

RECONCILING PRINCIPLES AND PRESCRIPTIONS: DO
PHARMACIST REFUSAL CLAUSES STRIKE THE
APPROPRIATE BALANCE BETWEEN PHARMACISTS' AND
PATIENTS' RIGHTS?

SARAH TOMKOWIAK*

The U.S. Supreme Court has repeatedly held that all women, married or single, have a right to privacy when making family planning decisions, including the right to receive and use birth control. Nearly all sexually active women choose to use oral contraceptives, the most popular form of birth control, during their child-bearing years for a variety of medical and physical reasons. Because these contraceptives require a prescription, pharmacists play a critical role in the reproductive health of a majority of American women. However, a string of reported incidents in recent years reflects an alarming trend: pharmacists, despite legal and professional obligations, are refusing to dispense prescription contraceptives because of their own moral and religious objections. Despite the established standard of care that places the patient as the focus of the pharmaceutical profession, four states have already passed “pharmacist refusal clauses,” laws or regulations that grant pharmacists the right to refuse to fill prescriptions based on personal beliefs. These laws explicitly allow pharmacists to circumvent their professional duties and protect pharmacists from adverse employment actions for doing so. In this note, the author argues that pharmacist refusal clauses fail to strike a proper balance between pharmacists’ rights to exercise their own conscience and patients’ rights to access legal prescriptions. Additionally, these regulations unreasonably expand the initial purpose of refusal laws, are sexually discriminatory, and violate pharmacists’ code of ethics. To address these problems, the author suggests that rather than enacting new pharmacist refusal clauses or adding transfer provisions to current laws, a variety of organizations—federal and state legislatures, state pharmacy boards, and the pharmaceutical community—must work together to adopt legislation and alternative policies that will balance the competing rights of pharmacists and patients, ultimately guaranteeing that women are never denied access to legally prescribed birth control.

* J.D. 2007, *summa cum laude*, University of Illinois College of Law; B.A. 2004, *summa cum laude*, University of Missouri-Columbia. I sincerely thank my family, and the University of Illinois College of Law faculty and staff, for their guidance and support throughout law school.

I. INTRODUCTION

In January 2006, dutifully obeying the written orders of his family physician, a married father of a newborn baby walked into a local drugstore to purchase a package of condoms. However, when he approached the counter to pay, the only pharmacist on duty refused to sell him the condoms. In addition, the pharmacist refused to inform the stunned father of the nearest drugstore where condoms were available, effectively jeopardizing the father's ability to obtain his prescribed birth control in a convenient or timely manner.

Men—married and single—can breathe a sigh of relief because, in reality, the above scenario never happened, and probably never will. As Representative Debbie Wasserman-Schultz has remarked, “[I]f pharmacists were refusing to sell men condoms this issue would have already been addressed by Congress.”¹ However, a similar confrontation did occur between a pharmacist and a female customer in northern California in the context of a prescription for emergency contraception,² which is representative of a string of reported incidents from at least nineteen different states that reflect an alarming and persistent trend: pharmacists, despite legal and professional obligations, are refusing to fill birth control prescriptions because of their own moral and religious objections.³ Engaging the pharmacy as a modern front for the national battle over reproductive rights, some pharmacists are not only refusing to dispense prescription contraceptives, but they are also taking the opportunity to dispense their own advice by lecturing and even humiliating the prescription holder.⁴ In some of these cases, the pharmacists were fired or disciplined, but in others, no formal disciplinary actions were taken.⁵ As a re-

1. Press Release, Representative Debbie Wasserman Schultz, Birth Control: On 40th Anniversary of Supreme Court Decision, Some Women Have Seen Their Rights Vanish (June 7, 2005), available at http://www.house.gov/apps/list/press/fl20_schultz/prescription40thpresser.html.

