Pharmacist Role in End of Life Decisions

BY

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The history of Euthanasia in medicine dates back to about 400 B.C. The “Father of Medicine,” Greek physician Hippocrates originated the Hippocratic Oath. A part of the oath states, “I will give no deadly medicine to any one if asked, nor suggest any such counsel.” Furthermore, the 14th through 20th century English common law had punished or otherwise disapproved of both suicide and assisted suicide. The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, and many of the new states and territories followed New York’s example thereafter. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnishing another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life.” In 1920, the book "Permitting the Destruction of Life not Worthy of Life" was published. In this book, authors Alfred Hoche, M.D., a professor of psychiatry at the University of Freiburg, and Karl Binding, a professor of law from the University of Leipzig, argued that patients who ask for "death assistance" should, under very carefully controlled conditions, be able to obtain it from a physician. This book helped support involuntary euthanasia by Nazi Germany. Later, in 1935 The Euthanasia Society of England was formed to promote euthanasia. "In October of 1939 amid the turmoil of the outbreak of war Hitler ordered widespread "mercy killing" of the sick and disabled. Code named "Aktion T 4," the Nazi euthanasia program to eliminate "life unworthy of life" at first focused on newborns and very young children. Midwives and doctors were required to register children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms included on a questionnaire from the Reich Health Ministry. The Nazi euthanasia program quickly expanded to include older disabled children and adults. Hitler's decree of October, 1939, typed on his personal stationery and back dated to Sept. 1, enlarged "the authority of certain physicians to be designated by name in such manner that persons who, according to human judgment, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death.” Almost 60 years later Australia's Northern Territory approved a euthanasia bill. It went into effect in 1996 and was overturned by the Australian Parliament in 1997. In 1998, Oregon legalizes physician assisted suicide. From 1998 through the present time debates have continued regarding assisted suicide.

Currently, the US Supreme Court is debating whether the Bush Administration can stop doctors from helping terminally ill patients take their own lives under the nation's only physician-assisted suicide law. The Oregon law, called the Death with Dignity Act, was twice approved by the state's voters. The only state law in the country allowing physician-assisted suicide, it has been used by 208 people since it took effect
in 1997. Several justices appeared sympathetic to Oregon's arguments that regulation of doctors and medicine has traditionally been left to the states rather than the federal government. “But other justices questioned how far a state could go and whether it could decide if doctors can prescribe morphine for depression or steroids for body building.” Under Oregon law, terminally ill patients must get a certification from two doctors stating they are of sound mind and have less than six months to live. A prescription for lethal drugs is then written by the doctor, and the patients administer the drugs themselves. Former Attorney General, John Ashcroft's directive declared that “assisting suicide was not a legitimate medical purpose under the Controlled Substances Act and that prescribing federally controlled drugs for that purpose was against the federal law.” A ruling is expected in the middle of next year.

It is important to recognize that end-of-life care is the responsibility of the entire health care team. The primary focus of most literature on the topic focuses on physician-assisted suicide. Pharmacists are also understood to enjoy a covenantal relationship with their patients. Their actions should always be designed to ensure that the desired patient outcomes are attained whenever pharmacotherapeutic agents are employed. However, they are also informed by the basic tenets of medical ethics, amongst which is the principle of respect for patient autonomy. Pharmacists are confronted with euthanasia: they not only have to provide the necessary drugs, but are also affected in every area of their life. Pharmacists are health care professionals that encounter terminally ill patients on a regular basis whether they practice clinically or in a community environment. A clinical pharmacy specialist may encounter end-of-life decisions while dealing with mentally competent patients who make decisions regarding their own medical treatment, by interacting with physicians in charge of the patient, and by interacting with the patient’s family/power of attorney when that patient can no longer make their own medical decisions. A community pharmacist on the other hand may deal with terminally ill patients requesting early refills on their pain medications and family members requesting confidential information. Euthanasia may be seen as a contradiction to the mission of pharmacy practice. If, however, the activities of pharmacists include pharmaceutical care, the contradiction may not necessarily be present. Pharmaceutical care begins with the recognition that responsibilities of patient care cannot be delegated solely to other health professionals. Pharmaceutical care recognizes some of the most important needs of the terminally ill. If based on a patient-centered approach, euthanasia might be a logical last step in the efforts to alleviate the patient's sufferings.

