

It is time to consider your ethical stance on physician-assisted suicide

By **Tim Hanlon**, a primary care pharmacist in the British Forces Germany Health Service

As a professional pharmacist, could you assist someone to end his or her life? Your reaction may be to recoil in horror from the mere suggestion that your professional skills could be used to kill rather than cure, or you may see a real and practical application for your skills to end human life.

Love or hate the idea of pharmacy's involvement in physician-assisted suicide (PAS), the debate has, at long last, arrived for the pharmacy profession.

PAS is currently illegal in Britain since it is covered under the Suicide Act 1961, but no one could have missed the recent string of articles and news stories about PAS in the media. Lord Joffe has proposed a Bill to the House of Lords which would make PAS legal in the UK, just as it is in a number of other countries.

News stories have filled our newspapers and been broadcast on our radios and television screens about Dignitas and the Swiss clinic which assisted Anne Turner and other British people to end their lives abroad because the choice to die in this manner in Britain is currently denied them. PAS has become headline news over the past weeks. All of these stories have one glaring omission in common: there is no mention of the role of the pharmacist in connection with physician-assisted suicide.

PAS describes an aspect of euthanasia (voluntary, active) when a health professional (usually a GP or specialist) provides a competent patient with pharmaceutical means to end his or her own life.

How is a pharmacist involved in PAS? We know from the Netherlands, where PAS is available, that a pharmacist is routinely involved in PAS by dispensing the medicines to the individual (or to their doctor) necessary to take their own life.¹ To qualify as PAS, the patient must self-administer the fatal dose, which almost always indicates an oral dosage form, commonly a combination of barbiturates and a muscle relaxant. There is nothing thus far to suggest that a change in UK law, as proposed by Lord Joffe, would cut community pharmacists out of this loop.

In the event that PAS is decriminalised or made legal, a patient will be able to obtain

the means to end his or her life legally from their doctor and pharmacist. They may even have the right to require such a service, dependent upon the direction of legislative change. So, agree or disagree with it, pharmacists would be directly involved in ending life if PAS becomes legal. If, as a pharmacist, you have not yet formed an opinion on PAS, you should start to think carefully about it now.

The pharmacy profession in Britain has, for whatever reason, resisted entering this particular end-of-life ethical debate for some years now. Apart from a small number of letters and articles, little debate has taken place. The danger of not entering a debate at an early stage is that the profession is then forced to react and adapt to legal change rather than proactively trying to ensure that appropriate measures and professional considerations are taken into account which can influence that same legal change.

What do we already know about pharmacy and legal change regarding PAS? When PAS was made legal in Oregon in January 1995, the President of the Oregon Society of Hospital Pharmacists reported concerns that under the Death With Dignity Act, no one was required to inform the pharmacist about the purpose of the prescription, leaving the pharmacist in ignorance, but potentially partly liable for bad consequences, eg, persistent vegetative state (PVS), where death did not occur as planned.²

Given that the role of pharmacy (pharmacist or technician) is rarely, if ever, considered in connection with PAS, it is worrying to consider that it is entirely conceivable that, in the event of a change in the law to legalise PAS in Britain, there would be no imperative for a pharmacist to be informed of the purpose of a prescription intended to end a patient's life in a case of PAS and that a pharmacist in Britain could be liable to prosecution if the patient in PAS did not die following an attempted suicide, but rather ended up in a PVS.

Some may say that ignorance is bliss, but the world of pharmacy has moved on since Oregon, which was over 10 years ago. Pharmacists are taking on extended roles.

These advances in professional roles are incompatible with an attitude expressed by some that they are merely acting as agents of supply. This argument is not extended to other areas, such as antihypertensive therapy. Under these circumstances, most pharmacists would agree that they are partly responsible for achieving the intended outcomes of drug treatment. Why would this be any different with PAS?

Some research from 1998, which I undertook with Marjorie Weiss and Judith Rees at the University of Manchester, suggested that a quarter of community pharmacists surveyed would not wish to be informed about the intended purpose of a prescription for use to end life in PAS.³ This ostrich-like attitude of ignoring a key moral and ethical issue is not the act of a mature profession and suggests a confused approach to this issue compared with the profession's mature approach to other developments, such as pharmacist prescribing.

Whether Lord Joffe's Bill is successful this time or not is not the most significant issue. There have been others before Lord Joffe proposing such legal change and there will be others after him. It is likely that PAS will become legal at some stage. What is particularly significant is that the profession of pharmacy considers its position on this issue, in line with other professions, and that each individual pharmacist considers his or her ethical stance on the issue in order to influence any future professional proposals in relation to PAS.

In the conclusion of a **Broad spectrum** article that I wrote with Dr Weiss on PAS and the role of the pharmacist over five years ago,⁴ we said that the pharmacy profession needed to take part in the process of change rather than being changed by the process. I have not changed my mind on this issue. The time for debate is now.

References

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