Ethics

Pharmacist Role in Capital Punishment (1531)
Source: Council on Pharmacy Practice
To acknowledge that an individual's opinion about capital punishment is a personal moral decision; further,

To oppose pharmacist participation in capital punishment; further,

To reaffirm that pharmacists have a right to decline to participate in capital punishment without retribution.

This policy supersedes ASHP policy 8410.

Pharmacist's Role on Ethics Committees (1403)
Source: Council on Pharmacy Practice
To advocate that pharmacists should be included as members of hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in health care ethics.

Ethical Use of Placebos in Clinical Practice (1116)
Source: Council on Pharmacy Practice
To affirm that the use of placebos in clinical practice is ethically acceptable only when patients have been informed of and agree to such use as a component of treatment; further,

To encourage hospitals and health systems to develop policies and procedures to guide clinicians in making informed decisions regarding the use of placebos; further,

To oppose the use of pharmacologically active substances or medications as placebos.

This policy was reviewed in 2015 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Pharmacist's Right of Conscience and Patient's Right of Access to Therapy (0610)
Source: Council on Legal and Public Affairs
To recognize the right of pharmacists, as health care providers, and other pharmacy employees to decline to participate in therapies they consider to be morally, religiously, or ethically troubling; further,

To support the proactive establishment of timely and convenient systems by pharmacists and their employers that protect the patient's right to obtain legally prescribed and medically indicated treatments while reasonably accommodating in a nonpunitive manner the right of conscience; further,

To support the principle that a pharmacist exercising the right of conscience must be respectful of, and serve the legitimate health care needs and desires of, the patient, and shall provide a referral without any actions to persuade, coerce, or otherwise impose on the patient the pharmacist's values, beliefs, or objections.

This policy was reviewed in 2015 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Patient's Right to Choose (0013)
Source: Council on Legal and Public Affairs
To support the right of the patient or his or her representative as allowed under state law to develop, implement, and make informed decisions regarding his or her plan of care; further,

To acknowledge that the patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment; further,

To support the right of the patient in accord with state law to (a) formulate advance directives and (b) have health care practitioners who comply with those directives.

This policy was reviewed in 2014 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

ASHP Position on Assisted Suicide (9915)
Source: Council on Legal and Public Affairs
To remain neutral on the issue of health professional participation in assisted suicide of patients who are terminally ill; further,

To affirm that the decision to participate in the use of medications in assisted suicide is one of individual conscience; further,

To offer guidance to health-system pharmacists who practice in states in which assisted suicide is legal.

This policy was reviewed in 2015 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

Nondiscriminatory Pharmaceutical Care (9006)
Source: Council on Professional Affairs
To adopt the following positions in regard to nondiscriminatory pharmaceutical care:

- All patients have the right to privacy, respect, confidentiality, and high-quality pharmaceutical care.
- No patient should be refused pharmaceutical care or denied these rights based solely on diagnosis.
- Pharmacists must always act in the best interest of individual patients while not placing society as a whole at risk.

This policy was reviewed in 2011 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

ASHP Policy Positions 2009–2016 (with Rationales): Ethics

1531

PHARMACIST ROLE IN CAPITAL PUNISHMENT

Source: Council on Pharmacy Practice

To acknowledge that an individual's opinion about capital punishment is a personal moral decision; further,

To oppose pharmacist participation in capital punishment; further,

To reaffirm that pharmacists have a right to decline to participate in capital punishment without retribution.

This policy supersedes ASHP policy 8410.

Rationale

Since 1977, when Oklahoma became the first state to adopt execution by lethal injection, many healthcare professional organizations have adopted policies opposing participation by members of their respective professions in capital punishment. The American Medical Association (AMA), the American Nurses Association (ANA), and the American Pharmacists Association (APhA) are among these groups; however, a wide variety of organizations have spoken out on the issue. The consistent theme of the opposition of those organizations is that the intentional infliction of death is contrary to the mission of healthcare and therefore unethical. ASHP's previous policy on pharmacist participation in capital punishment, which was adopted in 1984 and has been reaffirmed several times since, emphasized the pharmacist right to conscience when deciding whether to participate in capital punishment.