The topic remains highly controversial. The American Society of Health-System Pharmacists has published many positions as well as statements on topics related to physician assisted suicide. On April 21, 1999 the American Society of Health-System Pharmacists approved a statement focusing on “Pharmacist’s Decision-making on Assisted Suicide. This statement affirmed the ASHP policy (9802) that supports the right of the pharmacist to participate or not in morally, religiously, or ethically troubling therapy. The objective of the statement is stated as follows,
The 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.

The statement is based upon many guiding principles. These include: professional tradition, respect for patients, collaboration, confidentiality, barriers to care, obligation to team members, and pharmacist education. Professional tradition, “the basic tenet of the profession is to provide care and affirm life.” The profession is founded on the ideals of patient trust. This trust requires that members of the health care team evaluate 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.” The second guiding principle is the respect for patients or 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 the overall duty of health care professionals to preserve life.” A subcategory under respect for patients is confidentiality. The organization takes the position that pharmacists should maintain the confidentiality of all patient information, regardless of whether they agree with the values underlying the patient's choice of any treatment. The patient’s right to confidentiality and the right to determine his/her therapy, including end of life decisions, shall be respected, included, and considered in the decision process in health care systems. In addition, the next guiding principle relates directly to the topic at hand. End of life decisions compose of all health care team members, and the ideals of collaboration are presented in the position statement. It states, “Collaboration among members of the health care team must occur at both the patient care and public policy levels. It is the pharmacist's responsibility to educate members of the healthcare 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.” Barriers to care are also mentioned. 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 outcomes thereof
3) Insufficient education of 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

The last guiding principle deals with pharmacist education. The statement supports the fact that pharmacists are often inadequately trained the care of dying patients. It
suggests that pharmacist’s education should involve creating the skills and knowledge concerning care of the dying. “Pharmacists should make a personal, professional commitment to learn more about end of care life.

Moreover, in addition to the statement the American Society of Health-System Pharmacists has created positions on issues that directly relate to the topic at hand. For example, ASHP position 9915 on Assisted Suicide provides the following information:

1) ASHP will remain neutral on the issue of health professional participation in assisted suicide of patients who are terminally ill 
2) To affirm that the decision to participate in the use of medications in assisted suicide is one of individual conscience 
3) To offer guidance to health-system pharmacists who practice in states in which assisted suicide is legal.

Also, ASHP position 9802 on conscientious objection by Pharmacists to Morally, Religiously, or Ethically Troubling Therapies offers the following position:

1) ASHP recognizes a pharmacist’s right to conscientious objection to morally, religiously, or ethically troubling therapies and supports the establishment of systems that protect the patient’s right to obtain legally prescribed and medically indicated treatments while reasonably accommodating the pharmacist’s right of conscientious objection.

The American Society of Health System Pharmacists as well as many other professional pharmacy organizations supports the right of pharmacists to object to filling prescriptions that are ethically troubling therapies. However, recently the governments have been pushing toward a trend that requires pharmacists to fill medications without any right to object. It is becoming a common tendency that pharmacists are refusing to fill prescriptions for various medications such as: the 'morning after' birth-control pills. Many refusals have been noted in states, including California, Wisconsin, Georgia, New York, North Carolina, Ohio, Texas, and Missouri. Blagojevich, the governor of Illinois stated, “Our regulation says that if a woman goes to a pharmacy with a prescription for birth control, the pharmacy is not allowed to discriminate who they sell to and who they don’t. The pharmacy will be expected to accept that prescription and fill it in the same way, and in the same period of time they would fill any other prescription. No delays. No hassles. No lecture. Just fill the prescription.” This issue is important because according to the Washington Times, there is a growing movement among some pharmacists for so-called conscience clauses that would give them the legal right to refuse to fill prescriptions for things like birth control if doing so violated their moral, religious, or personal beliefs. Legislatures in eleven states are considering measures giving pharmacists the right to refuse to dispense medications. In addition, the Illinois law also enacted a toll free number for patient’s to make complaints about pharmacies not following the new law. This issue is quite troubling to a practicing pharmacist and/or
pharmacy student. It opens the thought that if one state can require the pharmacists to dispense oral contraception, what is holding other states back from enacting laws that would require the dispensing of all medications. It could even further be linked to the dispensing of medication for assisted-suicide in the future, with no thought toward religious objection. Colleges of Pharmacy implement the knowledge and skills to become a competent practicing professional of the health care team. It is disturbing to think that laws could turn our profession into a bunch of robots who are required to dispense medication that is against one’s beliefs.