2. The actual incident was reported by Kim Smith, a married mother of a newborn baby who attempted to fill a prescription for emergency contraception after experiencing a birth control failure with her husband. NARAL PRO-CHOICE AM. FOUND., GUARANTEE WOMEN'S ACCESS TO PRESCRIPTIONS 1 (2006), <http://www.prochoiceamerica.org/assets/files/Birth-Control-Pharmacy-Access.pdf> [hereinafter NARAL]. The pharmacist not only refused to fill the prescription, but also refused to transfer it, claiming: “If you and your ‘boyfriend’ were not so irresponsible, you would not have to be dealing with this.” *Id.* Encouragingly, when Smith subsequently filed a complaint against the pharmacist with the board of pharmacy, the board fined the pharmacist \$750 for violating California's new guaranteed access to prescriptions law, which requires pharmacies to fill all valid prescriptions in a timely manner. *Id.*

3. NAT'L WOMEN'S LAW CTR., PHARMACIST REFUSALS 101 (SEPTEMBER 2006 UPDATE), at 1 (2006), http://www.nwlc.org/pdf/PharmacyRefusals101_09.14.06.pdf [hereinafter REFUSALS 101]. These states are: Arizona, California, Georgia, Illinois, Louisiana, Massachusetts, Minnesota, Missouri, New Hampshire, New York, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Texas, Washington, West Virginia, and Wisconsin. *Id.* For more examples of reported incidents from these states, see *id.*

4. NARAL, *supra* note 2, at 1.

5. KOURTNEY STAMPS, NAT'L ORG. FOR WOMEN, PHARMACIST KNOWS BEST? WOMEN BEG TO DIFFER (2004), <http://www.now.org/issues/abortion/121704pharmacist.html>.

sult, women have left these pharmacies empty handed, unsure of their legal remedies.⁶

Pharmacy is a patient-focused profession, and women depend on pharmacists to assist them in complying with their doctors' orders.⁷ When a pharmacist is presented with a valid prescription for a legal medication by a patient aware of the risks of the medication and for whom the medication would be safe, the pharmacist has a professional duty to dispense that medication to avoid endangering that patient's health.⁸ Refusing to dispense a valid prescription, based on any grounds other than medical or scientific concerns, violates the standard of care expected of the pharmacy profession.⁹ Despite this established standard of care, four states have already passed laws or regulations that grant pharmacists (and sometimes other healthcare providers) the right to refuse to fill prescriptions based on religious or moral beliefs, explicitly allowing pharmacists to circumvent their professional duties and sometimes protecting pharmacists from adverse employment action for doing so.¹⁰ These "pharmacist refusal clauses"—referred to as "conscience clauses" by anti-choice advocates¹¹—not only fail to strike an appropriate balance between pharmacists' rights to exercise their own conscience and patients' rights to access legal prescriptions, but also impede women's abilities to access contraceptives, which can have devastating effects on women's reproductive health.¹² Despite these damaging consequences and public disapproval of pharmacist refusal clauses on the national level,¹³ twenty states introduced and considered similar laws in the 2006 legislative session.¹⁴

6. *Id.*

7. NARAL, *supra* note 2, at 4.

8. Donald W. Herbe, Note, *The Right to Refuse: A Call for Adequate Protection of a Pharmacist's Right to Refuse Facilitation of Abortion and Emergency Contraception*, 17 J.L. & HEALTH 77, 88 (2002).

9. JILL MORRISON, NAT'L WOMEN'S LAW CTR., DON'T TAKE 'NO' FOR AN ANSWER: A GUIDE TO PHARMACY REFUSAL LAWS, POLICIES AND PRACTICES 3 (2005), http://www.nwlc.org/pdf/8-2005_Don'tTakeNo.pdf.

10. REFUSALS 101, *supra* note 3, at 3. These states are Georgia, Arkansas, South Dakota, and Mississippi. *Id.* A more detailed examination of these laws is provided *infra* Part III.B.1.

11. STAMPS, *supra* note 5.

12. MORRISON, *supra* note 9, at 3. These consequences include unintended pregnancies and other physical health risks associated with pregnancies, including life endangerment for some women. *Id.*

13. A 2004 CBS News/New York Times poll revealed that eight in ten Americans believe that pharmacists who personally oppose birth control should not be allowed to refuse to sell oral contraceptives to women. REFUSALS 101, *supra* note 3, at 4. "This belief was strong despite party affiliation, with 85% of Democrat respondents and 70% of Republican respondents squarely opposed to pharmacist refusals." *Id.* Also, a 2002 report by the American Civil Liberties Union's Reproductive Freedom Project showed that 86% of Americans were "opposed to allowing pharmacists to refuse to fill prescriptions they object to on religious grounds." STAMPS, *supra* note 5. "Those polled especially objected to refusals that would interfere with a woman's access to reproductive health-care services . . ." *Id.*

