

Board Report on the Joint Council Task Force on Pharmacist Participation in Medical Aid in Dying

Pharmacist Participation in Medical Aid in Dying

- 1 To affirm that a pharmacist's decision to participate or decline to participate in medical aid
- 2 in dying for competent, terminally ill patients, where legal, is one of individual conscience;
- 3 further,
- 4 To reaffirm that pharmacists have a right to participate or decline to participate in medical
- 5 aid in dying without retribution; further,
- 6 To take a stance of studied neutrality on legislation that would permit medical aid in dying
- 7 for competent, terminally ill patients.

(Note: This policy would supersede 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](#).

Background

In June 2016, the ASHP House of Delegates considered a [resolution](#), ASHP Position on Assisted Suicide, and voted to refer the resolution to the appropriate ASHP committee, as determined by the Board of Directors, for further study. The Board of Directors convened the Council on Pharmacy Management, Council on Pharmacy Practice, and Council on Public Policy as a Joint Council Task Force to consider ASHP policy 9915, [ASHP Position on Assisted Suicide](#), and the [ASHP Statement on Pharmacist Decision-making on Assisted Suicide](#). The charge of the Joint Council Task Force was to review existing ASHP policy on assisted suicide and recommend to the Board of Directors what ASHP's official stance should be on the following questions:

- 1) Should ASHP reaffirm (through its current policy) that the decision to participate in the use of medications in assisted suicide is one of individual conscience, or should ASHP encourage or discourage pharmacist participation in dispensing medications for use in the suicide of terminally ill patients?
- 2) Based on the recommendation made regarding question 1 above, determine whether the guidance offered in the ASHP Statement on Pharmacist's Decision-making on Assisted Suicide is current, relevant, and complete. More specifically, does the statement appropriately address the following issues:
 - The practitioner's duty to care for the patient and caregiver vis-a-vis palliative care.
 - The practitioner's right to refuse to participate in treatments that are morally, religiously, or ethically troubling.
 - The practitioner's responsibility to the employer in the context of employment law.
 - The employer's responsibility to provide care to the patient.
 - The employer's responsibility to provide services to the patient's caregiver.

The Task Force met at a special session on Thursday, September 22, during ASHP Policy Week. Following a presentation and question-and-answer session conducted by [Dr. Mark Hughes](#), the Task Force discussed the policy and statement and recommended revising them. The Task Force agreed at the meeting that ASHP should maintain its stance of neutrality regarding pharmacist participation in assisted suicide as well as laws that permit it but recognized the

need to update the terminology of the position and the content of the statement. Following the Policy Week meeting, the Task Force considered several draft revisions to ASHP policy 9915 and recommended amending the policy as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To affirm that ~~the a pharmacist's decision to participate or decline to participate in the use of medications in assisted suicide~~ 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 ~~remain~~ take a stance of studied neutrality on the issue of health professional participation in assisted suicide of patients who are terminally ill legislation that would permit medical aid in dying for competent, terminally ill patients; further,

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

One of the Task Force's first decisions was selecting a term to describe the practice. The Task Force chose *medical aid in dying* because it is more accurate, objective, and recognizable than other terms. The Task Force concluded that the term *physician-assisted suicide* is inaccurate for several reasons. First, laws that permit the practice frequently include a provision that explicitly excludes actions taken under the law from the legal definition of suicide, and those laws sometimes explicitly reject use of the terms *assisted suicide* or *physician-assisted suicide*. Second, as noted in the American Public Health Association Policy, [Patients' Rights to Self-Determination at the End of Life](#), the American Psychological Association has recognized that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide," and numerous medical and legal experts agree that the term *suicide* "is inappropriate when discussing the choice of a mentally competent terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death." In addition, any term with the word *physician* in it minimizes the roles of other healthcare professionals in the practice, including pharmacists and hospice nurses, for example. The Task Force declined to use the term *death with dignity*, however commonly it is used in law and discourse, because the term is clearly not objective. As Dr. Hughes pointed out in his presentation, dignity has many aspects, and proponents on both sides of the debate argue that they are upholding the dignity of the individual. The Task Force considered numerous other terms (e.g., assisted death, hastened death) but decided against them because they have the same flaws as the others or are not commonly used.