The role of pharmacists in execution by lethal injection changed substantially after Hospira relocated its thiopental sodium manufacturing to Italy in 2011. The European Union bans the export of thiopental sodium to countries where it may be used in executions, including the U.S. The ban resulted in severe shortages of the drug, which was the cornerstone of the three-drug cocktail used in lethal injections. (At least nine drug manufacturers have followed suit in prohibiting use of their products for lethal injection.) States responded by substituting compounded anesthetic preparations or instituting other drug protocols, which came under criticism after several executions in which prisoners appeared to suffer despite being medicated. These developments increased the role of pharmacists in preparing and/or compounding drugs for execution by lethal injection, which in turn increased the scrutiny of that role both inside and outside the profession.

That increased scrutiny comes at a time when pharmacists are rapidly expanding their roles on the patient care team and are being recognized as patient care providers. This proposed policy developed by the ASHP Council on Pharmacy Practice recognizes that one's beliefs about capital punishment are a personal, individual decision but opposes pharmacist participation in capital punishment because it is contrary to their role as healthcare providers.

Given the ethical questions about pharmacist participation in capital punishment, pharmacists should not be punished for their refusal to participate.

1403
PHARMACIST'S ROLE ON ETHICS COMMITTEES
Source: Council on Pharmacy Practice

To advocate that pharmacists should be included as members of hospital and health-system ethics committees; further,

To encourage pharmacists to actively seek ethics consultations as appropriate; further,

To encourage pharmacists serving on ethics committees to seek advanced training in health care ethics.

Rationale
Many hospitals have a committee or other process by which they consider ethical decisions related to patient care. Many issues that face these committees involve medications, yet often pharmacists do not serve on the committee or are not directly involved in the decision-making process. The number of ethical issues involving medications is expected to increase, given many new and unique drug products coming into the market. Pharmacist involvement would better inform these committees and consultations. To effectively contribute to decision-making on ethics, pharmacists will require advanced education on the subject.

1116
ETHICAL USE OF PLACEBOS IN CLINICAL PRACTICE
Source: Council on Pharmacy Practice

To affirm that the use of placebos in clinical practice is ethically acceptable only when patients have been informed of and agree to such use as a component of treatment; further,

To encourage hospitals and health systems to develop policies and procedures to guide clinicians in making informed decisions regarding the use of placebos; further,

To oppose the use of pharmacologically active substances or medications as placebos.

This policy supersedes ASHP policy 0517.

Rationale
The Council reviewed previous action on ASHP policy 0517, the American Medical Association (AMA) *Opinion on Placebo Use in Clinical Practice*, and the *ASHP Guidelines on Clinical Drug Research*, which state in part:

> The principal investigator or designee is responsible for obtaining informed consent from each subject who is eligible for participation in the study (i.e., meets inclusion and exclusion criteria). The informed consent process shall conform to current federal and

state regulations. IRB approval of the consent form (and assent form for minors) is required. Review by legal counsel may be desirable.

After comparing use of placebos for research to prescribing for clinical use, the Council agreed with the stance expressed by AMA, i.e., patients should be informed of and agree to use of a placebo as a therapeutic intervention. The Council believed that the informed consent process should be reserved for research and medical interventions, where a consent contract and oral explanation of the patient's rights are required. In addition, the Council expressed concern that advocating informed consent could lead to a mistaken assumption that clinical use of placebos requires the review and approval of an institutional review board.

The Council disputed the AMA definition of a placebo as "a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated," however, and recommended that a placebo should be defined as an inert substance. The Board and the House concurred. Research on placebos found differing definitions of the term but did not provide an established or official definition. The Council concluded that the current policy lacks clarity in that it addresses an undefined term. The Council requested that ASHP identify the appropriate standards-setting or regulatory body to provide this definition or determine whether ASHP should establish a definition for the purpose of its policy.

The Council noted a number of other unresolved issues that require further exploration and action by ASHP. These include research for definitive guidance on the ethics of clinical placebo use, potential ethical dilemmas for pharmacists, and compliance with professional standards and regulatory requirements for reviewing placebo orders for appropriateness, labeling placebo prescriptions, and counseling patients. The Council suggested a comprehensive review by a bioethicist be published in *AJHP.*