CONFLICT OF INTEREST			
SECTION: III **ETHICS, RIGHTS & RESPONSIBILITIES**		**NO: 110**	
Issued By:	President & Chief Executive Officer	**APPROVAL DATES :**	
Approved by:	Board of Trustees	**Date Initially Issued:** 27/02/2014	
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Key Words:	Conflict of Interest, Disclosure of Personal Conflict, Vested Interest, Perceived conflict, actual conflict, potential conflict, disclosure,	**Cross Reference(s)**	CORP II-i 110 Regulatory Transparency, CORP II-i 100 Whistleblower, CORP II-ii 120 Expense Claims, CORP II-ii 130 Procurement, CORP II-i 190 Contract Administration, CORP III 100 Confidentiality, CORP III 111 Ethical Decision Making, CORP III 111 Board Conflict of Interest, CORP IV-i 100 Harassment-Free Workplace, CORP VIII-i 120 Pharmaceutical Representatives/ Medication Samples

1. PURPOSE:

To outline the processes the Royal Ottawa Health Care Group (ROHCG) adheres to in regards to potential, perceived or actual situations of conflict of interest.

2. POLICY STATEMENT:

All ROHCG staff have a responsibility to avoid placing themselves in situations where their personal interests potentially or actually conflict with the interests of the organization. Staff are expected to conduct themselves with personal integrity, honesty, a high standard of ethics and diligence in performing their duties. Staff will adhere to the policies and procedures of the ROHCG and associated legislation specifically, *Excellent Care for All Act* and *Regulated Health Professionals Act* and *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), 2014 (Chapter 7)*. Conflicts of interest cannot always be avoided or prohibited and need to be identified, disclosed and effectively managed.

3. SCOPE:

This policy applies to all staff of the ROHCG, including staff from the University of Ottawa Institute for Mental Health Research (IMHR), Royal Ottawa Volunteer Association (ROVA) and the Royal Ottawa Foundation for Mental Health (ROFMH).

4. GUIDING PRINCIPLES:

No conflict should exist or appear to exist between the private interests of ROHCG staff and their official duties. A conflict of interest may be considered to exist when the actions or activities of an individual on behalf of the ROHCG also involve:

- Obtaining a personal gain;
- Preferential treatment;
- An adverse effect on the ROHCG's interest;
- Obtaining by a third party of an improper gain or advantage;
- Entering into contracts with the ROHCG through the use of "inside" information learned as a result of their position in the organization and/or;
- Disclosing proprietary information to unauthorized individuals.
- Using confidential information obtained as a result of their position in the organization for business purposes.

The President & Chief Executive Officer (CEO) may permit exceptions to the application of the provisions of this policy if the interests of the organization are clearly better served.

5. DEFINITIONS:

Conflict of Interest: A conflict of interest means any situation in which the private interests or personal considerations of an individual/individuals/affiliates (including teams, committees and institutions) covered by this Policy may compromise, or does compromise, their judgment in acting in the best interests of the ROHCG or in the performance of their duties. A conflict of interest is not restricted to matters involving money but concerns the presence of factors that a reasonable individual might think are likely to bias a decision-maker's judgment, as outlined in this Policy.

Actual Conflict of Interest: an individual has the opportunity to act in a conflict and does.

Perceived Conflict of interest: a reasonable apprehension, which reasonably well informed individuals could properly have, that a conflict exists.

Potential conflict of interest: an individual is in a situation in which existence of some personal interest could influence the exercise of their public duties although the individual has not yet exercised such duty or responsibility.

Confidential information means information that is not available to the public including any form of information that the ROHCG wishes to safeguard from disclosure to external third parties or, internally, beyond what is necessary for the normal conduct of operations. This includes, but is not limited to, financial information, business plans, employee data, information concerning suppliers and service delivery providers, patient information, legal matters and technical and medical data including data collected in connection with research projects that are proprietary to the ROHCG.

Independent Practice: The provision of care by ROHCG credentialed physicians to patients of the ROHCG.

Nominal Value gifts: Pens, key chains, novelty items, etc., that have little or no monetary value.

Private Practice: Private practice is the provision of health care services to individuals, groups or agencies, excluding that by physicians, such that the service provider receives a fee directly from the patient/client/third party, which is generally understood to be personal income.

Research: External research projects, or research conducted jointly with an external third party or enterprise ("joint research"), means any research undertaking conducted on the

ROHCG premises in which the professional staff or health care service provider personally receives funding or other material consideration for the research from a source other than the ROHCG.

Staff: refers to regular, part-time, and casual staff, and includes employees, physicians, students, trainees, volunteers, Board of Trustees/Directors, officers, and contractors. This policy also encompasses those staff/personnel who, from time to time, willingly offer their services to external organizations, on behalf of the ROHCG, in a volunteer capacity.