Many pharmacy organizations are against the law in Illinois and movements closely related. For instance, The American Pharmacists Association, which represents 52,000 pharmacists, backs the right of pharmacists to not dispense a particular drug so long as it is available to patients from other sources or another pharmacist. On December 2, 2005 the organization along with the Illinois Pharmacist association issued a statement in regard to the new law in Illinois. Both organizations are ‘appalled’ at the governors comments that aired live on CNN the previous evening. “It is unfortunate that despite years of education and specialized training to which pharmacists commit and the daily honing of skills, the Governor chose to equate their role among health-care professionals with that of non-healthcare professionals. Such a characterization is patently unfair,” the statement concluded.

At this point in time, many aspects of the pharmacy profession are related to ethical dilemmas. It was my objective to assess the ethical dilemma regarding the role of pharmacy in end-of-life decisions. My individual research consisted of a survey assessing the answers to ethical questions, potential scenarios, demographics, values, and many others. The survey was created with the intent to answer the questions submitted in my paper abstract. Pharmacists, pharmacy students, other health-care professionals, as well as everyday people were included to participate in this study. The study included any prospect that was willing to fill out the short survey. Reasons for exclusion included objection and laziness.

The baseline characteristics of the surveyors were broad in category. Pharmacy students filled out the most surveys. Another twenty pharmacists, one nurse, and twenty everyday people were included. Many cultures and religions were represented, as well as a wide variety of ages.

The Survey

1) Is assisted-suicide morally ok?

Overall, I believe the results of this question are most shocking. Originally, I had assumed that the majority of individuals believed that ending one’s own life early was wrong. Contrary to my original beliefs, 60 percent of surveyors expressed that they were not opposed to the idea. The most common reason in support of the act is that it should be a person’s choice. Many surveyors were pro-choice. However, the 40 percent of patients opposed to assisted-suicide had underlying factors influencing their
opinions. The majority included things such as: religious beliefs, ethical values, family values, and culture to mention a few. A few health-care professionals stated the idea that “Who are we to decide whether or not it is someone’s time to go. If someone really wanted to kill themselves they could find ways on their own. As a health professional it is not in my scope of practice to assist someone in suicide.” In addition, age played a large role into the question. A majority of those opposed to euthanasia were over the age of fifty. Perhaps this has to deal with a different upbringing. Society is much more accepting of ideas that never would have been thought of in earlier years. Furthermore, religion played an enormous role in deciding the answer to this question. It was hard to assess percentages for the separate religions, due to the fact that this information was optional. In addition, one must take into account the fact that although someone supports to practicing one religion, he/she may not be a strong practicing follower. One Catholic faith supporter commented, “I am Catholic and it is against the values and the beliefs of the Catholic Church to take someone else’s life, its God’s decision when we are to die and go heavy.” This surveyor was very strong about his/her opinions on the topic. It is most likely that resistance to physician assisted suicide may stem from groups of individuals with the same common beliefs.

2) Should a pharmacist dispense a medication that they know is being used to end a patient’s life?

