Ethics – Special Interest Section

Thomas W. Paton

In this year's Hospital Pharmacy in Canada Survey, the special interest topic dealt with the subject of ethics in healthcare. Within that broad subject area, the survey gathered information concerning the organizational policies, structures, and processes that hospitals have in place to support ethical decision-making. The survey also looked at these issues within three separate healthcare domains - research, clinical care and business.

Research Ethics

- Seventy-three percent of respondents (103/142) reported that a Research Ethics Board (REB), also known as an Institutional Review Board (IRB), was in place in their institution. A higher percentage of teaching hospitals (81%) than non-teaching hospitals (70%) reported having a functional REB. The larger hospitals (>500 beds) were more likely to have a REB (81%) than the smaller hospitals with 100-200 beds (56%). The only notable regional difference was reported in the Prairie Provinces where only 35% of reporting hospitals indicated that a hospital-based REB was in place.

- Most organizations without a hospital-based REB (23%, 32/142) reported that a university-based REB (47%, 15/32) or an external REB (34%, 11/32) fulfilled this role. Not unexpectedly, teaching hospitals were more likely to take advantage of their university affiliation (83%, 5/6) to fulfill this role than non-teaching hospitals (38%, 10/26).

- In those hospitals with a hospital-based REB (103 respondents), 81% indicated that a pharmacist was an integral member of the committee. This appeared to be independent of the hospital teaching status or bed size. Fewer of the hospital-based REBs in the Prairies and Atlantic Canada (57%, 4/7 and 67%, 8/12 respectively) had a pharmacist on the committee.

- For those hospitals with a hospital-based REB, 98% (101/103) reported that all clinical trials had to be reviewed and approved by that committee. This was consistent irrespective of teaching status, bed size or regional distribution. Most respondents with a hospital-based REB also reported that practice-based research had to be reviewed and approved by their REB (87%, 90/103), with no notable differences reported based on teaching status, bed size or regional distribution. In contrast, quality improvement initiatives were only required to be reviewed and approved by the REB in 19% (20/103) of hospitals.

Clinical Care Ethics

- Seventy percent (99/142) of respondents indicated that their hospital had a bioethics/ethics advisory committee in place. This was consistent irrespective of teaching status or bed size. The percentage of respondents from BC that reported such a committee was in place (50%, 10/20) was somewhat lower than the percentages reported by respondents from other regions.

- Forty-one percent (14/34) of hospitals without a bioethics/ethics advisory committee, reported that this role was assumed by another hospital committee such as their REB, Medical Advisory Committee, Professional Advisory Committee or Interprofessional Patient Care Committee.

- Of the 113 respondents that indicated such a committee was present in their hospital, only 32% (36/103) indicated that a pharmacist was a member of the committee. This was independent of teaching status or bed size. Regionally, Ontario respondents (44%, 16/36) were most likely to report that a pharmacist was a member of the bioethics committee.

- The scope of issues dealt with by bioethics/ethics advisory committees is summarized in table J-1. Not surprisingly, 81% of respondents reported that quality of patient care was a part of the mandate of this committee. Of note, 73% of respondents reported that the committee had developed an ethical framework for clinical decision-making. Thirty-four percent of respondents reported that the committee provided guidance to senior management on budgetary issues affecting patient care. Policy development by the committee, on issues related to patient care, education, research and business, was reported by 75%, 51%, 60% and 32% of respondents, respectively. The bioethics committee was reported to provide educational programs, on a range of bioethics topics, by 71% of respondents. A somewhat higher percentage of hospitals with more than 500 beds (83%) reported that educational programs were provided, compared to 67% of respondents from hospitals in the 100-200 and 201-500 bed range. The promotion of ward-specific bioethics rounds was reported to be an activity of the bioethics committee by 26% of respondents. Ward-specific rounds were more frequently an initiative of this committee in hospitals with a bed size exceeding 500 (45%, 13/29), than in hospitals with 100-200 beds (24%, 5/21) or 201-500 beds (17%, 11/63). For all the elements listed in Table J-1, the main reported difference across the regions is a notably lower percentage of respondents from BC that reported their bioethics committee's involvement in these activities, compared to other regions.