6. PROCEDURE:

6.1 Private Practice, Independent Practice and Research:

6.1.1 ***Disclosure and Authorization for Private Practice:*** ROHCG professional staff and health care service-providers who engage in private practice using ROHCG resources must disclose the nature and extent of their undertaking in writing to the appropriate reporting body and also obtain prior written approval from Chief Operating Officer & Chief Financial Officer (COO & CFO) in order to engage in the private practice. The written authorization may provide other conditions for the private practice undertaking. The private practice will be conducted in compliance with the written authorization and ROHCG policies and the organization must be kept updated as to any changes in the undertaking. Additionally, those individuals who have a private practice will refrain from accepting referrals to their practice from ROHCG colleagues. As well, ROHCG staff must consider the potential conflict of interest when referring ROHCG patients to colleagues in private practice. Private Practice practitioners will not use ROHCG resources for their practice nor will they recruit ROHCG staff to work at the practice.

6.1.2 ***Independent Practice (Physicians Only):*** It is recognized that physicians at the ROHCG engage in independent practice. Should any physician engage in treatment of an individual (at the ROHCG facility or affiliated satellite sites) who does not have an open ROHCG chart or is not part of ROHCG outreach services this must be disclosed in writing to the Chief of Staff.

6.1.3 ***Disclosure and Authorization for Research:*** Through the Research Ethics Board of the ROHCG (REB), staff complete a *Checklist of Resources Form* that documents potential impacts on service provision and requires sign-off from IMHR Research Unit Directors or President, Clinical Program Directors and Directors – Patient Care Services. Researchers [Scientists, Clinicians/Physicians], research staff, and/or research trainees should disclose real, potential, or perceived conflict(s) of interest to allow the Research Ethics Board (REB) and ther IMHR President / VP Research to address them in an appropriate manner.

6.1.4 ***No Appropriation of Patients or Research:*** Staff will not solicit ROHCG's patients, clients or business opportunities for their own benefit, for a private practice or an outside or joint research undertaking, without advance disclosure in writing and the written approval from their appropriate management team member (i.e. Chief of Staff, COO & CFO, Board Chair, CEO, REB, IMHR President, etc.).

6.2 Outside Work, Business Activities and Research Projects:

6.2.1 ***Time and Attention:*** Staff (excluding Board of Trustees/Directors and Volunteers) are expected to bring their full attention and commitment to their duties and will not engage in any outside work, private practice or outside professional business activities that interfere with the performance of their duties for the ROHCG during their normal

working hours or to the full extent of time required to meet their clinical, academic and administrative commitments for the ROHCG, whichever is applicable considering the nature of their engagement.

6.2.2 ***No Conflicting Engagements*****:** Staff will not engage in any outside work, private practice or outside professional business activities or research projects that conflict with the performance of their duties for the ROHCG or that will, or are likely to, compromise their judgment in the performance of their duties for ROHCG in the best interests of the organization. The ROHCG will not assume any liability for these activities.

6.2.3 ***Engagements with Suppliers or Service Providers:*** Prior to engaging or working in any capacity with external suppliers or service providers, staff will ensure that their activities will not be perceived as an actual or potential conflict of interest. Should a potential conflict exist then they will disclose this conflict prior to engaging in the following activities:

- serve as a director, officer, partner, consultant, lobbyist or in any other role in any enterprise which does or seeks to do business with the ROHCG;
- own, control or direct a material financial interest in a supplier or contractor or in any business which does or seeks to do business with the ROHCG; or
- undertake any work in connection with a private professional practice.

6.3 Family and Personal Relationships:

6.3.1 ***Nepotism*****:** If a staff member is faced with making a decision that involves, directly or indirectly, the hiring, engagement on contract, evaluation, discipline, promotion, reward or any other form of discretionary control over family members or relatives (as defined below), then the staff member must refer the decision to his/her immediate supervisor and may not make a recommendation with regard to such a decision. In order to ensure objectivity and to maintain a professional character of the processes and to respect the interests of the individuals involved a staff member who has or had such relationship with another staff member should abstain from participating in the decision process without having to justify withdrawal. The ROHCG will not permit family members to work in any direct reporting relationship with each other nor in any situation where one family member may administer a financial benefit for another. When a relative is in a position of authority over another relative, one of the two may be transferred. For the purposes of this policy, family members and relatives are defined as spouses, brothers and sisters, parents, children, grandparents, grandchildren, in-laws (mother, father, daughter and son), stepchildren, aunts and uncles, nieces and nephews and live-in partner(s). Staff must disclose in writing to the appropriate individual any interest in property which they or their immediate family members propose to sell or lease to the ROHCG.