14. REFUSALS 101, *supra* note 3, at 3. In the 2006 legislative session, Alabama, Georgia, Illinois, Indiana, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, and

This note will identify the harmful nature and inherent flaws of pharmacist refusal clauses and recommend alternative legislation and policies that would allow individual pharmacists to abide by their own moral beliefs, yet still ensure that patients receive the professional standard of pharmaceutical care and guarantee that women receive access to legally prescribed birth control without delay. Part II describes as background the significance of the right to birth control and the widespread use of contraceptives in the United States. A brief discussion of emergency contraceptives and the FDA's recent decision to make emergency contraception available as an over-the-counter option highlights a central issue in the controversy surrounding pharmacist refusal clauses. Part III analyzes the inherent flaws of pharmacist refusal clauses, including their unreasonable expansion of the original purpose of refusal laws and their failure to adhere to the professional guidance and ethical code of the American Pharmacy Association. Part III also reveals the sexually discriminatory nature of pharmacist refusal clauses and rejects the addition of transfer provisions as an adequate compromise between the competing rights involved. Finally, Part IV advocates the adoption of "duty to dispense" legislation and recommends the implementation of stricter regulations by state pharmacy boards, the adoption of collaborative practice agreements, and the development of new procedures and policies within the pharmaceutical community to achieve a better balance between pharmacists' and patients' rights and ultimately guarantee women timely access to prescription contraceptives.

II. BACKGROUND

Pharmacist refusal clauses fail to appropriately balance the rights of pharmacists and patients, specifically the rights of female patients. An understanding of the constitutional right to access birth control, the prevalent use of contraceptives by American women, and the controversy surrounding emergency contraception is helpful to appreciate these competing rights.

A. *Constitutional Right to Birth Control*

The U.S. Supreme Court grants a woman's right to choose to use birth control "the highest level of constitutional protection."¹⁵ June 7, 2005, marked the 40th anniversary of the landmark Supreme Court decision *Griswold v. Connecticut*, in which the Court struck down a Con-

Wisconsin considered forty-three bills that would give either pharmacists, pharmacies, or both the right to refuse to dispense any prescription, or at minimum prescriptions for contraception, and in some cases, to refuse to transfer the prescription as well. *Id.*

15. Holly Teliska, Recent Development, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 232 (2005).

necticut law prohibiting the use of contraceptives.¹⁶ Recognizing a constitutional right to privacy implicit within the meaning of the Bill of Rights, the Court held that this fundamental right encompassed a married couple's right to privacy when making family planning decisions, including the decision to choose to use birth control without the government interfering with that choice.¹⁷ Seven years later, in *Eisenstadt v. Baird*, the Court expanded this right of access to birth control, affirming that all women, married or single, have a right to privacy, including the right to obtain contraceptive services free from governmental interference.¹⁸ Many argue that *Griswold* and its progeny gave women more than just a right to use birth control.¹⁹ In addition to protecting a woman's right to plan her pregnancies in the privacy of her home, these Supreme Court decisions represented significant steps towards truly equal healthcare rights for women: "Perhaps more than any other ruling, *Griswold* gave American women the ability to participate as equal partners in our society."²⁰

B. *The Widespread Use of Contraceptives in the United States*

Since *Griswold*, birth control has served many important functions in the lives and relationships of American women. In the United States, an overwhelming majority of women use and rely on birth control as an essential component of their basic healthcare regimen.²¹ The statistics are oft cited, yet are well worth repeating. Virtually all women (ninety-eight percent) in their childbearing years (fifteen to forty-four) who have ever had intercourse have used at least one form of contraception.²² The average woman in the United States wants only two children and will therefore spend five years of her life pregnant or trying to become preg-

16. See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

17. *Id.* at 485 ("The present case . . . concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand . . ."); see also *id.* at 487 (Goldberg, J., concurring) (emphasizing the relevance of the Ninth Amendment to the constitutional right of privacy).

18. See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972). The *Baird* majority opinion quoted the First Circuit's opinion, which provided that when the government denies access to birth control to anyone, married or single, on moral grounds alone, it is an interference with fundamental human rights:

To say that contraceptives are immoral as such, and are to be forbidden to unmarried persons who will nevertheless persist in having intercourse, means that such persons must risk for themselves an unwanted pregnancy, for the child, illegitimacy, and for society, a possible obligation of support. Such a view of morality . . . conflicts with fundamental human rights.

