure statement in the form provided by the Ethics Commissioner setting out the changes.

(3) Section 12(a) to (d) apply for the purpose of establishing the contents of and additional time requirements for the disclosure statements referred to in subsection (1).

Returns relating to persons directly associated

[Section 23.932 applies to only the AHS President and Chief Executive Officer.]

[Section 23.932 will come into effect for the incumbent AHS President and Chief Executive Officer when they are reappointed, when their contract is extended or renewed, or on April 4, 2020, whichever comes first.]

[Section 23.932 will come into effect for any new AHS President and Chief Executive Officer immediately upon their appointment.]

23.932(1) Every designated senior official shall file with the Ethics Commissioner a return relating to persons directly associated with the designated senior official, in a form and manner determined by the Ethics Commissioner,

(a) within 60 days after

(i) becoming a designated senior official in the case of a person who becomes a designated senior official after the coming into force of this section, or

(ii) the coming into force of this section, in the case of a person who is a designated senior official when this section comes into force,

(b) within 30 days after the occurrence of any material change in the information contained in a current return, and

(c) within 30 days after the day he or she ceases to be a designated senior official.

(2) Section 15(1)(a) and (b) and (2) apply for the purpose of establishing the contents of a designated senior official's returns and additional time requirements for a designated senior official's returns under this section.

(3) On receipt of a return under this section, the Ethics Commissioner shall provide a copy of the return

(a) in the case of a return concerning any designated senior official other than the chief executive officer or chair, to the chief executive officer or, if no chief executive officer exists, to the chair,

(b) in the case of a return concerning the chief executive officer, to the chair or, if no chair exists, to the responsible Minister, and

(c) in the case of a return concerning the chair, to the responsible Minister.

Post-employment restrictions

[Section 23.937 applies to only the AHS President and Chief Executive Officer.]

[Section 23.937 will come into effect for the incumbent AHS President and Chief Executive Officer when they are reappointed, when their contract is extended or renewed, or on April 4, 2020, whichever comes first.]

[Section 23.937 will come into effect for any new AHS President and Chief Executive Officer immediately upon their appointment.]

23.937(1) No former designated senior official shall, for a period of 12 months from the last day the former designated senior official held a position referred to in section 23.92(1)(d), lobby as defined in the *Lobbyists Act* any public office holder as defined in the *Lobbyists Act*.

(2) No former designated senior official shall, for a period of 12 months from the last day the former designated senior official held a position referred to in section 23.92(1)(d), act on a commercial basis or make representations on his or her own behalf or on behalf of any other person in connection with any ongoing matter in connection with which the former designated senior official, while a designated senior official, directly acted for or advised a department or public agency involved in the matter.

(3) No former designated senior official shall, for a period of 12 months from the last day the former designated senior official had a direct and significant official dealing with a department or public agency, make representations with respect to a contract with or benefit from that department or public agency.

(4) No former designated senior official shall, for a period of 12 months from the last day the former designated senior official had a direct and significant official dealing with a department or public agency, solicit or accept on his or her own behalf a contract or benefit from that department or public agency.

(5) No former designated senior official shall, for a period of 12 months from the last day the former designated senior official had a direct and significant official dealing with an individual, organization, board of directors or equivalent body of an organization, accept employment with that individual or organization or an appointment to the board of directors or equivalent body.

(6) Nothing in this section restricts a designated senior official or former designated senior official from being appointed to the board of directors or a governing body of another public agency.

(7) Nothing in this section restricts a designated senior official or former designated senior official from accepting employment with a department of the public service or a public agency in accordance with Part 1 of the *Public Service Act*.

27. Effective Date

27.1 The Bylaw replaces the AHS Conflict of Interest Bylaw approved and effective May 14, 2013.

27.2 This version of the Bylaw will be published upon approval by the Minister of Health. Publication will occur by no later than April 30, 2019.

27.3 This version of the Bylaw is effective 90 calendar days after it is published.

27.4 This Bylaw may be approved in counterpart.

Approved and adopted by Alberta Health Services this 12th day of December 2018.

Linda Hughes, Chair
Alberta Health Services Board

Approved in accordance with the *Regional Health Authorities Act* this 11 day of February, 20 19.

The Honourable Sarah Hoffman
Minister of Health

Schedule A: AHS Conflict of Interest Procedure for Contracting and Procurement Initiatives

1. This COI Procedure is intended to proactively address issues and manage disclosed or identified Conflicts in order to ensure that the potential for such Conflicts to impact the impartiality of the process or result in bias is mitigated. A "**Conflict**" is defined to include both a Conflict of Interest as such term is used and defined under the AHS Conflict of Interest Bylaw as well as other circumstances in which a Project Participant is, or has been involved, that could influence (or be perceived to influence) the impartiality of, or result in bias (or perceived bias) to, the Procurement Initiative (i.e. development of AHS requirements, assessment of proponents' proposals, transition and due diligence activities, negotiations with the preferred proponent). Such circumstances may include competing duties and interests undertaken for AHS that involve or impact AHS or the proponents and would include both current and prior relationships / interests, of a direct or indirect nature, with the proponents of a personal, operational, employment, contractual or financial nature which result in an actual, potential or perceived conflict. For clarification, as per AHS' Conflict of Interest Bylaw, Conflicts include those which may exist by virtue of relationships or interests of immediate family members or related persons of a Project Participant.

2. Conflicts of Interest must be managed during a contracting and procurement initiative (the "**Procurement Initiative**"). The AHS Conflict of Interest Bylaw is not specific to procurement and contracting as it only applies to AHS Board members, employees and staff and addresses Conflicts of individuals in their duties to AHS. For purposes of a Procurement Initiative it is also necessary for all individuals involved (both internally within AHS and external to AHS) to manage Conflicts as they relate to their relationships with prospective vendors or their ability to influence or bias the process of the Procurement Initiative. Individuals responsible for the development of a Procurement Initiative methodology, the assessment, evaluation and selection of proponents or the negotiations with selected or preferred proponents, (the "**Project Participants**") will be required to complete certain forms and follow the processes set out in this Conflict of Interest Procedure for Contracting and Procurement Initiatives (the "**COI Procedure**").

3. This COI Procedure has been developed to document the oversight and management process in relation to Conflicts identified and declared in connection with any Procurement Initiative, specifically for addressing direct or indirect interests or relationships which Project Participants may have resulting in a Conflict either with any organization or vendor participating in any Procurement Initiative.

4. All Project Participants will be required to sign the *Conflict of Interest Disclosure and Confidentiality Acknowledgement form* ("**COI & Confidentiality Declaration**" or "**Form A**") and submit it directly to the appropriate CPSM Contract Lead for the given Procurement Initiative. Subsequently there shall be a review of the circumstances surrounding any declared Conflict for each Project Participant.

5. Project Participants who disclose a Conflict are required to provide details describing the type and nature of the Conflict. The Conflicts will be categorized and assessed according to their type and significance, as well as on the role that the Project Participant has within the Procurement Initiative. The assessment should consider factors such as a balance of expertise and experience from different individuals, people's individual roles on the committee as evaluators or advisors, people's impact on the Procurement Initiative as a whole, and the necessary involvement of end-users in selection processes. Using this information, a management plan is required to be documented for each individual on the form *Management Plan for Declared Conflicts* (the "**Management Plan**" or "**Form B**").

6. Clear and accurate disclosure and documentation of each Project Participant's Conflict is required so that individual Conflicts are managed and the Project Participant's role may be adjusted or restricted, including (where necessary) being removed from participation in all or part of aspects of the Procurement Initiative. Individually declared Conflicts will be managed on a case by case basis by CPSM in consultation with AHS Legal & Privacy, AHS Internal Audit and the AHS Ethics and Compliance Office, and AHS Executive Leadership Team member(s), as required. The Management Plan for the Project Participant with the declared Conflict will document what if any, their ongoing role and participation in the Procurement Initiative will be.

7. CPSM will track and manage Conflicts by following the process as outlined below:

   a) Members of the Evaluation Committee and pertinent decision makers (e.g. people who nominated the Project Participant or other evaluators or advisors or those with process oversight) will be identified by CPSM and notified of this process in writing.

   b) CPSM Contract Lead for the Procurement Initiative will provide the *Conflict of Interest Disclosure and Confidentiality Acknowledgement* (Form A) to all Project Participants to fill out.

   c) CPSM Contract Lead will collect and track all signed forms and add details regarding the nature of the Conflict declared by Project Participants, if any, into a Management Plan. It will be CPSM Contract Lead's responsibility to complete Form B and submit to the Chief Program Officer - CPSM.

   d) The Chief Program Officer, CPSM or delegate will undertake an assessment of the Conflict. In consultation with representatives from AHS Legal & Privacy, AHS Internal Audit and AHS Ethics & Compliance, the Chief Program Officer of CPSM, and, where necessary, Executive Leadership Team member shall make, a final decision regarding a Project Participant's Management Plan for a declared Conflict. The Chief Program Officer, CPSM may consult with the Vice President, Corporate Services & Chief Financial Officer for advice and decisions on any significant Conflicts. For clarification, an assessment may lead to a requirement for the Project Participant to make additional or other COI declarations, or take certain actions or steps, to ensure that any Conflict is reasonably managed. The management of a Conflict may require a Project Participant to be partially or completely removed from participation in the Procurement Initiative. Project Participants will be notified of the assessment outcome and be provided with a copy of their Management Plan. The review will also consider the cumulative impact of all identified Conflicts on the Procurement Initiative and this review will be discussed with AHS Legal & Privacy, AHS Internal Audit and AHS Ethics & Compliance, and, where necessary, AHS Executive Leadership Team member(s) as required, to determine if any additional measures need to be implemented to manage the Conflicts.

   e) Proposals and other pertinent data related to the Procurement Initiative will only be released to Project Participants:

      i. who have returned a signed Form A and have not declared a Conflict, or

      ii. for those that have declared a Conflict, after a Management Plan (Form B) has been created and approved.

   f) Form A may be completed either after the receipt of vendor proposals by AHS upon CPSM having informed Project Participants of vendors who have submitted, or at any time before the closing date when vendors' proposals are due (including potentially prior to AHS' issuance of the competitive bid documents to which the Procurement Initiative relates). In the event that Form A is completed prior to the receipt of proposals from vendors, the CPSM Contract Lead is required to provide a listing of all vendors that have submitted proposals to Project Participants prior to distributing vendor's proposals to Project Participants, and is required to seek confirmation from Project Participants that no new Conflicts are present or have since arisen based on the vendors that have submitted proposals. Proposals will not be distributed to any Project Participants until this confirmation is received. The CPSM Contract Lead will provide an updated Conflict report to the Chief Program Officer, CPSM to identify any new Conflict declarations, all of which will need to be assessed using the above processes.

g) The Chief Program Officer, CPSM will report to the Vice President, Corporate Services and Chief Financial Officer of any declared Conflicts regularly.