6.3.2 ***Family/Personal Relationships in the Workplace:*** A variety of family and/or personal relationships may, at times, have an impact on the workplace. When such relationships intersect at work, they must not compromise, or threaten to compromise, the ability of an individual to act in the best interests of the ROHCG. Individuals are expected to openly declare such relationships before any conflict or potential conflict occurs. The ROHCG will not permit family members to work in any direct reporting relationship with each other nor in any situation where one family member may administer a financial or treatment benefit for another.

6.3.3*Family/Personal Relationships with Suppliers/Service Providers:* If a staff member (excluding Board of Trustees/Directors and Volunteers) or one of their immediate family members is involved in a personal relationship with a supplier or service provider and there is a potential for any conflict of interest, this must be disclosed for review.

6.3.4 *No Special Treatment:* Staff are not permitted to use their position with the ROHCG to give anyone special treatment in order to advance their own personal interests, or that of any member of their immediate family, their friends or business associates.

6.4 Property: Staff will not use ROHCG property or resources for their own benefit, or the benefit of an external third party or enterprise, without the prior written disclosure to, and approval from their appropriate management team member, as may be applicable in the circumstance. Staff must disclose in writing to their appropriate management team member any interest in property that they or their immediate family members propose to sell or lease to the ROHCG.

6.5 Gifts and Entertainment Gifts, Benefits and Hospitality: Offering or receiving a gift, gratuity or entertainment may be perceived to unfairly influence a business or service delivery decision and could place an individual in a conflict of interest. The ROHCG prohibits staff from accepting gifts, gratuities, hospitality, entertainment or other benefits that have the potential to influence their business decisions, judgment or performance of their duties, excepting those that are of nominal value and are customary and business related, or those which are unsolicited mementos or tokens of nominal value. Wherever possible, staff will disclose, prior to accepting or immediately after receiving any gift, benefit or hospitality. Gifts, benefits and hospitality cover but are not limited to food or alcohol, including lunches or dinners, giveaways or prizes, tickets to cultural or sporting events, and personal items. Receipt of any gifts, gratuity or entertainment, except those of nominal value, must be disclosed to the appropriate manager/management, as applicable. Senior Management or staff must never accept any gift or benefit if:

- The individual offering it, or another individual, would reasonably expect the staff member to be influenced in the way the staff member does his/her job or carries out his/her duties such that they would feel a sense of obligation or debt to the individual offering the gift or benefit; or
- The staff member is likely to be compromised by accepting a gift/item or benefit of significant value for personal use. Gifts and benefits that are not token in nature will be entered in a gift register. The following issues must be taken into account when determining whether a gift, benefit or hospitality is token:
    - the scale, lavishness or expense/cost/value of the gift or benefit.
    - the frequency of occurrence.
    - the degree of openness surrounding the occasion or gift.
    - traditional practices ***Appendix 2.***

6.6 Relationships with Government Officials, Accreditation Agencies and Professional Bodies: In dealing with government officials, accreditation agencies and professional bodies, staff (excluding Board of Trustees/Directors and Volunteers) are not allowed to accept or give any payments, gifts or entertainment of more than a nominal

value. Reporting to these officials, agencies and bodies must be done honestly, with the highest ethical standards and in compliance with all statutory and regulatory requirements.

6.7 Confidential Information: Staff must not disclose confidential information to an external third party, or internally in an improper fashion, in order to advance their personal interests or those of their family members, friends or business associates.

6.8 Duty to Report/Disclose: All ROHCG staff will identify and disclose any possible or actual conflict of interest to their managers for evaluation, regardless of whether or not the staff member derive a financial benefit from the outside activity or interest. It is the ongoing responsibility of the staff member to inform the appropriate Manager of potential conflict of interest situations in which they may be involved so that the issue can be addressed in a preventive manner between the staff member and the manager with any other resources necessary to make a determination if conflict exists. It is important not only for the ROHCG, but also to protect the staff member's own reputation. In case of doubt, disclosure is the best protection. Where a conflict of interest may arise or has arisen, the staff member will fully disclose the conflict of interest to the Manager/Director/Vice President for the staff member's area. In the case of the CEO, disclosure will be made to the Chair of the Board of Trustees. In the case of Board members, disclosure will be made to the Chair of the Board, the Secretary of the Board and/or the appropriate Chair of the specific Board Committee.

6.8.1 ***Reporting of Conflict or Potential Conflict Involving Another Person:*** All staff are required to report a conflict of interest, or a potential conflict, of which they become aware that involves another staff member. Staff considering a report of wrongdoing involving a conflict of interest involving another staff member may also follow the reporting processes under *CORP II-i 100 Whistleblower*.

6.8.2 ***Advice and Support:*** Should staff be uncertain whether a conflict, or the potential for a conflict of interest, may exist, or has questions about this Policy, they are encouraged to seek the advice and support of their manager, union representative, the Director-HR, COO & CFO, President & CEO, IMHR President, General Counsel or the Chair of the Board of Trustees/Directors.

