ASHP Statement on Pharmacist's Decision-making on Assisted Suicide

Preamble

Consistent with the intent of the Code of Ethics for Pharmacists "to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists," the American Society of Health-System Pharmacists issues this Statement on Pharmacist Decision-making on Assisted Suicide. The practice of providing competent patients with pharmaceutical means of ending their lives raises issues of professional obligations to patients and to other professionals involved in patient care. We affirm the ASHP policy (9802) that supports the right of a pharmacist to participate or not in morally, religiously, or ethically troubling therapies.

This Statement establishes a framework for pharmacist participation in the legal and ethical debate about the appropriate care of patients at the end of life. This Statement will help pharmacists resolve the growing questions about the ethical obligations of health care professionals to provide care and alleviate suffering. It is hoped that this framework and its use by pharmacists will virtually eliminate a patient's request for assisted suicide.

When asked to evaluate and comment on legislative, regulatory, or judicial actions or on organizational policies of health systems regarding pharmaceutical care, pharmacists should use the principles expressed in this Statement in developing their responses.

Guiding Principles

Professional Tradition. The basic tenet of the profession is to provide care and affirm life. The pharmacy profession is founded on a tradition of patient trust. The trust developed between each patient and members of the health care team makes it important for each professional to examine the moral and ethical issues of patients' requests for assistance in dying. Pharmacists should serve as advocates for the patient throughout the continuum of care.

Respect for Patients. *Patient autonomy.* Pharmacists should ensure the rights of competent patients to know about all legally available treatment options while communicating to patients and their caregivers (including family members if appropriate) the overall duty of health care professionals to preserve life.

Confidentiality. Pharmacists should maintain the confidentiality of all patient information, regardless of whether they agree with the values underlying the patient's choice of treatment or decision to forgo any particular treatment.

Decision-making. Patients' ability to exercise their ethical and legal right to choose or decline treatment is dependent upon pharmacists informing patients and their health care providers about the nature of pharmaceutical options. Those options are constantly changing, given the dynamic aspect of the pharmaceutical marketplace and the evolving nature of hospice care and available palliative treatments.

Health Care Systems. *Collaboration.* Collaboration among members of the health care team must occur at both the patient care and the public policy levels. It is the pharmacist's responsibility to educate members of the health care team about the pharmacotherapeutic options available in treating the patient's condition. Health care team members include the patient, members of the patient's family, and caregivers.

Confidentiality. The patient's right of confidentiality and right to determine his or her therapy, including end-of-life decisions, shall be respected, included, and considered in the decision process in health care systems. Pharmacists should maintain the confidentiality of all patient information, regardless of whether they agree with the values underlying the patient's choice of treatment or decision to forgo any particular treatment.

Covenant with society. Health care is delivered in a system in which each profession makes a contribution on the patient's behalf. An act in one part of the system has consequences in other parts of that system. Each profession has a covenant with society, founded on a relationship of trust with the patient. The trust developed between each patient and members of the health care team makes it important for each professional to examine the moral and ethical issues of patients' requests for assistance in dying.

Barriers to care. Health care professionals must address the following barriers to adequate end-of-life care:

1. Inadequate knowledge and use of pain- and symptom-management therapies.
2. The paucity of published data related to the ingestion of lethal drugs and the outcomes thereof.
3. Insufficient education of health care professionals about end-of-life and palliative care issues.
4. Inadequate recognition that end-of-life care is the responsibility of the entire health care team.
5. Legal and regulatory issues that deter appropriate provision of pain and symptom management.

Professional Obligations. *Conscientious objection.* Pharmacists must retain their right to participate or not in morally, religiously, or ethically troubling therapies. Procedures should be in place to ensure that employers are able to provide care to the patient and provide adequate services to the patient and caregiver. The employer has specific responsibilities, and the employee cannot be a barrier to the employer's ability to fulfill those obligations. Employers must reasonably accommodate the employee pharmacist's right to not participate in morally, religiously, or ethically troubling therapies.

Obligation to the patient. Pharmacists should support appropriate drug therapy to ensure that palliative care and aggressive pain management are available for all patients in need. Pharmacists, as part of their professional responsibility, must offer to provide counseling services to the patient and caregivers and be prepared to provide pharmaceutical care to the patient until the end of life.

Obligation to team members. The pharmacist, as a member of a health care team responsible for the care of a patient, is accountable for providing the team members with detailed information concerning efficacious use of pharmaceutical and other therapies available that may affect the options open to the patient.

As active members of an interdisciplinary team caring for patients, pharmacists must be central participants in all decisions relating to medication management of the patient. Pharmacists should respect the opinions and specific areas of expertise of the other members of the health care team.