Schedule B: AHS *Medical Staff Bylaws*, Definitions and Part 6

The entire AHS *Medical Staff Bylaws* are available to the public at www.ahs.ca and to AHS personnel on Insite.

The following definitions pertain to Schedule B and Schedule C of this Bylaw:

Academic Physician	A physician Practitioner who also possesses an appointment as a Full-Time Faculty or Clinical Faculty member with either the Faculty of Medicine & Dentistry of the University of Alberta or the Faculty of Medicine of the University of Calgary.
Advisor	A person, lay or professional, who provides guidance, support, or counsel to a Practitioner pursuant to these Bylaws.
Affected Practitioner	A Practitioner who is the subject of a Triggered Initial Assessment, Triggered Review or Immediate Action.
AHS Code of Conduct	The code of conduct established by AHS.
AHS Programs and Professional Services	Diagnostic and treatment services and programs operated by or for AHS to which Practitioners with relevant Clinical Privileges can refer Patients.
Chief Medical Officer or CMO	The most senior medical administrative leader of AHS, appointed by the CEO.
Clinical Privileges	The delineation of the Procedures that may be performed by a Practitioner; the Sites of Clinical Activity in which a Practitioner may perform Procedures or provide care to Patients; and the AHS Programs and Professional Services that are available to a Practitioner in order to provide care to Patients.
College	The relevant regulatory body which governs the Practitioner.
Complainant	A Patient or his/her legal representative(s), a member of the public, or another Practitioner(s) who initiate(s) a Concern.
Concern	A written complaint or concern from any individual or group of individuals about a Practitioner's professional performance and/or conduct, either in general or in relation to a specific event or episode of care provided to a specific Patient.
Consensual Resolution	A consensual and confidential process to resolve a Concern. Consensual Resolution includes the Affected

	Practitioner, the relevant AHS medical administrative leader(s), and any other relevant person(s).
Dentist or Oral & Maxillofacial Surgeon	A person licensed in independent practice and in good standing with the Alberta Dental Association and College pursuant to the *Health Professions Act* (Alberta).
Facilities	Approved hospitals, continuing care facilities, community health, urgent care, and public health centres, and any other facilities operated by AHS.
Hearing	The process of addressing Concerns where a Triggered Initial Assessment and Consensual Resolution have not resolved the matter or are not considered appropriate means to resolve the matter.
Hearing Committee	A committee established as such pursuant to these Bylaws.
Immediate Action	An immediate suspension or restriction of a Practitioner's Medical Staff Appointment and/or Clinical Privileges without first conducting a Triggered Review pursuant to these Bylaws.
Immediate Action Review Committee	A committee established as such pursuant to these Bylaws.
Locum Tenens	A Practitioner temporarily placed into an existing practice and/or Facility in order to facilitate the short term absence of another Practitioner, or to address a temporary shortfall in Practitioner workforce.
Medical Affairs Office	An operational and organizational office of the Chief Medical Officer portfolio.
Medical Director	The Practitioner who is the medical administrative leader of a Zone (Zone Medical Director); one or more Facilities (Facility Medical Director), one or more communities (Community Medical Director), an AHS provincial portfolio or program (Senior Medical Director or Medical Director); or a Zone program (Zone Program Medical Director).
Medical Staff	Collectively, all Practitioners who possess a Medical Staff Appointment pursuant to these Bylaws.
Medical Staff Appointment or Appointment	The admission of a Practitioner to the AHS Medical Staff.
Medical Staff Letter of Offer	An offer to join the Medical Staff which specifies the category of Appointment, assignment to a Zone(s)

	Clinical Department(s), delineation of specific Clinical Privileges (if applicable), and the details of major responsibilities and roles.
Patient	An individual receiving health services from a Practitioner.
Periodic Review	A periodic review of the professional performance and all matters relevant to the Appointment and Clinical Privileges of a Practitioner with an Appointment in the Active and Locum Tenens Staff categories.
Physician	A person licensed in independent practice and in good standing with the College of Physicians and Surgeons of Alberta pursuant to the *Health Professions Act* (Alberta).
Podiatrist	A person licensed in independent practice and in good standing with the Alberta Podiatry Association pursuant to the *Podiatry Act/Health Professions Act* (Alberta).
Policies	Administrative and operational objectives, plans, values, principles, practices and standards established by AHS with respect to its operations and Facilities, programs and services.
Practitioner	A Physician, Dentist, Oral & Maxillofacial Surgeon; Podiatrist, or a Scientist Leader, who has an AHS Medical Staff Appointment.
Procedure	A diagnostic or therapeutic intervention for which a grant of Clinical Privileges is required.
Professional Codes of Conduct	The Code of Conduct established by the College of Physicians and Surgeons of Alberta, the Code of Conduct established by the Alberta Podiatry Association, and the Code of Ethics established by the Alberta Dental Association and College.
Rules	The specific provisions established as Medical Staff Rules pursuant to these Bylaws.
Scientist Leader	A person other than a Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist who holds a doctorate degree in a recognized health-related scientific or biomedical discipline, and who is an AHS medical administrative leader responsible for, and accountable to, Physician, Dentist, Oral & Maxillofacial Surgeon and/or Podiatrist Practitioners.
Sites of Clinical Activity	The locations and programs, listed in the grant of Clinical Privileges, where a Practitioner may perform

	Procedures, or provide care or services to Patients. The Sites of Clinical Activity may include Zones, Facilities, specific AHS Programs and Professional Services within Facilities, and/or Telemedicine.
Telemedicine	The provision of services for Patients, including the performance of Procedures, via telecommunication technologies, when the Patient and the Practitioner are geographically separated. This may include Practitioners in Alberta, as well as those outside Alberta who are on the Telemedicine Register of the College of Physicians and Surgeons of Alberta.
Triggered Initial Assessment	An investigation and initial assessment of a Concern or other information/complaints about a Practitioner.
Triggered Review	A review undertaken in response to a Concern about a Practitioner's professional performance and/or conduct.
Universal Programs and Professional Services	Those diagnostic and therapeutic services and programs available, within their respective scope of practice, to all Alberta Physicians, Dentists, Oral & Maxillofacial Surgeons and Podiatrists without the need for an AHS Medical Staff Appointment or grant of Clinical Privileges.
Zone	A geographically defined organizational and operational sub-unit of AHS, the boundaries of which may be revised from time-to-time by AHS.
Zone Clinical Department or ZCD	An organizational unit of Practitioners established by the Zone Medical Director and Zone Medical Administrative Committee to which members of the Zone Medical Staff are assigned.
Zone Medical Administrative Committee or ZMAC	A committee established as such pursuant to these Bylaws.
Zone Medical Staff	Collectively, all Practitioners who are assigned to Zone Clinical Departments within a particular Zone.

PART 6 - TRIGGERED INITIAL ASSESSMENT AND TRIGGERED REVIEW

6.0 General

This part of these Bylaws establishes the processes for conducting a Triggered Initial Assessment of a Concern or other information/complaints, and a Triggered Review of a Concern. This part of these Bylaws applies to all Practitioners, including medical administrative leaders, and to all categories of Appointment.

6.0.1 A Triggered Initial Assessment:

a) shall be initiated upon receipt of a Concern

b) may be initiated upon receipt of other information / complaints regarding any aspect of a Practitioner's responsibilities and accountability pursuant to sections 4.2 and 6.1.3 of these Bylaws.

6.0.2 A Triggered Review may be initiated when recommended:

a) as a result of a Periodic Review pursuant to Part 5 of these Bylaws; or

b) by the Zone Medical Director at the conclusion of a Triggered Initial Assessment pursuant to section 6.3 of these Bylaws.

6.0.3 A Triggered Review may include:

a) Consensual Resolution pursuant to section 6.4 of these Bylaws;

b) a Hearing pursuant to section 6.5 of these Bylaws; and/or

c) an Appeal pursuant to section 6.6 of these Bylaws.

6.0.4 The timeframes for completion of a Triggered Initial Assessment and a Triggered Review, as described in this part of these Bylaws, are guidelines, and are meant to balance expediency in resolving Concerns with ensuring appropriate time for thorough investigation, a fair process, and best decisions. Unnecessary delays shall be avoided.

6.0.5 If the Affected Practitioner is a medical administrative leader with functions required of him/her pursuant to this part of these Bylaws, then such functions will be assumed by a more senior medical administrative leader selected by the Zone Medical Director.

6.0.5.1 If the Zone Medical Director is the Affected Practitioner, the functions required of him/her pursuant to this part of these Bylaws shall be fulfilled by an Associate Chief Medical Officer.

6.0.5.2 If an Associate Chief Medical Officer is the Affected Practitioner and the Concern or other information/complaints involve his/her professional performance and/or conduct related to his/her Appointment, rather than his/her role as Associate Chief Medical Officer, the Concern or other information/complaints shall be addressed pursuant to this part of these Bylaws, and the functions required of the Associate Chief Medical Officer shall be fulfilled by the Chief Medical Officer.

6.0.5.3 If an Associate Chief Medical Officer is the Affected Practitioner and the Concern or other information/complaints pertain to his/her role as Associate Chief Medical Officer, the Concern or other information/complaints shall be forwarded directly to the Chief Medical Officer.

6.0.5.4 If the Chief Medical Officer is the Affected Practitioner and the Concern or other information / complaints involve his/her professional performance and/or conduct related to his/her Appointment, rather than his/her role as Chief Medical Officer, the Concern or other information/complaints shall be addressed pursuant to this part of these Bylaws; and the functions required of the Chief Medical Officer pursuant to this part of these Bylaws shall be fulfilled by the Chief Executive Officer of AHS.

6.0.5.5 If the Chief Medical Officer is the Affected Practitioner and the Concern or other information/complaints pertain to his/her role and performance as the Chief Medical Officer, the Concern or other information/complaints shall be forwarded directly to the CEO.