- An institutional policy dealing with disclosure of adverse events was reported by 83% (118/142) of all respondents and by 95% (35/37) of teaching hospitals and 79% (83/105) of non-teaching hospitals. Sixty percent (12/20) of respondents from BC reported that such a disclosure policy exists, compared to 80-90% of respondents from other regions. Of the 118 respondents with a disclosure policy, 92% (109/118) reported that such events had to be disclosed to senior management and 90% (106/118) reported that disclosure of such events to patients and family was required. There were no notable differences in these results based on teaching status, bed size or region. Only 58% (68/118) of respondents reported that disclosure to a third party was required by their adverse event reporting policy, and there were again no notable differences based on teaching status, bed size, or region.

- A bioethicist was reported to be on staff by 39% (56/142) of respondents. Teaching hospitals reported a higher rate than non-teaching hospitals (68% compared to 30%). Only 15% (3/20) of BC respondents reported that a bioethicist was available for clinical consultation.

- Only two percent (3/142) of respondents reported that a bioethicist sits on their Pharmacy and Therapeutics (P&T) Committee, and only 6% (8/142) of respondents reported that a patient representative sits on that Committee.

- Of 142 respondents, 32% (45/142) reported that their institution had an end of life committee. There were no notable differences based on teaching status, bed size or region.

Table J-1 Responsibilities of the Bioethics Advisory Committee 2005/06

	All	Bed Size			Teaching Status	
		100- 200	201- 500	>500	Teaching	Non-Teaching
Hospitals (n=)	(113)	(21)	(63)	(29)	(30)	(83)
Quality of patient care issues	81%	81%	81%	79%	83%	80%
Provision of an ethical framework for decision making	73%	81%	70%	76%	77%	72%
Provide guidance to senior management on budgetary issues that affect patient care	34%	33%	30%	41%	47%	29%
Develop ethics related policies dealing with:						
Patient Care	75%	81%	73%	76%	80%	73%
Education	51%	48%	46%	66%	67%	46%
Research	60%	67%	56%	66%	77%	54%
Business	32%	43%	24%	41%	50%	25%
Provide educational programs on a range of bioethics topics	71%	67%	67%	83%	70%	71%
Promote ward-specific bioethics rounds	26%	24%	17%	45%	33%	23%

Business Ethics

- Sixty-eight percent (97/142) of respondents reported that their institution has a conflict of interest policy, with no notable differences reported based on teaching status or bed size. However there were differences based on region, with 85% (17/20) of BC respondents and 100% (20/20) of respondents from the Prairies reporting that such a policy was in place in their institutions, compared to only 62% (28/45), 55%(23/42), and 60%(9/15) of respondents from Ontario, Quebec and Atlantic Canada respectively.

- For those organizations that reported having a conflict of interest policy, 99% (96/97) reported that their conflict of interest policy applied to management staff, 92% (89/97) reported that the policy applied to other hospital staff, and seventy-seven percent (75/97) reported that the policy applied to the medical/dental staff. For all three groups of staff there were no notable differences reported based on teaching status, bed size or region.

- The scope of the conflict of interest policies is summarized in Table J-2. Issues most commonly reported to be dealt with in the conflict of interest policies were the employee as a supplier of goods and services (85%), the receipt of gifts (89%), the use of confidential information for personal gain (82%), and the inappropriate use of hospital resources (74%). Issues less likely to be included in such policies included the referral of clients to private practice (35%), educational program content and choice of speakers (31%), sponsorship to attend educational events (47%) and relationships with the pharmaceutical industry (46%). Fifty-nine percent of respondents from teaching hospitals reported that their policies addressed relationships with the pharmaceutical industry, compared to 41% of respondents from non-teaching hospitals. It is noteworthy that 63% of respondents reported that conflict of interest policies addressed the selling of data to external parties. A small majority of respondents reported that their institutions have addressed the complex issues of staff employment by other organizations (55%), outside remuneration (54%), and the receipt of outside honoraria (54%). There was considerable regional variation but no remarkable consistencies in the scope of conflict of interest policies.