6.19 Review of Disclosure/Report: The individual receiving the information will review the disclosure or report to determine whether additional inquiry is required, whether the conflict can be resolved or whether escalation to a higher level of management is required in order to respond appropriately to the conflict or potential conflict of interest. The individual will take such appropriate steps as are warranted with a view to achieving a prompt resolution of the conflict situation, which must include promptly removing the staff from any decision-making process or discussions associated with the conflict. If a conflict cannot be satisfactorily resolved at this level, or it is desirable to do so, the individual may consult with, or refer the matter to the General Counsel, the COO & CFO, the President & CEO or other members of senior management, in order to determine the appropriate management response in order to resolve the conflict situation.

6.10 Compliance with Other Reporting Obligations: Professional staff members who fall within the scope of the *Regulated Health Professionals Act or TCPS 2* must also comply with any reporting or disclosure requirements in compliance with their governing

College or other agencies or bodies. Staff who make a disclosure or report under this Policy and is also a regulated health professional, must ensure that if such disclosure includes any personal health information, then such disclosure or report is compliant with, and not prohibited by, the *Regulated Health Professionals Act*, *Personal Health Information Protection Act*, *Excellent Care for All Act and/*or other legislation and regulations governing the regulated health profession.

6.11 Resolution of Conflict and Consequences of Wrongdoing: If the review or investigation discloses that an actual, perceived or potential conflict of interest exists or that substantiated improper activity has taken place, appropriate action will be taken to resolve or manage the conflict situation or wrongdoing. Such action will include removing staff in conflict from any decision-making process or discussion associated with the conflict. Other management actions to resolve a conflict may also include revising organizational processes or practices or implementing training. In the event of substantiated willful or deliberate wrongdoing, additional management actions may include imposing performance management measures or imposing disciplinary actions against individuals involved in the wrongdoing up to and including termination of employment, the engagement or contract.

6.12 Confidentiality: Confidentiality of matters brought forward under this Policy will be maintained to the fullest extent possible subject to the provisions of the *Personal Health Information Protection Act,* the *Quality of Care Information Protection Act,* privacy legislation, the requirements of governing bodies of regulated health professions or other laws compelling disclosure of information. All staff involved in a disclosure or report must respect the sensitivity and confidentiality involved by refraining from discussing the disclosure, report, review and/or investigation with fellow staff members or other individuals, subject to legal or regulatory requirements or to give meaningful effect to this Policy, (for example, for the purpose of seeking advice from a union representative, manager or HR in order to make a disclosure or report, seeking advice in connection with a review, or other such disclosure as may be necessary in order to give effect to the resolution of the conflict).

6.13 Records: Disclosures, reports and related documents will be maintained in a segregated conflict of interest file in the office of the Director- HR, Chief of Staff, President and CEO/Secretary of the Board or IMHR President, as appropriate. External investigation reports and related documents will be maintained in a segregated investigation file in the office of the General Counsel. Information and records pertaining to investigations, and any associated documents and reports, will not be disclosed to any external third parties (for example, professional governing bodies, external agencies or tribunals etc.) except as required by law.

6.14 No Reprisal: Recognizing that matters of conflict of interest should typically involve individuals who inadvertently find themselves in a conflict situation rather than those who deliberately or willfully exploit a conflict situation for their personal benefit, disclosures of actual or potential conflicts of interest made in good faith and in compliance with this Policy will not be subject to reprisal. Disclosures that are deemed to be trivial or vexatious in nature will be investigated following ROHCG policies and procedures.

7. RELATED PRACTICES AND / OR LEGISLATIONS:

Public Hospitals Act
Health Care Consent Act, 1996
Personal Health Information Protection Act, S.O. 2004,
Regulated Health Professions Act, 1991,
Health Protection and Promotion Act
Excellent Care for All Act
Canadian Institutes of Health Research, Natural Science and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, (Chapter 7 – Conflicts of Interest), December, 2010
Interactions Between the Faculty of Medicine and the Pharmaceutical, Biotechnology, Medical Device, and Hospital and Research Equipment and Supplies Industry (policy), University of Ottawa, Office of Professional Affairs, January 2013
Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), 2014

8. REFERENCES:

Conflict of Interest Policy – Canadian Broadcasting Corporation (2003)
Conflict of Interest Policy – Cornwall Community Hospital (2006)
Conflict of Interest Policy – Hotel-Dieu Grace Hospital (2009)
Conflict of Interest Policy – Northern Health (2005)

9. APPENDICES:

http://oreo.rohcg.on.ca/policies/Resources-FormsTools.cfm
Appendix 1 - Conflict Of Interest Declaration
Appendix 2 – Examples of Gifts and Entertainment Gifts, Benefits and Hospitality