PAIN MANAGEMENT, JCAHO REQUIREMENTS AND THE ROLE OF ETHICS COMMITTEES

Buddha: "Now this, monks, is the noble truth of pain: Birth is painful, old age is painful, sickness is painful, death is painful, sorrow, lamentation, dejection and despair are painful. Contact with unpleasant things, not getting what one wishes is painful."

Pain Management as an Ethical Issue

Pain management was a late entry in the bioethics agenda and it has had trouble making headway. Brought up largely in the context of the euthanasia debate—which first began seriously in California almost four years ago—it has most often been seen as a technical issue, one to be handled by pain specialists. Yet, it is clearly an ethical issue in a culture that places so much importance on the value of patient autonomy. Nothing, not paternalistic physicians, not bureaucratic organizations; can coerce people or deprive them of their own best judgment, in the way that unrelieved, and often unconscionable pain does.

JCAHO Requirements

In the past year, JCAHO has increased its emphasis on issues related to pain management.

The more substantive focus on pain management for those on ethics committees is included in the standard RI.1.2) that addresses "the patient's involvement in all aspects of care." Here there is a JCAHO expectation that hospitals will have policies,
NETWORK NEWS

Baltimore Area Ethics Committee Network (BAECN)

The April 4th meeting of the Network was well attended. The topic of "Medical Futility" was addressed by three speakers: Jack Schwartz, J.D., Office of the Attorney General, August Lagemann, Ph.D., Pastoral Care Center of Maryland and Dean Tippett, M.D., Chairman, Ethics Committee, St. Agnes Hospital. A lively discussion followed.

As planned, the Network has established its two new working groups: an Ethics Committee Education and Standard Task Force and a Case Review Subcommittee. Members of these groups have been selected and they have already begun to operate. Anyone interested in joining in their efforts should contact Jack Syme, M.D., President, BAECN, at the Department of Neurology, St. Agnes Hospital, Baltimore, MD at (410) 368-3020.

Washington Metropolitan Bioethics Network (WMBN)

"The Rapid Organ Recovery Program: An Innovative Solution to the Organ Donor Crisis," was the topic of the March Network meeting. William Ritchie, Jr., Ph.D., Director, Office of Decedent Affairs, at the Washington Hospital Center presented this talk which stimulated a lively discussion.

At the April 18th meeting, members considered the possibility of the Network applying for a grant from the Open Society Institute for their "Project on Death in America." (See Announcement of this Program on page 10.)

The next DHEP will be held from August 14-August 19, 1995 at the University of Virginia in Charlottesville.

This is an intensive 6-day course of study for health care professionals
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procedures, or other mechanisms that document pain management.

Furthermore, the existence of such policies, procedures, or other mechanisms is determined by interviews with organization leaders, clinical staff, patients and families, and by review of patient medical records. It is not enough simply to have paper evidence that the issue has been considered.

JCAHO’s concern with pain management appears to view pain management as an integral aspect of informed consent, surrogate decisionmaking, research treatment decision conflicts, advance directives, forgoing treatment, and any other end-of-life treatment decisions. Evidence about how pain is managed is also evidence about how well these other categories are handled.

Most of this makes perfect sense, but some is unclear and, almost all of it, is poorly developed in terms of ethics committee function. For example, it is unclear in what way pain management policies or mechanisms are to be used to demonstrate appropriate attention to informed consent, unless the implication is that, if pain management is not provided, the patient has refused it and there should have been informed refusal.

Advance directives provide a similar kind of problem. In what way does JCAHO imagine that one might incorporate pain management into advance directives? It has surely been difficult enough to persuade people to complete advance directives that have fairly simple categories about treatment decisions. What then are they to be expected to add about pain management? Although advance directives are not exclusively intended to address the issue of forgoing treatment, that is their general orientation. Thus, perhaps those who do want pain managed might indicate this in their advance directive. It would seem that a preference for managing rather than ignoring pain might be understood to be a general default position. Therefore, one would not be expected to speak to pain management in an advance directive unless one’s wishes in that regard were fairly atypical. However, addressing pain management in the context of treatment conflicts and of forgoing life-sustaining treatments makes a lot of sense.