Table J-2 Issues Addressed in the Institution's Conflict of Interest Policies 2005/06

	All	Bed Size			Teaching Status	
		100- 200	201- 500	>500	Teaching	Non-Teaching
Hospitals (n=)	(97)	(18)	(51)	(28)	(27)	(70)
The employee as a supplier of goods and services to the institution	85%	89%	80%	89%	81%	86%
Relationships of family members with other member of the organization	65%	78%	57%	71%	59%	67%
Referral of clients to private practice	35%	44%	31%	36%	41%	33%
Solicitation of donations to your Foundation	52%	72%	47%	46%	56%	50%
Solicitation of sponsorship funds, grants or gifts	67%	72%	59%	79%	85%	60%
Educational program content and choice of speakers	31%	44%	22%	39%	22%	34%
Sponsorship to attend educational events	47%	56%	45%	46%	37%	51%
Acceptance of sponsorship for research grants	54%	50%	57%	50%	67%	49%
Receipt of gifts	89%	78%	90%	93%	89%	89%
Outside employment	55%	72%	45%	61%	63%	51%
Outside remuneration	54%	72%	55%	39%	44%	57%
Outside honoraria	54%	67%	53%	46%	56%	53%
Use of institutional resources for self-employment	71%	83%	67%	71%	70%	71%
Use of confidential information for personal gain	82%	83%	84%	79%	89%	80%
The selling of data to external parties	63%	61%	61%	68%	70%	60%
Inappropriate use of hospital resources	74%	67%	78%	71%	70%	76%
Relationships with the pharmaceutical industry	46%	50%	47%	43%	59%	41%

- Forty-five percent (64/142) of respondents reported that there was a conflict of interest policy, supporting the activities of P&T, that addresses the need for disclosure by employees involved in purchasing/contract decisions. There were no differences reported based on teaching status or bed size. Regional differences did exist with 85% (17/20) of BC respondents, compared to 21% (9/42) of Quebec respondents reporting the inclusion of this issue in their P&T conflict of interest policies.

- The requirement for disclosure of medical and pharmacy involvement with pharmaceutical companies whose drugs are being considered for the formulary was reported by 51% (73/142) of respondents. There were no notable differences reported based on teaching status and bed size. Regional differences did exist with 85% (17/20) of BC respondents, compared to 19% (8/42) of Quebec respondents, reporting the inclusion of this issue in their P&T conflict of interest policies.

- Only 39% (56/142) of respondents reported that their hospital's orientation program for new staff dealt with the issue of conflict of interest. There were no notable differences reported based on teaching status and bed size. Respondents in BC (60%, 12/20) and the Prairies (65%, 13/20) most frequently reported the inclusion of this item in their new staff orientation. Only 17% (7/42) of respondents from Quebec reported the inclusion of this item in their staff orientation program. New staff orientation addressing the code of professional conduct and confidentiality of patient information was reported by 73% (104/142) and 89% (127/142) of respondents respectively. The disclosure of medical error was reported to be addressed in the orientation program by 65% (92/142) of respondents. There were no notable differences reported based on teaching status, bed size or region. The requirement for an annual statement of disclosure regarding conflict of interest was reported by 15% (21/142) of respondents. Twenty-seven percent (10/37) of respondents from teaching hospitals compared to 10% (11/105) of respondents from non-teaching hospital reported this requirement. No notable differences were reported based on bed size or region.

- When asked what areas were perceived to be the institution's greatest risk for conflict of interest, the most frequently reported issue was the sponsorship of educational programs. (25%, 35/142), followed by drug formulary decisions (20%, 29/142), research (17%, 24/142) and clinical decision-making (17%, 24/142). Other areas less frequently perceived to be a risk by the respondents were the use of hospital resources for personal gain (7%, 10/142) and drug purchasing/contract decisions (2%, 3/142). There were no notable differences based on bed size. Thirty-five percent of respondents from teaching hospitals, compared to 10% of respondents from non-teaching hospitals, reported that research was an area at risk for conflict of interest. This is not surprising, given the large amount of clinical research conducted in teaching hospitals, compared to a much lower level of research activity in non-teaching hospitals.