

Ethics

Medical Aid in Dying (1704)

Source: *Board of Directors*

To affirm that a pharmacist's decision to participate or decline to participate in medical aid in dying for competent, terminally ill patients, where legal, is one of individual conscience; further,

To reaffirm that pharmacists have a right to participate or decline to participate in medical aid in dying without retribution; further,

To take a stance of studied neutrality on legislation that would permit medical aid in dying for competent, terminally ill patients.

This policy supersedes ASHP policy 9915.

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.

This policy was reviewed in 2019 by the Council on Pharmacy Practice and by the Board of Directors and was found to still be appropriate.

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 Policy Positions 2009–2019 (with Rationales): Ethics

1704

Medical Aid in Dying

Source: Board of Directors

To affirm that a pharmacist's decision to participate or decline to participate in medical aid in dying for competent, terminally ill patients, where legal, is one of individual conscience; further,

To reaffirm that pharmacists have a right to participate or decline to participate in medical aid in dying without retribution; further,

To take a stance of studied neutrality on legislation that would permit medical aid in dying for competent, terminally ill patients.

This policy supersedes ASHP policy 9915.

Rationale

Medical aid in dying (also called physician-assisted dying, physician-assisted suicide, physician aid in dying, physician-assisted death, hastened death, medically assisted dying, and death with dignity) has been legal in some areas of the U.S. since Oregon passed its Death with Dignity Law in 1995. By 2016, one sixth of U.S. citizens lived in a jurisdiction in which medical aid in dying was available, and more states were contemplating legislation to legalize it. Experience in Oregon and elsewhere demonstrates that pharmacists in those jurisdictions may be confronted with the difficult ethical question of whether to participate in medical aid in dying.

For purposes of this policy position, ASHP adapts [a common definition of medical aid in dying](#): the practice in which a physician provides a prescription for a lethal dose of medication to a terminally ill, competent patient at the patient's request that the patient can self-administer at a time of his or her choosing to end his or her life. ASHP notes that many of the terms commonly used to describe this practice ignore the patient care and dispensing roles of pharmacists as well as the roles of other healthcare professionals, such as hospice nurses, in providing care for patients requesting medical aid in dying. ASHP recognizes the utility of a term such as "medical aid in dying" that addresses the roles of all healthcare providers involved in or affected by the practice but acknowledges the term's ambiguity regarding self-administration of the lethal dose. ASHP therefore explicitly distinguishes medical aid in dying from all forms of euthanasia, which is not the subject of this policy.

ASHP takes a position of studied neutrality on whether pharmacists should participate in medical aid in dying. Studied neutrality has been defined as "the careful or premeditated practice of being neutral in a dispute" and has as its goals "to foster a respectful culture among people of diverse views and to guide action that does not afford material advantage to a [particular] group." (Johnstone M-J. [Organization Position Statements and the Stance of "Studied Neutrality" on Euthanasia in Palliative Care](#). *J Pain Symp Manag*. 2012; 44:896-907.)

ASHP respects the diversity of views of its members and other pharmacists on medical aid in dying and adopts a position of studied neutrality to promote patient autonomy and access to care and to protect pharmacists' professional integrity and comity.

The [Code of Ethics for Pharmacists](#) states that “a pharmacist promises to help individuals achieve optimum benefit from their medications [and] to be committed to their welfare” and that “a pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health.” In pharmacist decision-making about participation in medical aid in dying, those principles may clash. Self-determination dictates that patients should be free to exercise their ethical and legal right to choose or decline any legally available treatment. Many healthcare professionals, and their organizations (including the [American Medical Association](#), the [American College of Physicians](#), and the [American Nurses Association](#)), question whether death is ever an acceptable therapeutic goal. Others (including the [American Academy of Hospice and Palliative Medicine](#) and the [American Psychological Association](#)) acknowledge in their statements of neutrality that society may determine that medical aid in dying falls within a spectrum of treatments and withholding of treatments that has as its goal the relief of suffering through a compassionately hastened death, even while recognizing the risks of such a practice.

Pharmacists, like other healthcare professionals, have a right to examine and act on the moral and ethical issues involved in providing care to patients. ASHP policy position 0610, [Pharmacist's Right of Conscience and Patient's Right of Access to Therapy](#), outlines the rights and responsibilities of pharmacists and other pharmacy employees who decline to participate in therapies that they find morally, religiously, or ethically troubling, including the right to reasonable accommodation of their right to conscience in a nonpunitive manner. Procedures should be in place to ensure that healthcare organizations can provide mission-compatible care to patients, and that healthcare providers practicing there are not a barrier to the organization's ability to provide that care. In adopting its position of studied neutrality on pharmacist involvement in medical aid in dying, ASHP recognizes that adopting a position in favor of participation would infringe on the moral and ethical prerogatives of pharmacists. ASHP similarly recognizes that a stance against participation would make the same infringement and in addition present the risk of legal or professional sanction for pharmacists who participate in medical aid in dying where it is legal.

ASHP also takes a position of studied neutrality on whether medical aid in dying should be legally permitted for competent, terminally ill patients. ASHP recognizes that society may interpret the principle of patient autonomy to include the right to therapies that some may find morally, religiously, or ethically troubling, including medical aid in dying. Recognizing as well the role of healthcare professionals as guardians against practices that would undermine patient autonomy, ASHP advocates that, when permitted, medical aid in dying only be available to competent, terminally ill patients who freely and knowledgeably make that choice.

ASHP joins other healthcare professional organizations in noting that medical aid in dying is inextricably linked with hospice, palliative, and other end-of-life care. ASHP will therefore continue to advocate that patients receive appropriate pharmacist care at the end of life, including [pain management](#) (ASHP policy 1106), [support in dying](#) (ASHP policy 0307), and [hospice and palliative care](#).

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*.