This survey question was a lot clearer cut in regard to the responses submitted. A vast majority of responders felt it was very unethical to dispense a medication that was lethal. The most obvious reason for responding in this fashion dealt with the law. When asking surveyors to provide a reason to this question many felt it was against the law to dispense a medication that was not safe and could potentially harm someone. I suppose one could relate this ethical dilemma to the normative principles discussed in class this semester. The principles of autonomy, beneficence, and avoidance of killing directly relate. To begin, autonomy is the respect for individuality. Beneficence is to do good. One must weigh these first two principles very importantly. A practitioner, who believes more in the patient’s choice, would respect the principles of autonomy. However, another professional might consider the right to do good as being more important. But, is doing good dispensing or not dispensing the lethal medication?

3) Would your answer differ if the patient was terminally ill and had less than three months to live?

Overall, I think most individuals are more caring for patients that are suffering through their last days of life. It is a normal tendency to provide special consideration to these patients in all parts of health care. A nurse responded in the following:

“Yes, I think my answer would change. Working in the health profession I see many sick people daily especially on an oncology unit where some patients are palliative, their bodies are deteriorating, they are in extreme amounts of pain, and they know that they only have days to live. If giving them more pain medication is going to keep them comfortable, then yes.
Although I do not agree because legally giving someone a medication that you know could potentially harm them, you take the risk of losing your license to practice. Even though this may seem ethically correct, it can also be viewed as misconduct and malpractice.

As you can see responders to the two above questions are worried about the law, their license, and less about the patient. I’m not advocating the right to go and help every patient commit suicide, but I also believe that someone who is terminally ill should be cared for properly. For a practitioner to base every decision based on the law and in front of the ideals of patient care is a tough decision, and the ethical one that it may be.

4) For a patient in the hospital with no living will and who is incompetent of making end of life decisions such as ventilator support/resuscitation/nutritional support, who should make this decision if anyone?

This particular scenario was included to assess the surveyors’ thoughts on the Terry Schiavo case. Unfortunately, the results were too mixed to discuss. Optimally, every patient who became incompetent of their own health decisions would have a living will; however this is not always the case. In the Schiavo case this became a battle between a husband and parents. End of life decisions are difficult in assessing what is right verses wrong. My honest feelings are that a patient on ventilator support or one that needs resuscitation is completely different from the nutritional support that was withdrawn in the Schiavo case. I believe strongly that living on ventilator support is no life at all. I also insist that if an individual is married it should be the responsibility of the spouse to decide in the absence of a living will. For an unmarried individual with children the decision should rest upon the children. Finally, for an unmarried individual without children the decision should rest with the parents and then the siblings. On the other hand, I do not believe that starving anyone to death is morally correct. I don’t think it is any better than dispensing a medication that is lethal. It is our job as future pharmacists to engage in patient care, and part of that is nutrition. Arguments can be made that Terry Schiavo had no brain activity; she was a person living in a body with no other function. Does that make it right to take her life? Is this any different from a patient who suffers from Alzheimer’s disease? My grandma suffered with Alzheimer’s disease for many years. It got progressively worse. She lived in a body, she sustained life, and there was very little brain activity involved. Do we starve these patients because they are hard to deal with, aggressive, or they don’t remember their loved ones? We don’t intentionally starve them, rather they forget how to eat, breathe, walk, and eventually god takes them from us to a better place. I believe that individuals will reach mortality when they are ready, and starving a person to death to expedite their exit from this land is morally unacceptable. If I had been a pharmacist practicing while this situation was occurring I most definitely would have objected to any part of it. This is a situation that I could never go home at night and be able to sleep on my pillow. I think this situation has taught Americans a lesson. It should provoke people to support creating a living will or at least speak with their loved ones about what should occur if a devastating event such as this did happen. I have taken the opportunity to lay my cards
on the table and tell my family and friends exactly what should happen if such an event occurred.

6) There is a federal HIPPA act which protects the confidentiality of patient information. In what situation if any should pharmacists be able to disclose information regarding a patient who may be making a decision to end his/her life to the patient’s loved ones?