6.0.6 A Concern or other information/complaints of a clinical/Patient care nature involving a member of the Medical Staff who is also an Academic Physician shall be addressed through the provisions of these Bylaws. A Concern or other information/complaints of an academic (research or teaching) nature shall normally be addressed through the processes and procedures of the relevant Faculty of Medicine (University of Calgary)/ Faculty of Medicine & Dentistry (University of Alberta). In cases involving issues of both a clinical and an academic nature, or where the academic activities in question are undertaken in AHS Facilities and impact Patient care or clinical services in AHS Facilities, AHS and the relevant Faculty of Medicine/Medicine & Dentistry shall collaborate in addressing the Concern or other information/complaints and in determining which party's processes and procedures shall be followed.

6.0.7 A Triggered Initial Assessment or Triggered Review may, at the discretion of the Zone Medical Director, proceed notwithstanding that the Affected Practitioner has resigned from the Medical Staff.

6.0.8 A Triggered Initial Assessment or Triggered Review may, at the discretion of the Zone Medical Director, proceed notwithstanding that a Complainant has withdrawn the Concern.

6.1 Concerns

6.1.1 A Concern must be:

a) in writing;

b) signed by either the Complainant or by the individual(s) conveying the Concern involving the Affected Practitioner; and

c) supported by a reasonable degree of relevant detail forming the basis of the Concern.

6.1.2 A Concern may be received from a Complainant or may be initiated by AHS.

6.1.3 Matters which form the basis of a Concern include, but are not limited to:

a) quality and safety of patient care;

b) clinical performance;

c) participation in continuing professional development and maintenance of competence activities relevant to the Practitioner;

d) contribution to Zone Clinical Department objectives;

e) issues related to leadership as raised by a member(s) of the Medical Staff;

f) ethical conduct;

g) professional behaviour and conduct including interactions with patients, families, visitors, professional colleagues, and AHS clinical and non-clinical staff;

h) breach of the responsibilities and expectations pursuant to these Bylaws, the Medical Staff Rules, the Practitioner's Medical Staff Letter of Offer (or any subsequent amendments to the letter), applicable AHS policies and the AHS Code of Conduct, the Professional Code of Conduct of the relevant College and/or the respective code of ethics of the relevant profession. If AHS policies and/or the AHS Code of Conduct conflict with the Professional Code of Conduct of the relevant College and/or the respective code of ethics of the relevant profession, then the Professional Code of Conduct and the code of ethics of the relevant profession shall take precedence;

i) breach of any formal agreement with AHS; and,

j) any health problem that significantly affects the Practitioner's ability to carry out his/her AHS professional responsibilities.

6.1.4 A Concern initiated by a Complainant:

6.1.4.1 The Complainant will be notified by the AHS Patient Concerns Office, AHS Human Resources or the Medical Affairs Office that the Concern has been received and has been forwarded to the Zone Medical Director or designate.

6.1.4.2 The Zone Medical Director or designate, subject to any legal requirements, will contact the Complainant to:

a) explain the Triggered Initial Assessment and the Triggered Review processes;

b) inform the Complainant(s) that a Triggered Initial Assessment or Triggered Review, if recommended or required, cannot proceed without the Affected Practitioner being provided with a copy of the Concern, which shall include the identity of the Complainant(s);

c) confirm that the Complainant(s) wishes to have the complaint addressed as a Concern, and thus comply with the requirements specified in sections 6.1.1 of these Bylaws;

d) obtain from the Complainant(s) written acknowledgement that the nature and implications of the processes pursuant to section 6.1.4.2 a) and b) are understood.

6.1.4.3 The Affected Practitioner shall not communicate directly, in writing or verbally, about the Concern with the Complainant unless given permission to do so by the Zone Medical Director; there is mutual agreement to do so as part of Consensual Resolution; and/or if recommended as part of the resolution of the Concern.

6.1.5 A Concern initiated by AHS:

The Zone Clinical Department Head(s) or designate(s) or the Zone Medical Director or designate(s) may initiate a Concern on behalf of AHS when:

a) there are reasonable grounds to believe that one or more of the matters specified in section 6.1.3 of these Bylaws exists; and

b) those with direct knowledge are unwilling or unable to submit a Concern; and/or

c) a complaint fails to meet the requirements specified in section 6.1.1 of these Bylaws; and/or

d) the Complainant(s) does not agree or comply with the requirements specified in section 6.1.4.2 of these Bylaws.

6.2 Procedural Fairness

6.2.1 The Affected Practitioner is entitled to procedural fairness including, but not limited to:

a) the opportunity at any time to initiate, or participate in, Consensual Resolution, if mutually agreeable to the Affected Practitioner and AHS;

b) confidentiality consistent with the nature of the proceeding, and to the extent permitted by law, provided that the Affected Practitioner does not present a risk to Patients or the public;

c) being provided with a copy of the Concern, including the identity of the person(s) bringing the Concern forward;

d) the right to respond to the Concern;

e) full disclosure, to the extent permitted by law, of all information considered in the Triggered Initial Assessment and/or Triggered Review;

f) the assistance of an Advisor;

g) timely disposition of the Triggered Initial Assessment and/or Triggered Review consistent with the nature of the Concern;

h) being provided with a copy of any recommendations, decisions and the reasons leading to them;

i) being provided with a copy of any documentation sent to the relevant College, to the extent permitted by law; and

j) if a Hearing is required, to:

I. have a Hearing free of bias;

II. have the opportunity to object to the composition of the Hearing Committee provided that prior knowledge of the subject matter of the Hearing does not automatically disqualify a person from being a member of the Hearing Committee;

III. be represented by legal counsel, give evidence, examine and cross examine witnesses;

IV. request a review by the Zone Medical Administrative Committee of the report and/or recommendations of the Hearing Committee pursuant to section 6.6.1 of these Bylaws; and

V. be provided, to the extent permitted by law, with a copy of any documents, placed in the Affected Practitioner's file at the conclusion of the Triggered Initial Investigation and/or Triggered Review.

6.2.2 AHS is entitled to procedural fairness including, but not limited to:

a) the opportunity at any time to initiate, or participate in, Consensual Resolution, if mutually agreeable to the Affected Practitioner and AHS;

b) exclude documents or information from full disclosure if required by applicable legislation;

c) be represented by legal counsel, give evidence, examine and cross examine witnesses before the Hearing Committee (if a Hearing is required);

d) timely disposition of the Triggered Initial Assessment and/or Triggered Review consistent with the nature of the Concern;

e) make recommendations and decisions affecting the Medical Staff Appointment and/or the Clinical Privileges of the Affected Practitioner; and

f) request a review by the Zone Medical Administrative Committee of the report and/or recommendations of the Hearing Committee pursuant to section 6.6.1 of these Bylaws.

6.2.3 Any recommendations approved or decisions made by the Chief Medical Officer shall be final, subject only to legal rights of appeal.

6.3 Triggered Initial Assessment

6.3.1 The Zone Medical Director or designate(s) shall, upon receipt of a Concern, or may, upon receipt of other information/complaints:

a) conduct a Triggered Initial Assessment; or

b) direct that a Triggered Initial Assessment be conducted by the relevant AHS medical administrative leader(s), including the Affected Practitioner's Zone Clinical Department Head(s) or designate(s), Facility or Community Medical Director(s), and/or Senior Medical Director, or by another investigator.

6.3.2 A Triggered Initial Assessment initiated upon receipt of:

6.3.2.1 a Concern shall be completed within twenty-eight days of receipt of the Concern by the Zone Medical Director.

6.3.2.2 other information/complaints shall be completed within twenty-eight days, and shall either be dismissed or become a Concern to be addressed pursuant to this part of these Bylaws. If the result of the Triggered Initial Assessment is not to proceed to the status of a Concern, the Affected Practitioner shall be notified and such noted in the Affected Practitioner's file.

6.3.3 The AHS medical administrative leader(s) conducting the Triggered Initial Assessment on the basis of a Concern or on the basis of other information/complaints that have become a Concern pursuant to section 6.3.2.2 of these Bylaws shall provide a copy of the Concern to the Affected Practitioner within seven days of initiating the Triggered Initial Assessment. The Affected Practitioner's response, if any, shall be considered by the Zone Medical Director when deciding on the disposition of the Concern.

6.3.4 Within twenty-eight days of completing the Triggered Initial Assessment initiated upon receipt of a Concern, the Zone Medical Director may:

a) dismiss the Concern as being unfounded;

b) determine that further action is not required or will not contribute further to investigation and resolution of the Concern;

c) refer the Complainant to an appropriate body or agency internal or external to AHS if the Concern does not pertain to the responsibilities and expectations of the AHS Medical Staff Appointment of the Affected Practitioner;

d) request further investigation and/or appoint another investigator if he/she determines the Initial Assessment to be incomplete;

e) refer the matter to an Associate Chief Medical Officer, pursuant to section 6.3.5 of these Bylaws, if the Affected Practitioner is an AHS medical administrative leader and the Concern is determined to pertain primarily to his/her role as a medical administrative leader;

f) refer the Concern, or a portion thereof, for internal or external expert opinion;

g) request that the Affected Practitioner engage in Consensual Resolution pursuant to section 6.4 of these Bylaws;

h) refer the Concern for a Hearing if the Affected Practitioner declines to participate in Consensual Resolution;

i) refer for a Hearing pursuant to section 6.5 of these Bylaws if he/she determines that the Concern is not amenable to Consensual Resolution pursuant to section 6.4 of these Bylaws;

j) refer the Concern to the relevant College if the Practitioner agrees, in writing; or if the Zone Medical Director, after consultation with the Associate Chief Medical Officer, determines that:

i. the referral is required by law; or

ii. the referral is necessary to ensure public or Patient safety; or

iii. the Concern will not be amenable to resolution pursuant to this part of these Bylaws but only if the Concern is within the scope of authority of the College to receive and act upon, and only after considering all reasonable alternatives and meeting with the Affected Practitioner to review the determination to refer and the reasons for it. If referral to the relevant College is planned under these circumstances, it shall not be made earlier than seven days following the meeting between the Affected Practitioner and the Zone Medical Director, and the Practitioner shall be provided with a copy of all materials intended to be sent to the relevant College.

6.3.5 If the Affected Practitioner is an AHS medical administrative leader and it is determined that the Concern or other information/complaints pertains primarily to his/her role and function as an AHS medical administrative leader, the Zone Medical Director shall refer the matter to an Associate Chief Medical Officer.

6.3.5.1 The Associate Chief Medical Officer shall decide if the Concern or other information/complaints is most appropriately addressed through a Triggered Initial Assessment and/or Triggered Review pursuant to this part of these Bylaws, or through internal AHS processes, and in consideration of the Affected Practitioner's contractual arrangement with AHS.