Pharmacist education. Pharmacists are often inadequately trained in the care of dying patients. Therefore, pharmacists' education at all levels (undergraduate, graduate, continuing education) should be sensitive to these issues and offer the development of skills and knowledge concerning care of the dying. Pharmacists should make a personal, professional commitment to learn more about end-of-life care.

Recommended Readings

Supreme Court Decisions

1. *Washington v. Glucksberg,* decided June 26, 1997.
2. *Vacco v. Quill,* decided June 26, 1977.
3. Angell M. The Supreme Court and physician-assisted suicide—the ultimate right. *N Engl J Med.* 1997; 336: 50–3.
4. Annas GJ. The bell tolls for a constitutional right to physician-assisted suicide. *N Engl J Med.* 1997; 337:1098–103.
5. Burt RA. The Supreme Court speaks: not assisted suicide but a constitutional right to palliative care. *N Engl J Med.* 1997; 337:1234–6.
6. Gostin LO. Deciding life and death in the courtroom: from *Quinlan to Cruzan, Glucksberg,* and *Vacco*—a brief history and analysis of constitutional protection of the "right to die" *JAMA* 1997; 278:1523–8.
7. Orentlicher D. The Supreme Court and physician-assisted suicide: rejecting assisted suicide but embracing euthanasia. *N Engl J Med.* 1997; 337:1236–9.
8. Palmer LI. Institutional analysis and physicians' rights after *Vacco v. Quill, Cornell J Law Public Policy.* 1998; 7:415–30.

Professional Organization Position Statements/Policies

1. American Bar Association house of delegates. Report of action taken at 1997 annual meeting.
2. American Pharmaceutical Association. Code of Ethics for Pharmacists.
3. American Pain Society. Treatment of pain at the end of life.
4. National League for Nursing. Life-terminating choices: a framework for nursing decision-making.
5. American Medical Association Policy on Physician-Assisted Suicide, 1996.
6. American Nurses Association. Position statement on assisted suicide.
7. American Geriatrics Society. Position statement on the care of dying patients.
8. National Hospice Organization.

Assisted Suicide

1. Dixon KM, Kier KL. Longing for mercy, requesting death: pharmaceutical care and pharmaceutically assisted death. *Am J Health-Syst Pharm.* 1998; 55:578–85.
2. Hamerly JP. Views on assisted suicide: perspectives of the AMA and the NHO. *Am J Health-Syst Pharm.* 1998; 55:543–7.
3. Lee BC. Views on assisted suicide: the aid-in-dying perspective. *Am J Health-Syst Pharm.* 1998; 55: 547–50.
4. Meier DE, Emmons CA, Wallenstein S et al. A national survey of physician-assisted suicide and euthanasia in the United States. *N Engl J Med.* 1998; 338: 1193–201.
5. Mullan K, Allen WL, Brushwood DB. Conscientious objection to assisted death: can pharmacy address this in a systematic fashion? *Ann Pharmacother.* 1996; 30:1185–91.
6. Rupp MT. Issues for pharmacists in assisted patient death. In: Battin MP, Lipman AG, eds. Drug use in assisted suicide and euthanasia. Binghamton, NY: Haworth; 1996.
7. Rupp MT. Physician-assisted suicide and the issues it raises for pharmacists. *Am J Health-syst Pharm.* 1995; 52:1455–60.
8. Rupp MT, Isenhower HL. Pharmacists' attitudes toward physician-assisted suicide. *Am J Hosp Pharm.* 1994; 51:69–74.
9. Stein GC. Assisted suicide: an issue for pharmacists. *Am J Health-Syst Pharm.* 1998; 55:539. Editorial.
10. Van der Maas PJ, van der Wal G, Haverkate I et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. *N Engl J Med.* 1996; 335:1699–705.
11. Van der Wal G, van der Maas PJ, Bosma JM et al. Evaluation of the notification procedure for physician-assisted death in the Netherlands. *N Engl J Med.* 1996; 335:1706–11.
12. Vaux KL. Views on assisted suicide: an ethicist's perspective. *Am J Health–Syst Pharm.* 1998; 55:551–3.

End-of-Life Care

1. Foley KM. Competent care for the dying instead of physician-assisted suicide. *N Engl J Med.* 1997; 336:54–8.
2. Quill TE, Lo B, Brock DW. Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal seda-tion, physician-assisted suicide, and voluntary active euthanasia. *JAMA.* 1997; 278:2099–104.
3. Suicide prevention: efforts to increase research and education in palliative care. Washington, DC: General Accounting Office, 1998 Apr; report HEHS-98-128.

Miscellaneous

1. Board of Directors report on the Council on Legal and Public Affairs, ASHP House of Delegates Session—1994.
2. Board of Directors report on the Council on Professional Affairs, ASHP House of Delegates Session—1998.