The Role of Ethics Committees
The three time-honored ethics committee functions (education, policy writing, and care review) provide a reasonable format for integrating pain management into ethics committee consciousness.

A. Education
Education will need, as usual, to focus first on self and then on others. The committee will need to have some mastery of the technical issues involving pain management. They need to know what is possible, what is not possible, and whom to look to in their institution for reliable and timely information. Thus, they need to seek out institutional or community resources (i.e., hospice programs) to start their education process.

Along with technical education, the committee needs to look within itself, to do some introspection and some consciousness raising to discover its own unjudged attitudes, biases, and prejudices about pain, its treatment, and its meaning. Caregivers often have distinct opinions about whether a patient “should” be feeling as much pain as the patient is reporting. Talking about pain and what it means is an important aspect of committee education.

A second aspect of education is learning about cultural variations in attitudes toward pain. Ed Martinez, an administrator at the Multicultural Primary Care Medical Group in San Diego, talked about this recently, noting that “some Native American and Asian cultures ... condition patients to respond to pain in a quiet, stoic manner. Other cultures, such as Middle Eastern and Hispanic, accept open—even hysterical—expression of pain.” Although one cannot generalize from the culture to the individual, just knowing that there can be differ-

“... the committee needs to look within itself, to do some introspection and some consciousness raising to discover its own unjudged attitudes, biases, and prejudices about pain...”

ences in patients’ responses to pain can extend the caregivers’ repertoire of responses to these patients. And beyond culture, there is considerable individual variation about stoicism. We will have to talk about pain to find out who has what view and whether it is a view that is grounded in values or unrealized habit.

Education can also mean raising consciousness and assessing practice in the larger hospital community. Conducting surveys to determine whether caregivers think pain management practices in the institution are an asset or a liability to the hospital, can work as an initial needs assessment. Working with administrators to determine whether it is possible to survey patients and their families to discover their experience with pain management in the hospital.

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can provide additional illumination about what is needed. Working with quality assurance committees to investigate the possibility of assessing pain management practices will give further depth to this community education effort.

Finally, the committee may want to organize formal education programs about the ethical implications of pain management or to join with other groups in the hospital to sponsor more general programs about pain management that will include attention to the ethical aspect.

B. Policy Writing  
1. Forgoing Treatment  
Just because pain management has a large technical component, the ethics committee is unlikely to be the source of policies about pain management. But, as JCAHO points out, pain management can have an important role in policies for which the ethics committee has already taken responsibility. Forgoing treatment policies do not often include specific attention to pain management in the course of ending treatment. Although the policy may make clear who is to actually remove the ventilator support, does it make clear that the patient should be kept comfortable when that is happening? It may be that nothing more, in terms of policy work, is needed than to add sections stating that “in the course of any decision to forego treatment, caregivers will consider and discuss with the patient or surrogate, if appropriate, any potential for pain or suffering caused by the withholding or withdrawal of treatment, and the available methods for reducing or eliminating such pain and suffering to the patient.”

There must also be an assessment to determine whether in practice this actually happens. It is the outcome that JCAHO is interested in (and that ethics committees should be interested in). Although it may not be the exclusive function of the ethics committee to do such evaluation, it may want to work with quality assurance committees to do so. What the history of ethics committees shows, however, is that carefully crafted policies are seldom followed-up. If pain management matters, then this part of the process must also matter.

2. Advance Directives  
Although it may not be wise to address pain management in formal advance directives, that does not mean that patients should not be encouraged to discuss their wishes about pain management in advance. That is, clinicians—doctors and nurses—should discuss with seriously ill patients their views about how aggressive pain management should be in terms of the patient’s values. There is at least some trade-off between consciousness and full management of pain. If ethics committees have not made much headway in encouraging advance directive discussions, then they will have little to build on for these discussions. However, because pain management is an issue filled with ambiguous meanings and ambivalent feelings, discussion is even more important. Documentation is important if the conversations reflect real depth of consideration. What we probably don’t need is more phrases like “patient does not want tubes” or “patient does not want to be vegetable” but now cast in the framework of pain management: “Patient does not want to be addicted” or “patient does not want to be snowed.”