6.3.5.2 If internal AHS processes are to be followed, the Associate Chief Medical Officer shall designate an appropriate AHS medical administrative leader to explain the process to the Complainant(s), conduct an investigation of the Concern or other information/complaints and periodically inform the Complainant(s) of the progress of the internal AHS process.

6.3.5.3 Pursuant to section 6.9 of these Bylaws, at the conclusion of the AHS process, the Complainant(s) shall only be informed that the matter has been investigated and either dismissed or has resulted in appropriate action.

6.3.5.4 If the Concern or other information/complaints has been dismissed, the Complainant(s) may be provided with other options to pursue the matter should he/she be dissatisfied with the outcome of the internal AHS process.

6.3.6 The Affected Practitioner shall disclose to the Zone Medical Director If the relevant College is independently in receipt of the Concern, or investigating the Concern, and shall authorize the relevant College to confirm to the Zone Medical Director that this is the case.

6.3.7 A copy of any documentation placed in a Practitioner's file regarding the disposition of a Concern shall be provided to the Practitioner.

6.4 Consensual Resolution Process

6.4.1 At any time throughout the processes specified in Part 6 of these Bylaws, the Affected Practitioner and/or the relevant AHS medical administrative leader(s) may recommend Consensual Resolution to address the matter. This shall be a consensual process between the Affected Practitioner and the relevant AHS medical administrative leader(s), and may also include any other relevant persons including the Complainant(s).

6.4.2 The relevant AHS medical administrative leader(s) shall be selected by the Zone Medical Director and may include the Affected Practitioner's Zone Clinical Department Head(s) or designate(s), Facility or Community Medical Director(s), and/or Senior Medical Director; The Zone Medical Director may also request that an Associate Zone Medical Director participate in Consensual Resolution. The process may include mediation.

6.4.3 The Affected Practitioner and the relevant AHS administrative leader(s) shall meet and consider the Concern; the Affected Practitioner's response, if any; the Triggered Initial Assessment; and any other information they consider relevant, provided however that the Affected Practitioner is entitled to review and respond to all such information to the extent permitted by law.

6.4.4 Consensual Resolution shall result in a report and recommendation(s) from the relevant AHS medical administrative leader(s) to the Zone Medical Director. Unless the Affected Practitioner and AHS mutually agree to an extension, Consensual Resolution shall be concluded and result in a report and recommendation(s) within twenty-eight days of referral of the matter by the Zone Medical Director for Consensual Resolution.

6.4.4.1 Discussions and communications that occur during Consensual Resolution are strictly confidential and shall not be disclosed, except in accordance with section 6.8.5 of these

Bylaws, or used in any process or proceeding outside Consensual Resolution without the written consent of the Affected Practitioner and all others who participated in Consensual Resolution.

6.4.4.2 No information or documents arising from Consensual Resolution shall be shared with a Hearing Committee other than that Consensual Resolution was attempted but was unsuccessful.

6.4.5 The Zone Medical Director shall review the report and the recommendation(s) arising from Consensual Resolution.

6.4.6 The Zone Medical Director may accept the report and recommendation(s) or may request clarification of the report and/or recommendation(s). In the latter case, the Zone Medical Director may meet with the relevant medical administrative leader(s) and/or the Affected Practitioner to discuss the report and/or recommendations.

6.4.7 The Zone Medical Director shall forward a written final report and recommendation(s), including any amendments, to the Affected Practitioner within fourteen days of receipt of the initial report and recommendation(s) from the relevant AHS medical administrative leader(s).

6.4.8 If the Affected Practitioner accepts the report and recommendation(s), he/she and the relevant medical administrative leader(s) shall be accountable for implementation of the recommendation(s).

6.4.9 If the Affected Practitioner rejects the report and/or recommendation(s), the Zone Medical Director and the Affected Practitioner shall meet to ensure a common understanding of the report and recommendations, and to determine if agreement can be reached, failing which the matter shall proceed to a Hearing pursuant to section 6.5 of these Bylaws.

6.4.10 The Affected Practitioner shall have fourteen days to provide a written response to the final report and recommendation(s) arising from Consensual Resolution.

6.5 Hearing

6.5.1 A Hearing before a Hearing Committee is required when:

a) the Zone Medical Director determines that a Concern is not amenable to Consensual Resolution;

b) the Affected Practitioner declines participation in Consensual Resolution; or

c) the Affected Practitioner rejects the final report and/or recommendation(s) of Consensual Resolution.

6.5.2 The Zone Medical Director shall refer a Concern to a Hearing Committee within seven days of determining that a Hearing is required, and shall notify the Affected Practitioner as soon as possible thereafter.

6.5.3 The composition and procedures of a Hearing Committee shall be described in the Rules.

6.5.4 Mandate and Functions of the Hearing Committee

6.5.4.1 The Hearing Committee shall receive information, hear evidence, consider the Concern, and prepare a report and make recommendations.

6.5.4.2 The Hearing Committee is entitled to retain independent legal counsel to advise it on process and procedure in conducting the Hearing.

6.5.4.3 AHS shall present, and the Hearing Committee shall consider, the Concern and any evidence (either oral or written) that is relevant to the matters in issue, provided however that in advance of the hearing the Affected Practitioner is entitled to reasonable notice of evidence to be produced in order to allow for a fair response.

6.5.4.4 At any time during the Hearing, the Hearing Committee may ask the relevant AHS medical administrative leader(s) to provide further information.

6.5.4.5The Hearing Committee may receive and consider relevant expert opinion(s) from within AHS, or external to AHS.

6.5.4.6 The Affected Practitioner shall appear before the Hearing Committee and is a compellable witness. In addition, the Committee may request that the Complainant(s) or any other person who may have knowledge or information relevant to the matters at issue give evidence.

6.5.4.7 Evidence may be given before a Hearing Committee in any manner that the Hearing Committee considers appropriate. The Hearing Committee is not bound by the rules of law respecting evidence that are applicable to judicial hearings.

6.5.5 After receiving and considering all relevant information and evidence, the Hearing Committee shall prepare a report and recommendation to either:

a) dismiss the Concern as being unfounded; or

b) if the Concern or the issues raised in the report are well-founded, prepare recommendations regarding remedial action or sanctions to be imposed upon the Affected Practitioner. Such action or sanctions may include but are not limited to:

i. no further action

ii. placing a caution or reprimand in the Affected Practitioner's file;

iii. requiring the Affected Practitioner to undergo counselling or treatment;

iv. requiring upgrading or further education;

v. requiring the Affected Practitioner to undertake a period of clinical supervision with prospective review of cases with or without special requirements of concurrent consultation or direct supervision;

vi. in the case of conduct which is unprofessional, unethical, unbecoming, improper, or deemed to be disruptive workplace behaviour, requiring the Affected Practitioner to undertake remedial measures to address the behaviour that gave rise to the Concern;

vii. temporary suspension of all or specified Clinical Privileges;

viii. permanent change of specified Clinical Privileges;

ix. a change in the category of Appointment;

x. termination of the Affected Practitioner's Appointment; and/or

xi. any other recommendation considered appropriate to ensure public or Patient safety.

6.5.6 The Hearing Committee report and recommendation(s) shall be forwarded to the Zone Medical Director within sixty days of establishment of the Hearing Committee. The Zone Medical Director shall review the report of the Hearing Committee, and provide a copy to the Affected Practitioner.

6.5.6.1 Within fourteen days of receiving the report of the Hearing Committee, the Affected Practitioner shall provide written notification to the Zone Medical Director as to whether he/she accepts or rejects the findings and/or recommendation(s) of the report.

a) If the Affected Practitioner accepts the report and/or recommendation(s) of the Hearing Committee, the report and the Affected Practitioner's response are sent by the Zone Medical Director to the Chief Medical Officer for a decision pursuant to section 6.8 of these Bylaws.

b) If the Affected Practitioner does not accept the report and/or recommendation(s) of the Hearing Committee, he/she may request a review by his/her Zone Medical Administrative Committee of the procedure of the Hearing Committee but only if he/she contends that:

i. the findings are materially inconsistent with the evidence; or

ii. breaches of process and fairness occurred and may have affected the findings and/or recommendations;

iii. the Hearing Committee erred in law; or

iv. there is new evidence that could not have been produced through reasonable efforts at the time of the Hearing, and that may have affected the findings and/or recommendation(s).

c) The Zone Medical Director shall inform the Zone Medical Administrative Committee within seven days of receipt of the request from the Affected Practitioner.

d) If the Affected Practitioner does not provide written notification to the Zone Medical Director as to whether he/she accepts or rejects the report and/or recommendation(s) of the Hearing Committee within fourteen days, the Zone Medical Director shall forward the report and recommendation(s) of the Hearing Committee to the Chief Medical Officer for a decision.

6.6 Appeal of the Hearing Committee Process

6.6.1 The Affected Practitioner or AHS may request that the Zone Medical Administrative Committee review the report and/or recommendations of the Hearing Committee. The appeal will only consider whether:

a) the findings are materially inconsistent with the evidence; or

b) breaches of process and fairness occurred and affected the findings and/or recommendations of the Hearing Committee;

c) the Hearing Committee erred in law; or

d) there is new evidence that could not have been produced through reasonable efforts at the time of the original Hearing and may have affected the findings and/or recommendation(s).

6.6.2 The Zone Medical Administrative Committee will not repeat the investigation or Hearing. The review will only consider the appeal items outlined in Section 6.6.1 a), b) or c) above, and will only refer to the documented record of evidence to the extent necessary to determine whether the process was fair.

6.6.3 Where the Zone Medical Administrative Committee determines that the findings are materially inconsistent with the evidence, or that there have been breaches of process and/or fairness that affected the findings and/or recommendations, it shall remit the matter to the Zone Medical Director for a further Hearing by a differently composed Hearing Committee.

6.6.4 Where the Zone Medical Administrative Committee determines that the Hearing Committee has erred in law, the Zone Medical Administrative Committee may remit the matter to the Zone Medical Director for a further Hearing by a differently composed Hearing Committee, or may, based on the documented record of evidence provided to it, vary or remove the relevant finding(s) or recommendation(s), and submit its report to the Zone Medical Director to forward to the Chief Medical Officer for decision.