Id. at 452-53.

19. Press Release, Representative Debbie Wasserman Schultz, *supra* note 1.

20. *Id.* (quoting Karen Pearl, interim President, Planned Parenthood Federation of America).

21. See THE ALAN GUTTMACHER INST., FACTS IN BRIEF: CONTRACEPTIVE USE 1 (2006), http://www.guttmacher.org/pubs/fb_contr_use.pdf.

22. *Id.*

nant and roughly three decades trying to avoid pregnancy.²³ Currently, there are approximately forty-three million women of reproductive age who are sexually active and trying to avoid pregnancy.²⁴ Of those women who practice contraception, sixty-four percent use reversible methods of avoiding pregnancy, such as oral contraceptives or condoms.²⁵ Specifically, women in their teens and twenties, never-married women, and women with at least a college degree rely predominantly on oral contraceptives.²⁶

Timely access to contraception is not only essential to prevent unwanted pregnancies, but is a valuable tool to control the timing and spacing of desired pregnancies as well.²⁷ If the average woman did not have access to contraception, she could have between twelve and fifteen pregnancies in her lifetime.²⁸ Pregnancies carry heavy financial and physical burdens, and, for some women, entail serious health risks that can endanger the lives of both the mother and the child.²⁹ Furthermore, some women rely on oral contraceptives for a range of medical and physical reasons beyond birth control, including amenorrhea, dysmenorrhea, and endometriosis.³⁰ Oral contraceptives simply are, for various reasons, a basic health necessity for many American women. Access to oral contraceptives depends on prescriptions that are filled by pharmacists, so it naturally follows that pharmacists play a critical role in the quality of the reproductive healthcare that women receive in the United States.³¹

C. *Emergency Contraception*

To a large extent, the debate surrounding pharmacists' right to refuse to fill prescriptions focuses on the dispensation of emergency contraception.³² An explanation of the difference between oral contraceptives and emergency contraception, a discussion of the competing

23. *Id.*; NARAL, *supra* note 2, at 5.

24. THE ALAN GUTTMACHER INST., *supra* note 21, at 1.

25. *Id.*

26. *Id.*

27. MORRISON, *supra* note 9, at 3.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.* (“[T]he health care system . . . depends on pharmacists to help patients comply with doctors’ orders.”).

32. See, e.g., Kelsey C. Brodsho, Recent Developments, *Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses*, 7 MINN. J.L. SCI. & TECH. 327, 332 (2005) (“[R]ecent media attention regarding emergency contraception has fueled public debate regarding the role of the pharmacist.”); Herbe, *supra* note 8 (discussing the tension between moral beliefs regarding abortion and emergency contraception and professional duties to illustrate the need for pharmacist refusal clauses); Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs*, GUTTMACHER REP. ON PUB. POL’Y, Aug. 2005, at 1–2, <http://guttmacher.org/pubs/tgr/07/3/gr070301.pdf> (“The growing use of emergency contraception has helped bolster a movement to give pharmacists the right to refuse to fill prescriptions, for this drug and for others.”).

theories of when human life begins, and a brief look at the impact of the FDA's recent decision to make emergency contraception available as an over-the-counter option are necessary to understand this central issue of the debate.

1. *Distinguishing Oral and Emergency Contraception*

Ordinary oral contraceptives, commonly known as "the pill," are contraceptives composed of one or both female hormones called oestrogen and progesterone.³³ When taken on a regular (daily) basis, the pill works in various ways to prevent ovulation and therefore avoid pregnancy,³⁴ or to effectively treat various other medical conditions.³⁵ Emergency contraception (EC), sometimes referred to as the "morning-after pill," is simply a highly concentrated dose of the hormones contained in ordinary birth control.³⁶ EC is prescribed postintercourse to accomplish the same purpose as ordinary contraceptives—to avoid pregnancy.³⁷ Taken after intercourse, EC reduces a woman's chance of experiencing an unintended pregnancy by up to eighty-nine percent.³⁸ It is estimated that the use of EC could prevent approximately 1.7 million unintended pregnancies and eight hundred thousand abortions each year.³⁹