C. Case Review  
Many committees have documents that they use in case reviews that will help them to ensure they have asked all the relevant questions. They should ensure that pain management is put on that list. Whenever patients are asking to stop treatment, the question should at least be asked: is this patient in pain? Have there been attempts to relieve that pain? Relieving the pain may not make any difference in the patient’s views about forgoing treatment, but the question needs, at least, to be asked.

Finally, although the JCAHO categories seem to apply primarily to pain in the context of terminal illness, committees need to work through the issues of chronic pain management as well. Here, cultural values and biases become very important and it will be a long time before we have sorted out our feelings and thoughts on this issue. Any case that involves patients with chronic illness should also trigger a discussion about pain management. There are significant numbers of people who face real problems in having their pain believed in, and case reviews should incorporate that aspect, even if the question posed by those who come to the committee does not directly address pain management.

Conclusion  
Pain management is a large new area for ethics committees to work in, but there is little question that there is need for it. The ethics committee has an important role as a member of the community in bringing the issue to the forefront, in being the “conscience of the institution.”

Submitted by  
Judith Wilson Ross, M.A.  
Associate Center for Healthcare Ethics  
St. Joseph Health System  
Orange, California
Case Presentation

One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee in the region and how the committee resolved it. Individuals are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information of patients and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to: Editor, Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201-1786.

Case Study From a Maryland Nursing Home

Ms. Jones, an 86-year-old woman, was admitted to a nursing home because of progressive dementia due to Alzheimer’s Disease. She had significant tardive dyskinesia (a movement disorder) due to previous administration of psychoactive medications. She was bedbound, totally dependent in her activities of daily living, and fed via a gastrostomy tube. She was also on Dilantin for a seizure disorder. Although alert, Ms. Jones made only some incoherent noises in response to questions.

This patient had never made any advance directives and was, at this point, incapable of doing so. According to her family, however, she had previously expressed her wish that her life not be prolonged indefinitely by extraordinary measures.

After several years in the facility with little change, Ms. Jones’ family felt that her persistent bedbound state and limited cognitive function were not consistent with a desirable quality of life. Subsequently, they requested that Ms. Jones’ physician treat her as a terminal patient, foregoing any aggressive medical intervention. Her physician agreed not to implement antibiotics, although he did not believe that Ms. Jones’ condition was terminal. A consultant physician concurred with the appropriateness of not using antibiotics, but also found Ms. Jones not to be terminally ill.

Approximately six months later, the patient developed an abscess of her left thigh. Her attending physician insisted on treating this medical problem with antibiotics, since Ms. Jones was not terminal. The patient’s family decided to switch to another physician. This new physician agreed not to use antibiotics and was prepared to treat Ms. Jones as if she were terminally ill.

The medical director and other physicians in the nursing home met and decided that it was not appropriate to manage her case in this way. Consequently, the administration, nursing staff and physicians sought consultation from the ethics committee.

Submitted by
Steven Levenson, M.D.
Medical Director
Asbury Methodist Village
Gaithersburg, MD

This case was originally presented in our Fall 1993 newsletter as a case study dealing with the withholding of antibiotics. Given the topic of this newsletter, we are presenting the case a second time and have asked individuals from two different perspectives—theology and law—to comment.

Case Discussion: Comments From A Maryland Attorney

This case serves as an example of how a discussion of end of life issues, before a crisis occurs, might eliminate questions as to how to care for an aged loved one facing a medical dilemma. An advance directive indicating Ms. Jones’ choices might have obviated the need for this ethics committee meeting. Those in the health care field are all too aware that execution of an advance directive, either written or oral, in compliance with the law, can well prevent conflict-ridden ethical disputes in long-term care. Although patients and families may have some sense of their wishes regarding the initiation, withholding or withdrawal of life-sustaining procedures such as CPR, artificial hydration and nutrition, and mechanical respiration, for example, it may be less clear when the issue of other medical treatment arises in a non-terminal state, or end-stage condition. For although the issue of who shall speak for Ms. Jones may not be in dispute here, the question of what should be done for Ms. Jones is clearly “up for grabs.”

In this case, the family of Ms. Jones seems to be in concurrence about the proper course of treatment for her; it is the health care providers who differ over how to best treat the current medical dilemma facing this resident. The issue presented before the ethics committee, thus, is simply how aggressively should the abscess be treated given Ms. Jones’ current quality of life and advanced years? Will the introduction of antibiotics prolong the dying process or restore health until such time as the dying process begins?