6.6.5 Should the Zone Medical Administrative Committee determine that new evidence exists that may have affected the findings and/or recommendations of the initial Hearing, the Zone Medical Administrative Committee shall refer the matter to the original Hearing Committee for further consideration and recommendation to the Zone Medical Director.

6.6.6 Within sixty days of notification of the request to review the Hearing Committee proceedings and process, the Zone Medical Administrative Committee shall deliver a report of their findings and recommendations to the Zone Medical Director (pursuant to section 6.6.3 or 6.6.4), or the original Hearing Committee (pursuant to section 6.6.5).

6.7 Immediate Action

...

6.8 Decisions of the Chief Medical Officer

6.8.1 All final reports and recommendation(s) of a Hearing Committee and the Zone Medical Administrative Committees with respect to an appeal of a Hearing Committee process shall be sent to the Chief Medical Officer for a decision.

6.8.2 The Chief Medical Officer will render a decision within fourteen days of receipt of the report and recommendation(s) from a Hearing Committee and, if applicable from a Zone Medical Administrative Committee, and within four days of receipt of the report and recommendation(s) from the Immediate Action Review Committee. The Chief Medical Officer may:

a) dismiss the Concern and/or the Immediate Action as being unfounded;

b) determine that no further action is required; or

c) determine appropriate remedial actions or sanctions. These may include, but are not limited to, a temporary or permanent change to the Appointment or Clinical Privileges, or termination of the Appointment of the Affected Practitioner. The Affected Practitioner may choose to voluntarily submit to such actions or sanctions. If he/she does not, the actions or sanctions shall be imposed.

6.8.3 The decision of the Chief Medical Officer may be the same as, or different from, the recommendations of a Hearing Committee or the Zone Medical Administrative Committee. If the decision of the Chief Medical Officer differs from the recommendations of the Hearing Committee or the Zone Medical Administrative Committee, written reasons for the difference shall be provided to the Hearing Committee and/or Zone Medical Administrative Committee, the Zone Medical Director and the Affected Practitioner.

6.8.4 The Affected Practitioner, Zone Medical Administrative Committee, Zone Medical Director and relevant Zone Clinical Department Head(s) shall be notified in writing of the decision of the Chief Medical Officer and the rationale for the decision.

6.8.5 If, in the decision of the Chief Medical Officer, a substantive change in the Appointment or Clinical Privileges of the Affected Practitioner is authorized, the Chief Medical Officer will inform the relevant College.

6.8.6 The decision of the Chief Medical Officer is final, subject only to legal rights of appeal.

6.9 Notification of the Complainant

The Zone Medical Director, or if applicable, the Associate Chief Medical Officer pursuant to section 6.3.5 of these Bylaws, or the Chief Medical Officer shall periodically inform the Complainant(s), if any, of the progress of Triggered Initial Assessment or Triggered Review. At its conclusion, the Complainant(s) shall only be informed that the matter has been investigated and either dismissed or has resulted in appropriate action. If the Concern has been dismissed, the Complainant(s) may be provided with other options to pursue the matter should they be dissatisfied with the outcome of the Triggered Initial Assessment and/or Triggered Review.

6.10 Practitioner-Initiated Reviews

6.10.1 A Practitioner may voluntarily self-report a Concern about his/her own professional performance and/or conduct to the AHS medical administrative leader(s) who is his/her immediate supervisor, or to a more senior leader if warranted by the nature and significance of the Concern.

6.10.2 By voluntarily self-reporting a Concern, the Practitioner is entitled and expected to work collaboratively with the relevant medical administrative leader(s) to review and resolve the Concern.

6.10.3 The Practitioner and the relevant medical administrative leader(s) shall develop, in writing, a mutually agreed upon plan to review and resolve the Concern. The proposed plan must be approved by the Zone Medical Director and, if appropriate, may include temporary or permanent changes to the Practitioner's Medical Staff Appointment or Clinical Privileges. The Practitioner shall receive a copy of the approved plan.

6.10.4 The Practitioner shall be compliant with the conditions and terms of the plan, including any periodic monitoring, review, or reporting that has been agreed upon.

6.10.5 If the Practitioner and the relevant medical administrative leader(s) are unable to reach agreement upon a plan, or if, during the implementation of the plan, the Practitioner is unable or unwilling to comply with the conditions and terms of the plan, then review and resolution of the Concern shall immediately proceed to a Hearing pursuant to section 6.5 of these Bylaws.

6.10.6 Upon conclusion of the plan and resolution of the Concern, or if the process is unsuccessful in resolving the Concern, a written report shall be placed in his/her file(s), and a copy provided to the Practitioner.

6.11 Disposition of Records

All information obtained, reviewed, discussed and otherwise used or developed in any process related to this part of these Bylaws, and that is not otherwise publicly known, publicly available, or part of the public domain, is considered to be privileged and strictly confidential information of AHS. It shall not to be disclosed to anyone outside of the process related to this part of these Bylaws except if agreed to, in writing by the Affected Practitioner or where determined by the Chief Medical Officer as required by law or necessary to ensure public or Patient safety. Records of the proceedings outlined in this section (e-mails, correspondence, reports, and notes) will be retained in a manner consistent with the AHS record retention policy.

Schedule C: AHS *Medical Staff Rules*, Section 2.12

The entire AHS *Medical Staff Rules* are available to the public at www.ahs.ca and to AHS personnel on Insite.

2.12 Hearing Committee

2.12.1 Establishment

A Hearing Committee is established pursuant to sections 6.5 and 6.7.9 of the Bylaws.

2.12.2 Composition

A Hearing Committee shall be composed of a designated chair and four voting members all of whom are drawn from the provincial pool of Hearing Committee designates following the Hearing Committee and pool selection process pursuant to section 2.11 of these Rules.

2.12.3 Duties and Responsibilities

The purpose of the Hearing Committee is to consider a Concern referred to it in respect to an Affected Practitioner by receiving information and hearing evidence, and shall make recommendations pursuant to section 6.5 of the Bylaws. A Hearing Committee shall fulfill its duties in a fair and impartial manner.

2.12.4 Conduct of Meetings

(a) Meetings of the Hearing Committee may be held in person, by videoconference or teleconference provided that hearings shall require the personal attendance of members.

(b) Meetings of the Hearing Committee shall be held in the Zone of the Affected Practitioner or another Zone as the Hearing Committee in its sole discretion may determine.

(c) A Hearing Committee shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with section 6.5 of the Bylaws.

(d) Unless the Affected Practitioner agrees otherwise, a Hearing shall be closed to the public, and only the following persons may attend:

I. The Affected Practitioner, the Affected Practitioner's legal counsel and/or an Advisor;

II. Legal counsel for the Hearing Committee;

III. Staff necessary to support the Hearing Committee;

IV. The relevant Zone Medical Director(s) or designate(s);

V. AHS legal counsel;

VI. Witnesses but only for the duration of their testimony unless otherwise entitled to attend; and

VII. Any other person(s) agreed to by the Hearing Committee, the Affected Practitioner and AHS.

(e) Only the Hearing Committee members and Chair, its legal counsel, and the Hearing Committee support staff shall be present when the Hearing Committee deliberates, formulates recommendations and reviews draft reports

Schedule D: AHS *Midwifery Staff Bylaws*, Definitions and Part 6

The entire AHS *Midwifery Staff Bylaws* are available to the public at www.ahs.ca and to AHS personnel on Insite.

The following definitions pertain to Schedule D and Schedule E of this Bylaw:

Academic Midwife	A member of the Midwifery Staff who also possesses an appointment as a Full-Time Faculty or Clinical Faculty member with the Faculty of Health and Community Studies of Mount Royal University.
Advisor	A person, lay or professional, who provides guidance, support, or counsel to a Midwife with an Appointment pursuant to these Bylaws.
Affected Midwife	A Midwife with an Appointment who is the subject of a Triggered Initial Assessment, Triggered Review or Immediate Action.
AHS Code of Conduct	The code of conduct established by AHS.
Bylaws	The specific provisions established as these Midwifery Staff Bylaws.
Clinical Privileges	The delineation of the Procedures that may be performed by a Midwife; the Sites of Clinical Activity in which a Midwife may perform Procedures or provide care to Patients; and the Programs and Professional Services that are available to a Midwife in order to provide care to Patients.
Collaboration or Collaborate	Process of communication and decision-making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence client/patient care. (Way, et al., 2000)
College of Midwives of Alberta	The relevant regulatory body which governs the Midwife.
Complainant	A Patient or her legal representative(s), a member of the public, a Practitioner, or another Midwife(s) who initiate(s) a Concern.
Concern	A written complaint or concern from any individual or group of individuals about an appointed Midwife's professional performance and/or conduct, either in general or in relation to a specific event or episode of care provided to a specific Patient.

Consensual Resolution	A consensual and confidential process to resolve a Concern. Consensual Resolution includes the Affected Midwife, the relevant AHS midwifery administrative leader(s), and any other relevant person(s).
Hearing	The process of addressing Concerns where a Triggered Initial Assessment and Consensual Resolution have not resolved the matter or are not considered appropriate means to resolve the matter.
Hearing Committee	A committee established as such pursuant to these Bylaws.
Immediate Action	An immediate suspension or restriction of a Midwife's Midwifery Staff Appointment and/or Clinical Privileges without first conducting a Triggered Review pursuant to these Bylaws.
Immediate Action Review Committee	A committee established as such pursuant to these Bylaws.
Locum Tenens	A Midwife temporarily placed into an existing practice and/or Site of Clinical Activity in order to facilitate the short term absence of another Midwife with an Appointment, or to address a temporary shortfall in Midwife workforce.
Midwife	A person registered and in good standing with the College of Midwives of Alberta.
Midwifery Director	The Midwife with an Appointment who is the midwifery administrative leader of a Zone.
Midwifery Staff	Midwives who possess an Appointment pursuant to these Bylaws, collectively and individually as the context requires.
Midwifery Staff Appointment or Appointment	The admission of a Midwife to the AHS Midwifery Staff.
Midwifery Staff Letter of Offer	An offer to join the Midwifery Staff which specifies the category of Appointment, assignment to a Zone(s) Clinical Department(s), delineation of specific Clinical Privileges (if applicable), and the details of major responsibilities and roles.
Patient	An individual receiving health services from Midwifery Staff.