In addition, the Task Force considered the use of studied neutrality by professional associations. The Task Force appreciated that the primary goal of studied neutrality is "to guide action that does not afford material advantage to a [particular] group." The Task Force acknowledged the diversity of views of ASHP members and other pharmacists and concluded

that a position of studied neutrality would promote patient autonomy and access to care and protect pharmacists' professional integrity and comity. The Task Force agreed that, as before, ASHP policy on the topic should focus primarily on the patient. The Task Force was concerned that a stance against pharmacist participation could interfere with a patient's right to access to obtain legally prescribed and medically indicated treatments (ASHP policy 0610, [Pharmacist's Right of Conscience and Patient's Right of Access to Therapy](#)). Further, the Task Force was concerned that a stance against pharmacist participation would infringe on the moral and ethical prerogatives of pharmacists and could introduce the possibility, however remote, that pharmacists could face legal or professional sanctions for participating in a legal practice. Similarly, the Task Force recognized that adopting a position in favor of participation would infringe on the moral and ethical prerogatives of pharmacists to decline to participate in therapies they consider morally, religiously, or ethically troubling.

The Task Force's recommendation of a position of studied neutrality on legislation allowing medical aid in dying was based on similar reasoning. A stance against such legislation could inhibit public discourse on an important healthcare topic and potentially limit patient access to desired therapies. In addition, a stance against such legislation could negatively affect public and professional perception of pharmacists who chose to participate. A stance in favor of such legislation would not serve the interests of ASHP members who oppose the practice and could negatively affect public and professional perception of pharmacists who decline to participate. Finally, a stance in favor of either side would alienate a significant number of pharmacists and damage the comity of the profession.

The Task Force also recognized that, given the widespread adoption of medical aid in dying, ASHP has an obligation to the pharmacists it serves and the patients they care for to continue to provide education about the topic but agreed that such education should encompass the broad spectrum of end-of-life care rather than focus solely on medical aid in dying. The Task Force noted that such education is the subject of ASHP policy 0307, [Support for Dying Patients](#), and concluded that any statement regarding education in this policy would be redundant. To help pharmacists navigate the issues presented by medical aid in dying, the Task Force recommended revising the [ASHP Statement on Pharmacist's Decision-making on Assisted Suicide](#) to provide an overview of the guiding principles for the pharmacist's decision-making on the topic, including professional tradition, respect for the patient, and professional obligations.

Genesis of ASHP Policy on Assisted Suicide

In September 1997, the ASHP Council on Legal and Public Affairs (now the Council on Public Policy) voted to develop a policy on the role of the pharmacist in assisted suicide. In March 1998, ASHP President John E. Murphy appointed a task force to develop an ASHP policy that would serve as ASHP's official stance on the concept of healthcare professionals assisting in the death of patients and offer practical guidance on the responsibilities, duties, and areas of concern that face practitioners in jurisdictions in which assisted suicide is legal. The task force included ASHP members (including a pain management practitioner) and three outside experts: a legal scholar, a former executive of a professional society with a sociological perspective, and an ethicist.

The Council and the Board concluded that ASHP's policy on the practice of assisted suicide at the public policy level and at the individual practitioner level should be neutral. The Council and the Board emphasized that the focus of ASHP policy should be on patients and caregivers, including family members, and highlighted existing ASHP policies regarding conscientious objection, use of drugs in capital punishment, adequate pain management, and appropriate care for dying patients.

ASHP Policies on Assisted Suicide and Related Issues

ASHP Policy on Assisted Suicide (9915)

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.

Pharmacist's Right of Conscience and Patient's Right of Access to Therapy (0610)

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.

Pharmacist Role in Capital Punishment (1531)

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.

Pharmacist Support for Dying Patients (0307)

To support the position that care for dying patients is part of the continuum of care that pharmacists should provide to patients; further,

To support the position that pharmacists have a professional obligation to work in a collaborative and compassionate manner with patients, family members, caregivers, and other professionals to help fulfill the patient care needs, especially the quality-of-life needs, of dying patients of all ages; further,

To support research on the needs of dying patients; further,

To provide education to pharmacists on caring for dying patients, including education on clinical, managerial, professional, and legal issues; further,

To urge the inclusion of such topics in the curricula of colleges of pharmacy.

Pain Management (1106)

To advocate fully informed patient and caregiver participation in pain management decisions as an integral aspect of patient care; further,

To advocate that pharmacists actively participate in the development and implementation of health-system pain management policies and protocols; further,

To support the participation of pharmacists in pain management, which is a multidisciplinary, collaborative process for selecting appropriate drug therapies, educating patients, monitoring patients, and continually assessing outcomes of therapy; further,

To advocate that pharmacists lead efforts to prevent inappropriate use of pain therapies, including engaging in strategies to detect and address patterns of abuse and misuse; further,

To encourage the education of pharmacists, pharmacy students, and other health care providers regarding the principles of pain management and methods to minimize drug diversion.

Members of the Joint Council Task Force

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