In order to render an opinion, it is imperative that the ethics committee accumulate as much information as possible to ascertain the wishes of Ms. Jones. If this cannot be determined, what would be in Ms. Jones’ best interests?

Pursuant to the Maryland Health Care Decision Act, codified at Md. Health-Gen’l. Code Ann.§5-601 et. seq (1994 Repl. vol.), surrogates (I assumed that the family of Ms. Jones meets the statutory requirements for serving as surrogates for health care decisions, and that all surrogates are in agreement regarding the course of treatment for her) and health care agents must base health decisions on the wishes of the patient, and if those are not discernible, on the best

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interests of the patient. Surrogates may make a decision to withhold or withdraw life-sustaining treatment only if two physicians certify that the patient has a terminal or end-stage condition or is in a persistent vegetative state.

Patient Wishes
With respect to Ms. Jones’ wishes, the committee has been told by the family that “she had previously expressed her wish that her life not be prolonged indefinitely by extraordinary measures.” In determining whether Ms. Jones would consider the taking of antibiotics as “extraordinary,” the committee must consider the following: 1) current diagnosis and prognosis with and without the treatment at issue. In this case, would the abscess lead to death if left untreated at all? Would antibiotics prevent death due to the abscess? Could any resultant infection resolve itself without the administration of antibiotics? 2) expressed preferences regarding the treatment at issue or similar treatments. Did Ms. Jones even consider antibiotics or similar medications at any time when she made any statement regarding the initiation or use of life-prolonging treatments? Did she consider the use of medication as intrusive? 3) religious and moral beliefs and personal values, behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally. Thus, what did Ms. Jones mean by “extraordinary” measures? Are those that are morally optional, elective or extremely expensive?” Or could she have been referring only to those treatments that are physically invasive or that cause pain and suffering? 4) reactions to similar treatments provided to another individual and 5) expressed concerns about the effect on family if the particular treatment were withheld.

As stated, with the existence of an advance directive, the use of antibiotics and comfort medications may have been considered. Without such a focused discussion with her family, one needs to be cautious before accepting the notion that a patient considered and rejected antibiotics as an “extraordinary” life-prolonging measure. In this case, the wishes of the patient must be discerned from more than the bold assertion that she did not desire extraordinary medical intervention. As a committee, members should be particularly curious about the previous placement of the gastrostomy tube, i.e., was this considered “extraordinary,” yet still performed? Who authorized its placement on behalf of Ms. Jones? Additionally, a surrogate may not base a decision to withhold a life-sustaining procedure on a patient’s pre-existing long-term mental or physical disability. In this case, care and concern should be utilized in exploring the true basis for the family’s decision to withhold antibiotics. Specifically, does their determination to withhold treatment for the abscess emanate from their reaction to Ms. Jones’ dementia due to Alzheimer’s Disease and her already lengthy stay in the nursing home?

Patient’s Best Interests
If there is a lack of evidence regarding Ms. Jones’ preferences, then the committee must consider her best interests, i.e., do the benefits to the patient of the treatment outweigh the burdens to the patient resulting from that treatment? In this particular case, a discussion must take place regarding her life expectancy and prognosis. Here an examination must occur regarding Ms. Jones’ true state of being. Is she, in fact, in a “terminal condition” as defined in the governing statute—“an incurable condition caused by... disease or illness which to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery”? If so, then perhaps the choice is no treatment. If she is not terminal, as at least three physicians seem to believe, but suffering from an end-stage condition (“advanced, progressive, irreversible condition caused by injury, disease, or illness that has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective”), does this make a difference? (The Maryland Health Care Decisions Act allows the withholding or withdrawal of life-sustaining treatment in such cases.) While the facts indicate that Ms. Jones cannot coherently communicate, we know that she is “alert.” Will she have anything more than a “physical life” even with the intervention of antibiotics at this stage of her life?

Further, in weighing the benefits and burdens to Ms. Jones, one must consider any risks and side effects she should take the medication. Will infection lead to sleep or coma before other symptoms appear, thus hastening death, but in a peaceful manner? By curing an infection will Ms. Jones be more fully conscious of her discomfort? Is there a possibility of side effects such as kidney failure? In short, the committee must consider whether the introduction of antibiotics will merely prolong the dying process, prolong suffering, do both or do neither.