Periodic Review	A periodic review of the professional performance and all matters relevant to the Appointment and Clinical Privileges of a Midwife with an Appointment in the Active or Locum Tenens Staff categories.
Policies	Administrative and operational policies, practices, bylaws, procedures, directives, guidelines, manuals and standards established by AHS with respect to its operations and Sites of Clinical Activity, facilities, programs and services.
Procedure	A diagnostic or therapeutic intervention for which a grant of Clinical Privileges is required.
Professional Code of Conduct	The Code of Conduct established by the provincial College of Midwives of Alberta.
Programs and Professional Services	Diagnostic and treatment services and programs operated by or for AHS to which Midwives with relevant Clinical Privileges can refer Patients.
Provincial Midwifery Executive Committee or PMEC	A committee established as such pursuant to these Bylaws.
Request to Change	A request to change the category of Appointment and/or the Clinical Privileges of a Midwife pursuant to these Bylaws.
Rules	The specific provisions established as Midwifery Staff Rules pursuant to these Bylaws.
Scientist Leader	A person other than a Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist who holds a doctorate degree in a recognized health-related scientific or biomedical discipline, and who is an AHS medical administrative leader responsible for, and accountable to, Physician, Dentist, Oral & Maxillofacial Surgeon and/or Podiatrist Practitioners.
Search Committee	A committee established as such pursuant to the Rules.
Senior Vice President or SVP	The most senior executive of AHS responsible for midwifery services.
Sites of Clinical Activity	The locations and programs operated by AHS, listed in the grant of Clinical Privileges, where a Midwife with an Appointment may perform Procedures, or provide care to Patients. The Sites of Clinical Activity may include Zones, facilities, specific Programs and Professional Services within facilities, and/or Telemedicine.

Specified Clinical Services or Clinical Services	Clinical services as defined by the College of Midwives of Alberta and the relevant Alberta midwifery regulation.
Telemedicine	The provision of services for Patients, including the performance of Procedures, via telecommunication technologies, when the Patient and the Midwife with an Appointment are geographically separated.
Triggered Initial Assessment	An investigation and initial assessment of a Concern or other information/complaints about a Midwife with an Appointment.
Triggered Review	A review undertaken in response to a Concern about an appointed Midwife's professional performance and/or conduct.
Zone	A geographically defined organizational and operational sub-unit of AHS defined by the Senior Vice President, the boundaries of which may not be aligned with AHS zones and which may be revised from time-to-time by the Senior Vice President.
Zone Midwifery Clinical Department or Midwifery Clinical Department	An organizational unit of Midwives with Appointments established by the Midwifery Director to which members of the Zone Midwifery Staff are assigned.

Part 6: Triggered Initial Assessment and Triggered Review

6.0 General

6.0.1 This part of the Bylaws establishes the processes for conducting a Triggered Initial Assessment of a Concern or other information/complaints, and a Triggered Review of a Concern. This part of the Bylaws applies to all appointed Midwives, including midwifery administrative leaders, and to all categories of Appointment. The flowchart for a Triggered Initial Assessment, Triggered Review and Hearing is located in Appendix C of these Bylaws.

6.0.2 A Triggered Initial Assessment:

c) shall be initiated upon receipt of a Concern; and

d) may be initiated upon receipt of other information / complaints regarding any aspect of a Midwife's responsibilities and accountability pursuant to sections 4.2 and 6.1.3 of these Bylaws.

6.0.3 A Triggered Review may be initiated when recommended:

c) as a result of a Periodic Review pursuant to Part 5 of these Bylaws; or

d) by the Senior Vice President or designate, at the conclusion of a Triggered Initial Assessment pursuant to section 6.3 of these Bylaws.

6.0.4 A Triggered Review may include:

d) Consensual Resolution pursuant to section 6.4 of these Bylaws;

e) a Hearing pursuant to section 6.5 of these Bylaws; and/or

f) an Appeal pursuant to section 6.6 of these Bylaws.

6.0.5 The timeframes for completion of a Triggered Initial Assessment and a Triggered Review, as described in this part of these Bylaws, are guidelines, and are meant to balance expediency in resolving Concerns with ensuring appropriate time for thorough investigation, a fair process, and best decisions. Unnecessary delays shall be avoided.

6.0.6 A Concern or other information/complaints of a clinical/Patient care nature involving a member of the Midwifery Staff who is also an Academic Midwife shall be addressed through the provisions of these Bylaws. A Concern or other information/complaints of an academic (research or teaching) nature shall normally be addressed through the processes and procedures of the relevant faculty. In cases involving issues of both a clinical and an academic nature, or where the academic activities in question are undertaken in Sites of Clinical Activity and impact Patient care or Clinical Services in Sites of Clinical Activity, AHS and the relevant faculty shall Collaborate in addressing the Concern or other information/complaints and in determining which party's processes and procedures shall be followed.

6.0.7 A Triggered Initial Assessment or Triggered Review may, at the discretion of the Senior Vice President or designate, proceed notwithstanding that the Affected Midwife has resigned from the Midwifery Staff.

6.0.8 A Triggered Initial Assessment or Triggered Review may, at the discretion of the Senior Vice President or designate, proceed notwithstanding that a Complainant has withdrawn the Concern.

6.1 Concerns

6.1.1 A Concern must be:

d) in writing;

e) signed by either the Complainant or by the individual(s) conveying the Concern involving the Affected Midwife; and

f) supported by a reasonable degree of relevant detail forming the basis of the Concern.

6.1.2 A Concern may be received from a Complainant or may be initiated by AHS.

6.1.4 Matters which form the basis of a Concern include, but are not limited to:

k) quality and safety of Patient care;

l) clinical performance;

m) participation in continuing professional development and maintenance of competence activities relevant to the Midwife;

n) contribution to Zone Midwifery Clinical Department objectives;

o) issues related to leadership as raised by a member(s) of the Midwifery Staff;

p) ethical conduct;

q) professional behaviour and conduct including interactions with Patients, families, visitors, professional colleagues, and AHS clinical and non-clinical staff;

r) breach of the responsibilities and expectations pursuant to these Bylaws, the Rules, the Midwife's Midwifery Staff Letter of Offer (or any subsequent amendments to the letter), applicable Policies and the AHS Code of Conduct, the Professional Code of Conduct of the College of Midwives of Alberta and the code of ethics of the midwifery profession. If Policies and/or the AHS Code of Conduct conflict with the Professional Code of Conduct or the code of ethics of the midwifery profession, then the Professional Code of Conduct and the code of ethics of the midwifery profession shall take precedence;

s) breach of any formal agreement with AHS; and,

t) any health problem that significantly affects the Midwife's ability to carry out her AHS professional responsibilities.

6.1.4 A Concern initiated by a Complainant:

6.1.4.1 The Complainant will be notified by the AHS Patient Relations Department, AHS Human Resources or the Midwifery Administrative Office that the Concern has been received and has been forwarded to the Senior Vice President.

6.1.4.2 The Senior Vice President or designate, subject to any legal requirements, will contact the Complainant to:

e) explain the Triggered Initial Assessment and the Triggered Review processes;

f) inform the Complainant(s) that a Triggered Initial Assessment or Triggered Review, if recommended or required, cannot proceed without the Affected Midwife being provided with a copy of the Concern, which shall include the identity of the Complainant(s);

g) confirm that the Complainant(s) wishes to have the complaint addressed as a Concern, and thus comply with the requirements specified in sections 6.1.1 of these Bylaws; and

h) obtain from the Complainant(s) written acknowledgement that the nature and implications of the processes pursuant to section 6.1.4.2 a) and b) are understood.

6.1.4.3 The Affected Midwife shall not communicate directly, in writing or verbally, or indirectly about the Concern with the Complainant unless given permission to do so by the Senior Vice President or designate; there is mutual agreement to do so as part of Consensual Resolution; and/or if recommended as part of the resolution of the Concern.

6.1.6 A Concern initiated by AHS:

6.1.5.1 The Midwifery Director or designate(s) may initiate a Concern on behalf of AHS when:

e) there are reasonable grounds to believe that one or more of the matters specified in section 6.1.3 of these Bylaws exists; and

f) those with direct knowledge are unwilling or unable to submit a Concern; and/or

g) a complaint fails to meet the requirements specified in section 6.1.1 of these Bylaws; and/or

h) the Complainant(s) does not agree or comply with the requirements specified in section 6.1.4.2 of these Bylaws.

6.2 Procedural Fairness

6.2.1 The Affected Midwife is entitled to procedural fairness including, but not limited to:

k) the opportunity at any time to initiate, or participate in, Consensual Resolution, if mutually agreeable to the Affected Midwife and AHS;

l) confidentiality consistent with the nature of the proceeding, and to the extent permitted by law, provided that the Affected Midwife does not present a risk to Patients or the public;

m) being provided with a copy of the Concern, including the identity of the person(s) bringing the Concern forward;

n) the right to respond to the Concern;

o) full disclosure, to the extent permitted by law, of all information considered in the Triggered Initial Assessment and/or Triggered Review;

p) the assistance of an Advisor;

q) timely disposition of the Triggered Initial Assessment and/or Triggered Review consistent with the nature of the Concern;

r) being provided with a copy of any recommendations, decisions and the reasons leading to them;

s) being provided with a copy of any documentation sent to the College of Midwives of Alberta, to the extent permitted by law; and

t) if a Hearing is required, to:

i. have a Hearing free of bias;

ii. have the opportunity to object to the composition of the Hearing Committee provided that prior knowledge of the subject matter of the Hearing does not automatically disqualify a person from being a member of the Hearing Committee;

iii. be represented by legal counsel, give evidence, examine and cross examine witnesses;

iv. request a review by the Senior Vice President of the report and/or recommendations of the Hearing Committee pursuant to section 6.6.1 of these Bylaws; and

v. be provided, to the extent permitted by law, with a copy of any documents, placed in the Affected Midwife's file at the conclusion of the Triggered Initial Assessment and/or Triggered Review.

6.2.2 AHS is entitled to procedural fairness including, but not limited to:

g) the opportunity at any time to initiate, or participate in, Consensual Resolution, if mutually agreeable to the Affected Midwife and AHS;

h) exclude documents or information from full disclosure if required by applicable legislation;

i) be represented by legal counsel, give evidence, examine and cross examine witnesses before the Hearing Committee (if a Hearing is required);

j) timely disposition of the Triggered Initial Assessment and/or Triggered Review consistent with the nature of the Concern;

k) make recommendations and decisions affecting the Midwifery Staff Appointment and/or the Clinical Privileges of the Affected Midwife; and

l) request a review by the Senior Vice President of the report and/or recommendations of the Hearing Committee pursuant to section 6.6.1 of these Bylaws.