The answer to this question was exactly as I thought it would turn out. Greater than 90 percent of those participating in the survey believed that there is absolutely no reason to disclose information to the loved ones of a patient. If a patient is competent of making his/her health decisions then family should not be included unless the patient requests. It is of the utmost importance that health care professionals stick to this ideal. Pharmacists need to remember that although they do not support all decisions of the patients they care for, it is not the decision that they should make. I believe the results of this question may have been influenced by the fact that a majority of the surveyors must abide by the current HIPPA laws. I think the results may have been different had more of everyday people been surveyed.

7) A patient who is a regular patient at your pharmacy and you know is terminally ill has been requesting early refills on his narcotic pain medications. Would you fill the medication early in any circumstance?

Most pharmacists concurred that this is a personal call and a right as practicing health care professionals. A majority of students (>70%) believed that they would dispense the early refills. Pharmaceutical care recognizes some of the most important needs of the terminally ill. It is our role as member of the health-care team to provide care to our patients, including end of life care. I believe that starting with education in the classroom in pharmacy school regarding caring for the terminally ill could help improve patient outcomes. The American Society for Health System Pharmacists had stated that pharmacists are not trained fully to handle these situations. This could be the reason why most of the issues regarding end of life care are published regarding physicians. If pharmacy students were better equipped with the skills to manage these patients, we as a profession could possibly improve patient outcomes and quality of life in the last days. We should be advocates in managing patients as long as they need the assistance.

8) Currently, Illinois just passed a state law enforcing pharmacists to fill every oral contraceptive prescription that presents as being legal and that pharmacists do not have any ethical rights to object to filling prescriptions. Do you agree?

I feel this is the most imperative question in my assessment of this topic. 100 % of pharmacists and pharmacy students do not agree with this law at all. It degrades our training, specialty, and place in the health care team. How can it be concluded by the governor of Illinois that pharmacists have no ethics or moral standards. It is almost
implying that society doesn’t need pharmacists in their communities. We could just as well train a technological robot and put them in a pharmacy to count by fives, stick a label, and bag up the medication for pick-up. This really upsets me as a future pharmacist. I have spent years of my life training to become a pharmacist. I plan on doing a residency after I graduate and perhaps even a fellowship. I chose pharmacy because I want to be a trusted, liked, visible member of the health-care team to help patients. There isn’t a regret I have about choosing pharmacy as my future profession. I speak highly of the profession at any given chance. However, if laws such as these sweep the nation in trends my perception of my future career may change. I cannot imagine being forced to dispense a medication against my beliefs. Imagine assisted suicide became legal in Michigan as it is in Oregon and a law required that pharmacists dispense medications to kill a patient. I could never live with myself knowing I caused the death of another human being. Quite honestly, there are certain things you pick your battles on. I believe this would be one of them for me. I think I would almost be forced out of the profession, because sleeping on my pillow at night would be impossible. I feel it is important for the current pharmacy students to set a message now through example just how important pharmacists can be to the public. If we as the future of the profession promote the change, we can perhaps stop ridiculous laws such as these dictating our futures. In addition, we should be advocates toward conscience objection laws for pharmacists and assuring pharmacists get the same removal from scenarios such as these. Physicians have obtained that right, why not us and why not NOW?

This course has been very beneficial to my future in the profession. I feel the topics discussed and the assignments helped me grow as an individual. It has prepared me with the skills to assess ethical dilemmas that I may encounter in the future. In addition, this research project has taught me many things:

1) There is no clear cut answer regarding the debate of assisted suicide.
2) End-of-Life care is the responsibility of the entire health care team.
3) Pharmacists need to step up and commit to improving the quality of life of these patients.
4) The pharmacy professional organizations recognize the ethical, religious, and cultural objections to dispensing medications and fully support pharmacists in having the right to dispense or not.
5) We are currently facing some key issues in the United States. The Oregon Supreme Court Trial as well as the Illinois dispensing mandate may play key parts in the future of pharmacy practice.
6) This class was intended to stimulate a type of reasoning with no right answer. Every future clinician will respond differently to ethical situations. The main goal is to be able to live with the decisions you make.
References


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