In summary, the role of the ethics committee is to explore, accumulate and analyze data to ensure that the proper course of treatment is accor- ded to Ms. Jones as she nears the end of her life. The committee must insist that it be given enough information to decide how to best treat Ms. Jones so that her wishes, whatever they are and however they were expressed, are respected, and that her rights to dignity, autonomy and integrity are protected.

Submitted by
Deborah L. Moran
Attorney-At-Law
Chairperson, Patient Care Advisory Committee
Hebrew Home of Greater Washington
Rockville, MD
Case Discussion:
Comments From a Priest/Virginia Attorney

The ethics committee is faced with the problem posed by the family’s request: May antibiotics and other treatments be withheld from Ms. Jones? This question implies another, deeper one: Should Ms. Jones be allowed to die now? Either her abscess should be treated aggressively and her present plan of care continued, or all life sustaining treatment should be stopped entirely.

The Principle Ethical Issue
The heart of this case is an issue over which reasonable people of goodwill differ: what constitutes futile treatment. Is a treatment futile if it will improve an acute condition yet do nothing to change a patient’s chronic, underlying condition?

If, it is the opinion of those physicians who care for her, with the concurrence of a physician not involved in the case, that Ms. Jones will never be able to swallow again, then the gastrostomy is providing “permanent” artificial feeding. Some would argue on the other hand, if there is any likelihood that Ms. Jones might regain her ability to swallow, the gastrostomy is providing “temporary” artificial feeding. In this case, other aspects of her condition will have to be considered in order to determine whether life prolonging treatment, feeding tube as well as antibiotics, should be withdrawn or withheld. Additionally, is a decision to withhold antibiotics a sort of chemical DNR? If so, ought not a DNR also be discussed?

Six Related Ethical/Legal Issues
The first issue is the nature of Ms. Jones’ condition. Does she meet accepted criteria for being in a terminal condition? The ambiguities inherent in defining “terminal,” require that the committee begin a review of the matter with the law of the state where they are located. While the statutes may clarify Ms. Jones’ situation legally, there are important aspects of her condition which make such a determination ethically uncertain given the different interpretations of “terminal” among those providing her care. Indeed, how much should the diagnosis of Alzheimer’s contribute to determining whether Ms. Jones’ condition is terminal?

Second, there is no clear evidence of Ms. Jones’ wishes regarding treatment toward the end of her life. While this may limit the ability of family members to render a substituted judgement as to what she wanted, it does not preclude the family from deciding what is really best for her. But who ought to be the proxy or surrogate? The family members and their relationship to the patient are not well known. How close are they? Are they in agreement among themselves? Are there others, perhaps higher in the hierarchy of relationships, who have not been consulted or heard? What motivates their interest in her care? The facts suggest that these are compassionate relatives who believe their loved one has suffered enough and that future antibiotic treatment will not improve her quality of life. What about other treatment decisions like removing the gastrostomy tube? Could it be that the family is frustrated and angry at having to render extended assistance to one who is virtually helpless. Even worse, are there possibly selfish, perhaps financial interests, pushing them to end this expensive episode before resources they might have enjoyed are depleted?

Third, what did Ms. Jones mean when she said she did not wish her life to be prolonged by extraordinary measures? While the definitions of “extraordinary” and “ordinary” treatment are fairly settled, there is no way of knowing exactly what Ms. Jones meant when she made the statement: if, in fact, she said it at all. Here, decisions regarding her future will have to be tested within a benefits/burdens calculus to determine whether ordinary procedures like a feeding tube and antibiotic therapy create a situation so burdensome as to render them extraordinary.

Fourth, there are the professional relationships of the various caregivers to the patient and her family, to each other, and the institution. These parties appear to be in conflict with regard to their understanding of “terminal” and what constitutes an acceptable quality of life as reflected in their treatment plans. Most people would say they would not wish to live as Ms. Jones is now living. Does that subjective judgement, together, with the alleged statement by Ms. Jones to family members, serve as sufficient evidence to withhold, and withdraw treatment?