6.3 Triggered Initial Assessment

6.3.1 The Senior Vice President or designate(s) shall, upon receipt of a Concern, or may, upon receipt of other information/complaints:

c) conduct a Triggered Initial Assessment; or

d) direct that a Triggered Initial Assessment be conducted by the Midwifery Director.

6.3.2 A Triggered Initial Assessment initiated upon receipt of:

6.3.2.1 a Concern shall be completed within twenty-eight days of receipt of the Concern by the Senior Vice President.

6.3.2.2 other information/complaints shall be completed within twenty-eight days upon receipt of other information/ complaints by the Senior Vice President, and shall either be dismissed or become a Concern to be addressed pursuant to this part of these Bylaws. If the result of the Triggered Initial Assessment is not to proceed to the status of a Concern, the Midwife shall be notified and such noted in the Midwife's file.

6.3.3 The Senior Vice President or designate conducting the Triggered Initial Assessment on the basis of a Concern or on the basis of other information/complaints that have become a Concern pursuant to

section 6.3.2.2 of these Bylaws shall provide a copy of the Concern to the Midwife within seven days of initiating the Triggered Initial Assessment. The Midwife's response, if any, shall be considered by the Senior Vice President or designate when deciding on the disposition of the Concern.

6.3.4 Within twenty-eight days of completing the Triggered Initial Assessment initiated upon receipt of a Concern, the Senior Vice President or designate, may:

k) dismiss the Concern as being unfounded;

l) determine that further action is not required or will not contribute further to investigation and resolution of the Concern;

m) refer the Complainant to an appropriate body or agency internal or external to AHS if the Concern does not pertain to the responsibilities and expectations of the Midwifery Staff Appointment of the Affected Midwife;

n) request further investigation and/or appoint another investigator if he/she determines the Triggered Initial Assessment to be incomplete;

o) consider the matter pursuant to section 6.3.5 of these Bylaws, if the Affected Midwife is the Midwifery Director and the Concern is determined to pertain primarily to her role as a midwifery administrative leader;

p) refer the Concern, or a portion thereof, for internal or external expert opinion;

q) request that the Affected Midwife engage in Consensual Resolution pursuant to section 6.4 of these Bylaws;

r) refer the Concern for a Hearing if the Affected Midwife declines to participate in Consensual Resolution;

s) refer for a Hearing pursuant to section 6.5 of these Bylaws if he/she determines that the Concern is not amenable to Consensual Resolution pursuant to section 6.4 of these Bylaws;

t) refer the Concern to the College of Midwives of Alberta if the Midwife agrees, in writing; or if the Senior Vice President or designate, after consultation with the CEO, determines that:

i. the referral is required by law; or

ii. the referral is necessary to ensure public or Patient safety; or

iii. the Concern will not be amenable to resolution pursuant to this part of the Bylaws but only if the Concern is within the scope of authority of the College of Midwives of Alberta to receive and act upon, and only after considering all reasonable alternatives and meeting with the Affected Midwife to review the determination to refer and the reasons for it. If referral to the College of Midwives of Alberta is planned under these circumstances, it shall not be made earlier than seven days following the meeting between the Affected Midwife and the Senior Vice President or designate, and the Midwife shall be provided with a copy of all materials intended to be sent to the College of Midwives of Alberta.

6.3.5 If the Affected Midwife is the Midwifery Director and it is determined that the Concern or other information/complaints pertains primarily to her role and function as an AHS midwifery administrative leader, the Senior Vice President or designate shall consider the matter.

6.3.5.1 The Senior Vice President or designate shall decide if the Concern is most appropriately addressed through a Triggered Review pursuant to this part of the Bylaws, or through internal AHS processes, and in consideration of the Affected Midwife's contractual arrangement with AHS.

6.3.5.2 If the Concern is to be addressed through internal AHS processes, the Senior Vice President or designate shall periodically inform the Complainant(s) of the progress of the internal AHS process.

6.3.5.3 Pursuant to section 6.9 of these Bylaws, at the conclusion of the AHS process, the Complainant(s) shall only be informed that the matter has been investigated and either dismissed or has resulted in appropriate action.

6.3.5.4 If the Concern has been dismissed, the Complainant(s) may be provided with other options to pursue the matter should he/she be dissatisfied with the outcome of the internal AHS process.

6.3.6 The Affected Midwife shall disclose to the Senior Vice President if the College of Midwives of Alberta is independently in receipt of the Concern, or investigating the Concern, and shall authorize the College of Midwives of Alberta to confirm to the Senior Vice President that this is the case.

6.3.7 A copy of any documentation placed in a Midwife's file regarding the disposition of a Concern shall be provided to the Midwife.

6.4 Consensual Resolution Process

6.4.1 At any time throughout the processes specified in Part 6 of these Bylaws, the Affected Midwife or the relevant Midwifery Director may recommend Consensual Resolution to address the matter. This shall be a consensual process between the Affected Midwife and the relevant Midwifery Director and may also include any other relevant persons including the Complainant(s). The process may include mediation.

6.4.2 The relevant Midwifery Director shall be selected by the Senior Vice President or designate.

6.4.3 The Affected Midwife and the relevant Midwifery Director shall meet and consider the Concern; the Affected Midwife's response, if any; the Triggered Initial Assessment; and any other information they consider relevant, provided however that the Affected Midwife is entitled to review and respond to all such information to the extent permitted by law.

6.4.4 Consensual Resolution shall result in a report and recommendation(s) from the Midwifery Director to the Senior Vice President. Unless the Affected Midwife and AHS mutually agree to an extension, Consensual Resolution shall be concluded and result in a report and recommendation(s) within twenty-eight days of referral of the matter by the Senior Vice President or designate for Consensual Resolution.

6.4.4.1 Discussions and communications that occur during Consensual Resolution are strictly confidential and shall not be disclosed, except in accordance with section 6.8.5 of these Bylaws, or used in any process or proceeding outside Consensual Resolution without the

written consent of the Affected Midwife and all others who participated in Consensual Resolution.

6.4.4.2 No information or documents arising from Consensual Resolution shall be shared with a Hearing Committee other than that Consensual Resolution was attempted but was unsuccessful.

6.4.5 The Senior Vice President or designate shall review the report and the recommendation(s) arising from Consensual Resolution.

6.4.6 The Senior Vice President or designate may accept the report and recommendation(s) or may request clarification of the report and/or recommendation(s). In the latter case, the Senior Vice President or designate may meet with the relevant Midwifery Director and/or the Affected Midwife to discuss the report and/or recommendations.

6.4.7 The Senior Vice President or designate shall forward a written final report and recommendation(s), including any amendments, to the Affected Midwife within fourteen days of receipt of the initial report and recommendation(s) from the relevant Midwifery Director.

6.4.8 If the Affected Midwife accepts the report and recommendation(s), she and the relevant Midwifery Director shall be accountable for implementation of the recommendation(s).

6.4.9 If the Affected Midwife rejects the report and/or recommendation(s), the Senior Vice President or designate and the Affected Midwife shall meet to ensure a common understanding of the report and recommendations, and to determine if agreement can be reached, failing which the matter shall proceed to a Hearing pursuant to section 6.5 of these Bylaws.

6.4.10 The Affected Midwife shall have fourteen days to provide a written response to the final report and recommendation(s) arising from Consensual Resolution.

6.5 Hearing

6.5.1 A Hearing before a Hearing Committee is required when:

d) the Senior Vice President or designate determines that a Concern is not amenable to Consensual Resolution;

e) the Affected Midwife declines participation in Consensual Resolution; or

f) the Affected Midwife rejects the final report and/or recommendation(s) of Consensual Resolution.

6.5.2 The Senior Vice President or designate shall refer a Concern to a Hearing Committee within seven days of determining that a Hearing is required, and shall notify the Affected Midwife as soon as possible thereafter.

6.5.3 The composition and procedures of a Hearing Committee shall be described in the Rules.

6.5.4 Mandate and Functions of the Hearing Committee

6.5.4.1 The Hearing Committee shall receive information, hear evidence, consider the Concern, and prepare a report and make recommendations.

6.5.4.2 The Hearing Committee is entitled to retain independent legal counsel to advise it on process and procedure in conducting the Hearing.

6.5.4.3 AHS shall present, and the Hearing Committee shall consider, the Concern and any evidence (either oral or written) that is relevant to the matters in issue, provided however that in advance of the Hearing the Affected Midwife is entitled to reasonable notice of evidence to be produced in order to allow for a fair response.

6.5.4.4 At any time during the Hearing, the Hearing Committee may ask relevant Midwifery Staff members to provide further information.

6.5.4.5 The Hearing Committee may receive and consider relevant expert opinion(s) from within AHS, or external to AHS.

6.5.4.6 The Affected Midwife shall appear before the Hearing Committee and is a compellable witness. In addition, the Committee may request that the Complainant(s) or any other person who may have knowledge or information relevant to the matters at issue give evidence.

6.5.4.7 Evidence may be given before a Hearing Committee in any manner that the Hearing Committee considers appropriate. The Hearing Committee is not bound by the rules of law respecting evidence that are applicable to judicial hearings.

6.5.5 After receiving and considering all relevant information and evidence, the Hearing Committee shall prepare a report and recommendation to either:

e) dismiss the Concern as being unfounded; or

f) if the Concern or the issues raised in the report are well-founded, prepare recommendations regarding remedial action or sanctions to be imposed upon the Affected Midwife. Such action or sanctions may include but are not limited to:

i. no further action;

ii. placing a caution or reprimand in the Affected Midwife's file;

iii. requiring the Affected Midwife to undergo counseling or treatment;

iv. requiring the Affected Midwife to obtain upgrading or further education;

v. requiring the Affected Midwife to undertake a period of clinical supervision with prospective review of cases with or without special requirements of concurrent consultation or direct supervision;

vi. in the case of conduct which is unprofessional, unethical, unbecoming, improper, or deemed to be disruptive workplace behaviour, requiring the Affected Midwife to undertake remedial measures to address the behaviour that gave rise to the Concern;

vii. temporary suspension of all or specified Clinical Privileges;

viii. permanent change of specified Clinical Privileges;

ix. a change in the category of Appointment;

x. termination of the Affected Midwife's Appointment; and/or

xi. any other recommendation considered appropriate to ensure public or Patient safety.

6.5.6 The Hearing Committee report and recommendation(s) shall be forwarded to the Senior Vice President within sixty days of establishment of the Hearing Committee. The Senior Vice President or designate shall review the report of the Hearing Committee, and provide a copy to the Affected Midwife.