Fifth, the ethics committee should review the legality of withdrawing treatment from one who lacks the capacity to decide for herself. Cruzan established that such withdrawal may be done in accordance with state laws.

Sixth, I am concerned that Ms. Jones was admitted to the nursing home “several years ago,” suggesting that she has been in a care facility at least since 1991. With the Patient Self-Determination Act in effect since then, one has to ask why her wishes regarding end of life treatment were not more fully explored, given the nature of her prognosis. When first admitted, she evidently had the capacity to express her wishes and select surrogate decision-makers. At this point, however, decisions regarding her care will have to rest on what others determine to be in her best interest.

In summary, the Committee will have to approach this case ready to

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engage in a conversation about the morality of withholding treatment from a patient who is probably not terminal, but one who is incurably ill. Is it too soon to withhold all treatment? Is it cruel to continue, knowing the eventual outcome of her disease? The goal is to reach a resolution that will be mutually acceptable and, above all else, will respect the dignity of a severely diminished human being.

Submitted by
Henry N. F. Minich, J.D., S.T.M.
Research Fellow
Center for Biomedical Ethics
Health Sciences Center
University of Virginia

PHARMACY SERVICE CONTRACTS:
DO THEY HARBOR POTENTIAL CONFLICTS?

Ethics committees usually focus on patient specific dilemmas which are brought to their attention for recommendation or resolution. Yet, the increasing complexity and changing nature of the health care system may necessitate a more proactive role for ethics committees. Such a role would serve to help prevent the emergence of patient specific dilemmas by calling attention to problem areas before they impact upon individuals.

One area in which objective, multidisciplinary scrutiny would be welcome is that of conflicts of interest in pharmacy services. Like other health professions, pharmacists fulfill many different roles in the course of day to day practice. Frequently, these roles conflict with one another. Furthermore, these conflicts may be poorly recognized and their potential impact on patient care may be minimized by individual practitioners, practice groups or facilities.

Such conflicts are prone to occur when health professionals attempt to balance their primary obligations toward individual patients or clients with their responsibilities to employers, institutions, payers and society. While physicians have often been subject to scrutiny with regard to potential conflicts of interest, pharmacy services are frequently overlooked as a source of potential conflicts of interest.

Pharmacy Services
Pharmacists provide a wide array of services to long term care facilities. They not only provide medication, but various medication usage reports, pre-printed medication administration records for nursing staff and several types of consultative services. In addition, pharmacy contracts may call for the provision of equipment such as emergency boxes, medication carts and facsimile machines. This mixture of services ranging from consumable products (medication) and equipment, to personal services, puts pharmacists at particular risk for conflicts of interest.

To fully comprehend the potential for conflict, one must first understand more about pharmacy services. Consultative services provided by pharmacists usually include federally mandated medication regimen reviews. During these reviews, the pharmacist looks for medication related problems such as drug-drug, drug-diet and drug-disease state interactions, indicators of adverse reactions to medication, unnecessary duplication of medication, and indicators that drugs are having their desired therapeutic effects.

Consultants may recommend changes in dosage forms (liquid versus tablet or capsule) that make a drug more palatable, changes in dose or dosage schedule to minimize side effects, reduce medication administration time or better treat the indicated disease or addition of medication to counter unwanted effects of other agents. The review should result in optimization of drug regimens, discontinuation of duplicative agents, minimization of side effects, detection of potential problems in drug therapy, increases in compliance with drug therapy and switches to lower cost medication.

Vendor pharmacy services usually include provision of medication and equipment. The vendor pharmacy is reimbursed either directly, by the contracting facility, or via direct billing of Medicaid, insurers or patients. The vendor generates a profit through dispensing fees assessed for each prescription (dispensed in a month) and/or mark-ups on drug costs. Each change in drug, dose, or dosage form or regimen generally results in an additional dispensing fee for the month in which the change takes place. The profits generated by dispensing fees and/or mark-ups may be great enough that the vendor agrees to provide equipment, additional reports, forms and/or consulting pharmacist services at no cost or at a discounted rate.

Potential for Conflicts of Interest
These two different types of pharmacy services set the stage for conflicts of interest. What happens if the pharmacist consultant responsible for reviewing drug regimens is an employee of the pharmacy which has a contract for supplying medication? If the consultant pharmacist recommends that a duplicative agent be discontinued, the vendor loses a dispensing fee or profit from the mark-up. If the consultant recommends discontinuation of a highly priced medication or a switch to a lower cost item, there are again financial ramifications for the vendor. Conversely, recommendations for changes in drug, dose or dosage form result in new dispensing fees.
While the conflict in such an arrangement is readily evident, the pressure (real or perceived) on the consultant pharmacist is even more intense when consultant services are not reimbursed separately. If the consultant is aware that his or her salary comes out of the profits generated by the vendor service or if the consultant is entitled to bonuses or shared profits from overall pharmacy operations, the potential for conflicts increases dramatically.

In recent years, changes in the health care system and in reimbursement have led many facilities to open their own on-site pharmacies. While this approach may alter the nature of the potential conflict, it does not remove the potential for problems. Operators of long term and intermediate care facilities enter the pharmacy business for profit. Thus, pharmacist employees of those firms are still charged with holding down costs and maximizing profits.

The American Society of Consultant Pharmacists (ASCP) represents pharmacists serving many intermediate and long term care facilities. ASCP addresses these potential conflicts of interest by calling for separate contracts for consultant and vendor services. Yet, they do not recommend or require that these separate contracts be awarded to different parties. Thus, a single pharmacy could contract to provide both consultant and vendor services to a facility. In fact, provision of all pharmacy services by a single source is common practice. Furthermore, if the agreements are separate and do not include discounts or rebates, they are entirely consistent with the “safe harbor” regulations adopted by the U.S. Department of Health and Human Services.

Obviously, the current provisions for the delivery of pharmacy in many instances can present the appearance of conflict of interest or generate opportunities for conflicts to arise. While most pharmacists are honest individuals committed to providing the highest quality care for their patients, such conflicts may alter the provision of care, i.e., in the number, amount or type of drug(s) dispensed. It is these prescription decisions, made as a result of institutional planning service arrangements, which may not always be motivated by the best interest of the patients. Ethics committees are, therefore, well advised to begin the proactive identification and consideration of cases where contract pharmacy services may impact upon patient care.

Selected References


Raymond C. Love, Pharm.D.
Assistant Professor and Vice-Chair
Department of Pharmacy Practice and Science
School of Pharmacy
University of Maryland at Baltimore

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from hospitals and other health care institutions. It is designed to start or strengthen the implementation of an ethics program within these institutions.

This unique course is limited to 24 participants to assure maximum interaction among the Fellows (graduating participants.)

The course has attracted participants from 15 states, from large, medium and small hospitals with ethics committees in various stages of development. Fellows have represented a host of health care professions and the evaluations from the program indicated that it has been of significant help in the formulation and achievement of individual goals.

Developing Nursing Homes Ethics Programs (DNHEP)

The next DNHEP will be offered from July 19-21 at the University of Virginia.

DNHEP grew out of the DHEP project and is in response to requests by nursing home and long-term care staff and administration for appropriate educational resources. The program has been developed with the help of these individuals and attempts to address the need for practical clinical ethics in these facilities.

For further information on the DNHEP or the DNHEP course, please call (804) 924-5974 or e-mail AMH2R@Avery.med.virginia.edu.
ANNOUNCEMENTS...

Summer Seminar in Health Care Ethics

This seminar is sponsored by the Department of Medical History and Ethics, School of Medicine, University of Washington and is being held in Seattle, Washington from July 31 - August 4, 1995. This annual Summer Seminar is an intensive introduction to the concepts, methods, and cases of bioethics. Albert Jonsen, Chair of the Department of Medical History & Ethics, will lead the seminar which is designed to sufficiently familiarize physicians, nurses, educators, chaplains, social workers, administrators, and other health care professionals with the field of bioethics, to enable them to make clinical-ethical decisions and to lead others in doing so. For information on specific objectives, and to receive a seminar brochure with full details and registration form, contact: Marilyn J. Barnard, Program Coordinator, Medical History & Ethics, SB-20, University of Washington, School of Medicine, Seattle, Washington 98195. Phone (206) 616-1864, Fax (206) 685-7515, E-MAIL: mbarnard@u.washington.edu.