6.5.6.1 Within fourteen days of receiving the report of the Hearing Committee, the Affected Midwife shall provide written notification to the Senior Vice President as to whether she accepts or rejects the findings and/or recommendation(s) of the report.

c) If the Affected Midwife accepts the report and/or recommendation(s) of the Hearing Committee, the report and the Affected Midwife's response are sent to the Senior Vice President or designate for a decision pursuant to section 6.8 of these Bylaws.

d) If the Affected Midwife does not accept the report and/or recommendation(s) of the Hearing Committee, she may request a review by the Provincial Midwifery Executive Committee of the procedure of the Hearing Committee but only if she contends that:

i. the findings are materially inconsistent with the evidence;

ii. breaches of process and fairness occurred and may have affected the findings and/or recommendations;

iii. the Hearing Committee erred in law; or

iv. there is new evidence that could not have been produced through reasonable efforts at the time of the Hearing, and that may have affected the findings and/or recommendation(s).

g) The Senior Vice President or designate shall inform the Provincial Midwifery Executive Committee within seven days of receipt of the request from the Affected Midwife.

h) If the Affected Midwife does not provide written notification to the Senior Vice President as to whether she accepts or rejects the report and/or recommendation(s) of the Hearing Committee within fourteen days, the Senior Vice President or designate shall make a decision pursuant to section 6.8 of these Bylaws. .

6.6 Appeal of the Hearing Committee Process

6.6.1 The Affected Midwife or AHS may request that the Provincial Midwifery Executive Committee review the report and/or recommendations of the Hearing Committee. The appeal will only consider whether:

e) the findings are materially inconsistent with the evidence;

f) breaches of process and fairness occurred and affected the findings and/or recommendations of the Hearing Committee;

g) the Hearing Committee erred in law; or

h) there is new evidence that could not have been produced through reasonable efforts at the time of the original Hearing and may have affected the findings and/or recommendation(s).

6.6.2 The Provincial Midwifery Executive Committee will not repeat the investigation or Hearing. The review will only consider the appeal items outlined in section 6.6.1 a), b) or c) above, and will only refer to the documented record of evidence to the extent necessary to determine whether the process was fair.

6.6.3 Where the Provincial Midwifery Executive Committee determines that the findings are materially inconsistent with the evidence, or that there have been breaches of process and/or fairness that affected the findings and/or recommendations, it shall remit the matter to the Senior Vice President for a further Hearing by a differently composed Hearing Committee.

6.6.4 Where the Provincial Midwifery Executive Committee determines that the Hearing Committee has erred in law, the Provincial Midwifery Executive Committee may remit the matter to the Senior Vice President for a further Hearing by a differently composed Hearing Committee, or may, based on the documented record of evidence provided to it, vary or remove the relevant finding(s) or recommendation(s), and submit its report to the Senior Vice President for decision.

6.6.5 Should the Provincial Midwifery Executive Committee determine that new evidence exists that may have affected the findings and/or recommendations of the initial Hearing, the Provincial Midwifery Executive Committee shall refer the matter to the original Hearing Committee for further consideration and recommendation to the Senior Vice President.

6.6.6 Within sixty days of notification of the request to review the Hearing Committee proceedings and process, the Provincial Midwifery Executive Committee shall deliver a report of their findings and recommendations to the Senior Vice President (pursuant to section 6.6.3 or 6.6.4), or the original Hearing Committee (pursuant to section 6.6.5).

...

6.8 Decisions of the Senior Vice President

6.8.1 All final reports and recommendation(s) of a Hearing Committee and the Provincial Midwifery Executive Committee with respect to an appeal of a Hearing Committee process shall be sent to the Senior Vice President for a decision.

6.8.2 The Senior Vice President or designate will render a decision within fourteen days of receipt of the report and recommendation(s) from a Hearing Committee and, if applicable from a Provincial Midwifery Executive Committee. The Senior Vice President or designate may:

a) dismiss the Concern as being unfounded;

b) determine that no further action is required; or

c) determine appropriate remedial actions or sanctions. These may include, but are not limited to, a temporary or permanent change to the Appointment or Clinical Privileges, or

termination of the Appointment of the Affected Midwife. The Affected Midwife may choose to voluntarily submit to such actions or sanctions. If she does not, the actions or sanctions shall be imposed.

6.8.3 The decision of the Senior Vice President or designate may be the same as, or different from, the recommendations of a Hearing Committee or the Provincial Midwifery Executive Committee. If the decision of the Senior Vice President or designate differs from the recommendations of the Hearing Committee or the Provincial Midwifery Executive Committee, written reasons for the difference shall be provided to the Hearing Committee and/or Provincial Midwifery Executive Committee, the Midwifery Director and the Affected Midwife.

6.8.4 The Affected Midwife and Midwifery Director shall be notified in writing of the decision of the Senior Vice President or designate and the rationale for the decision.

6.8.5 If, in the decision of the Senior Vice President or designate, a substantive change in the Appointment or Clinical Privileges of the Affected Midwife is authorized, the Senior Vice President or designate will inform the College of Midwives of Alberta.

6.8.6 The decision of the Senior Vice President or designate is subject only to the rights of appeal under Part 7 of these Bylaws.

6.9 Notification of the Complainant

6.9.1 The Senior Vice President or designate, or if applicable, the Midwifery Director pursuant to section 6.3.5 of these Bylaws, shall periodically inform the Complainant(s), if any, of the progress of Triggered Initial Assessment or Triggered Review. At its conclusion, the Complainant(s) shall only be informed that the matter has been investigated and either dismissed or has resulted in appropriate action. If the Concern has been dismissed, the Complainant(s) may be provided with other options to pursue the matter should they be dissatisfied with the outcome of the Triggered Initial Assessment and/or Triggered Review.

6.10 Midwife-Initiated Reviews

6.10.1 A Midwife may voluntarily self-report a Concern about her own professional performance and/or conduct to the relevant Midwifery Director, or to a more senior leader if warranted by the nature and significance of the Concern.

6.10.2 By voluntarily self-reporting a Concern, the Midwife is entitled and expected to work Collaboratively with the relevant Midwifery Director to review and resolve the Concern.

6.10.3 The Midwife and the relevant Midwifery Director shall develop, in writing, a mutually agreed upon plan to review and resolve the Concern. The proposed plan must be approved by the Senior Vice President or designate and, if appropriate, may include temporary or permanent changes to the Midwife's Midwifery Staff Appointment or Clinical Privileges. The Midwife shall receive a copy of the approved plan.

6.10.4 The Midwife shall be compliant with the conditions and terms of the plan, including any periodic monitoring, review, or reporting that has been agreed upon.

6.10.5 If the Midwife and the relevant Midwifery Director are unable to reach agreement upon a plan, or if, during the implementation of the plan, the Midwife is unable or unwilling to comply with the conditions

and terms of the plan, then review and resolution of the Concern shall immediately proceed to a Hearing pursuant to section 6.5 of these Bylaws.

6.10.6 Upon conclusion of the plan and resolution of the Concern, or if the process is unsuccessful in resolving the Concern, a written report shall be placed in her file(s), and a copy provided to the Midwife.

6.11 Disposition of Records

6.11.1 All information obtained, reviewed, discussed and otherwise used or developed in any process related to this part of these Bylaws, and that is not otherwise publicly known, publicly available, or part of the public domain, is considered to be privileged and strictly confidential information of AHS. It shall not to be disclosed to anyone outside of the process related to this part of these Bylaws except if agreed to, in writing by the Affected Midwife or where determined by the Senior Vice President or designate, as required by law or necessary to ensure public or Patient safety. Records of the proceedings outlined in this section (e-mails, correspondence, reports, and notes) will be retained in a manner consistent with the AHS record retention Policy.

Schedule E: AHS *Midwifery Staff Rules*, Section 2.5 – 2.6

The entire AHS *Midwifery Staff Rules* are available to the public at www.ahs.ca and to AHS personnel on Insite.

2.5 Hearing Committees, Immediate Action Review Committee & Membership Selection Process

[2.5.1 – 2.5.4 omitted]

2.5.5 A Hearing Committee shall be established as required pursuant to sections 6.5 and 6.6 of the Bylaws and consist of five members including a chair selected by the Senior Vice President or designate.

2.5.6 The Midwifery Administrative Office shall be responsible for the orientation, training and remuneration of the Hearing Committee members. The payment of honoraria and expenses to members assigned to a specific Hearing Committee shall be in accordance with relevant Policies.

2.5.7 The Senior Vice President or designate shall be responsible for selecting a five-person Hearing Committee, which shall consist of three members of the Midwifery Staff selected by the Senior Vice President or designate which are drawn from a pool of five Midwifery Staff nominated by the Midwifery Staff Association; and two representatives appointed by the Senior Vice President or designate for each specific Hearing Committee established pursuant to sections 6.5 and 6.6 of the Bylaws. The Senior Vice President or designate shall select a chair from amongst the members of the Hearing Committee.

2.5.8 The Senior Vice President or designate shall also be responsible for considering any objection to the composition of a Hearing Committee established pursuant to section 2.5.7 above provided by an Affected Midwife. Prior knowledge of the subject matter of the Hearing does not automatically disqualify a designate from being a member of the Hearing Committee. Should the Senior Vice President or designate determine that the objection of the Affected Midwife is with merit, she shall designate a replacement member for that Hearing Committee.

2.5.9 The quorum for each Hearing Committee shall be three members including the chair.

2.6 Hearing Committee

2.6.1 Establishment

A Hearing Committee is established pursuant to sections 6.5 and 6.7.9 of the Bylaws.

2.6.2 Composition

A Hearing Committee shall be composed of five voting members including a chair, all of whom are selected following the Hearing Committee selection process pursuant to section 2.5 of these Rules.

2.6.3 Duties and Responsibilities

The purpose of the Hearing Committee is to consider a Concern referred to it in respect to an Affected Midwife by receiving information and hearing evidence, and shall make recommendations pursuant to section 6.5 of the Bylaws. A Hearing Committee shall fulfill its duties in a fair and impartial manner.

2.6.4 Conduct of Meetings

a) Meetings of the Hearing Committee may be held in person, by videoconference or teleconference provided that Hearings shall require the personal attendance of members.

b) Meetings of the Hearing Committee shall be held in a location of its choice.

c) A Hearing Committee shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with section 6.5 of the Bylaws.