The mission of this project is to understand and transform the culture and experience of dying in the United States through initiatives in research, scholarship, the humanities, and the arts; to foster innovations in the provision of care, public education, professional education, and public policy.

The Project invites proposals for funding in the following areas: 1) the epidemiology, ethnography, and history of dying and bereavement in the United States; 2) the physical, emotional, spiritual, and existential components in dying and bereavement; 3) the contribution of the art and humanities; and 4) the design, implementation, evaluation, and dissemination of new service delivery models for the dying and their network of family and friends.

Requests for support may range from $5,000-$250,000.

There are four funding cycles. The next one begins on June 5, 1995.

For more information contact Project on Death in America, Open Society Institute, 888 Seventh Avenue, 19th Floor, New York, New York 10017, (212) 887-0150, Fax (212) 489-8455.

Available June 30, 1995 from the American Association of Homes and Services for the Aging (AAHSA) Publications

HANDBOOK FOR NURSING HOME ETHICS COMMITTEES
by
Diane E. Hoffmann, J.D., M.S.
Philip Boyle, Ph.D.
Steven A. Levenson, M.D.

This handbook, written by a law professor, theologian and a nursing home medical director, provides nursing homes with the information they need to successfully establish and operate an ethics committee in their facility. It includes lots of practical advice as well as educational materials for ethics committee self education. This handbook belongs on your bookshelf. For more information or to place an order, call 1-800-508-9442 or locally 301-490-0677.

New Program Announcement

The Open Society Institute, a non-profit foundation which supports the development of open societies worldwide, is requesting applications for its “Project on Death in America.”

Legislative Update

The 1995 Maryland Session passed a law which prohibits nursing homes, under certain circumstances, from discharging patients who do not pay their bills. Senate Bill 677.
MAY
15 Southeastern Virginia Bioethics Meeting. Topics: "Policy Writing as a Tool of Organization Development," and "Reflections on the Richmond Bioethics Consortium: The Virginia Bioethics Experience," 7:00 p.m. at Chesapeake General Hospital Health Resource Center, Norfolk, VA. Call Joe Riddick, M.D. at (804) 482-6235.

23 Metropolitan Washington Bioethics Network Meeting, Topic: TBA, 4:00-6:00 p.m., at the American Occupational Therapy Association, 4720 Montgomery La., Bethesda, MD. Call Joan Lewis at (202) 682-1581.


24 "Breast Cancer Controversies and Challenges: Understanding the Medical, Legal, Ethical and Policy Issues," symposium sponsored by the Law & Health Care Program, University of Maryland School of Law, 7:45 a.m. - 4:30 p.m., Westminster Hall, UMAB. For more information call (410) 706-3378 or (410) 706-7239.

JUNE
1-4 Second Annual Bioethics Course, "Suffering, Dying, and Death: The Ethics of Finitude," sponsored by the Center for Clinical Bioethics, Georgetown University Medical Center. Contact Marti Patchell at (202) 687-8999 for details.

6 Baltimore Area Ethics Committee Network Meeting, Case Presentations and Discussion, 4:30 p.m., University of Maryland Medical System. Call Jack Syme, M.D. at (410) 368-3020.

8 Medical Humanities Hour, Topic: "Regulating Physician-Assisted Death: Oregon and Beyond," Franklin G. Miller, Ph.D., Assistant Professor, Center for Biomedical Ethics, University of Virginia, 4:30-5:30 p.m., Shock Trauma Auditorium, University of Maryland Medical System, Baltimore, MD. Call Henry Silverman, M.D. at (410) 706-6250.

9 Eighth Annual Symposium, "The Ethics of Managed Care," Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown, WV. Call Cindy Jamison at (403) 293-7618.

13 Metropolitan Washington Bioethics Network Meeting, 4:00-6:00 p.m., Bethesda Rehabilitation and Nursing Center, 8700 Jones Mill Road, Chevy Chase, MD. Call Joan Lewis at (202) 682-1581.

13 Ethical Decisionmaking: A Workshop for Clergy and Pastoral Caregivers, Center for Clinical Bioethics, Pastoral Care Department, Georgetown University Medical Center. For more information or to make reservations call (202) 687-8999 or (202) 687-1122.
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