EC has actually "been available and used by American women" throughout the last twenty years.⁴⁰ During this time, oral contraceptives were basically repackaged in higher dosages, labeled for use as emergency contraception, and distributed "primarily in hospital emergency rooms, reproductive health clinics, and university health centers."⁴¹ In 1998 and 1999, the Food and Drug Administration (FDA) approved two specific EC regimes, Preven and Plan B, deeming these regimes "safe and effective emergency contraceptives, to be packaged and marketed as such."⁴²

33. PHARMACISTS FOR LIFE INT'L, ABORTIFACIENT FAQs: "ORAL CONTRACEPTIVES" FAQs: A PILL YOU MIGHT NOT WANT TO SWALLOW 1 (2005), http://www.pfli.org/faq_oc.html [hereinafter ABORTIFACIENT FAQs].

34. *Id.*

35. *See supra* text describing medical conditions accompanying note 30.

36. A.D.A.M. Healthcare Center, Emergency Contraception, <http://adam.about.com/encyclopedia/007014.htm> (last visited Mar. 28, 2007). Approximately two to five "regular" birth control pills taken together equal a single dose of emergency contraception. *Id.*

37. Herbe, *supra* note 8, at 79.

38. Press Release, NARAL Pro-Choice America, Food and Drug Administration Ends Political Posturing, Allows Over-the-Counter Access to "Morning-After" Pill (Aug. 24, 2006), http://www.prochoiceamerica.org/news/press-release/2006/pr08242006_fda_planb.html.

39. PLANNED PARENTHOOD, EC OVER THE COUNTER, <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-prevention/ec-otc-6698.htm>.

40. Herbe, *supra* note 8, at 80.

41. *Id.* (quoting AM. PHARM. ASS'N, SPECIAL REPORT, EMERGENCY CONTRACEPTION: THE PHARMACIST'S ROLE 1 (2000)).

42. *Id.*

The physical effects of EC are not controverted.⁴³ EC prevents the development of pregnancy by inhibiting one of four biological events pre- or postfertilization: “EC works before fertilization by either suppressing ovulation . . . or preventing fertilization . . . by inhibiting the movement of the sperm or the egg,” or after fertilization by disrupting the “transport of the fertilized egg to the uterus or, if transport through the fallopian tube is complete, prevent[ing] implantation of the fertilized egg in the . . . uterus.”⁴⁴ EC is extremely time-sensitive and is most effective when used within twelve to twenty-four hours after unprotected sex, birth control failure, or rape.⁴⁵ Although EC can be effective if taken within five days of unprotected sex, EC is more likely to prevent pregnancy the sooner it is taken.⁴⁶ If EC is taken after implantation occurs, typically six to seven days after intercourse, EC is entirely ineffective.⁴⁷

2. *The Heart of the Debate: When Does Human Life Begin?*

The core of the moral debate surrounding EC consists of conflicting views about when human life actually begins: does life begin at implantation or fertilization?⁴⁸ The answer to this question affects one’s opinion on whether EC actually causes an abortion.⁴⁹ On one side of the dispute is the medical and scientific consensus that conception occurs and life begins at the moment of the implantation of a fertilized egg in the woman’s uterus.⁵⁰ However, EC only works to prevent the implantation of an egg, rather than destroying an egg that is already implanted.⁵¹ Thus, EC is merely a form of birth control and cannot *cause* an abortion because human life has not begun.

On the opposite side of the debate is the belief that conception occurs and human life actually begins at the moment of fertilization.⁵² Accordingly, because EC has the potential to destroy a fertilized egg, it ef-

43. Herbe, *supra* note 8, at 79.

44. *Id.* at 79–80. It is important to distinguish EC from the drug mifepristone, formerly known as RU-486, which the FDA has approved for use as an early pregnancy abortifacient. *Id.* at 79. Mifepristone induces a spontaneous abortion by working to “destroy an [already] implanted egg [in the uterus], as opposed to a fertilized yet not implanted egg, [which] is what distinguishes it from emergency contraception.” *Id.*

45. MORRISON, *supra* note 9, at 3. Access to EC is especially critical for rape and sexual assault victims. It is estimated that twenty-two thousand out of the twenty-five thousand annual pregnancies caused as a result of rape could be avoided if sexual assault victims were provided with timely access to EC. NARAL, *supra* note 2, at 3. Additionally, a 2002 study revealed that EC use was likely responsible for up to forty-three percent of the decline in the number of abortions in the United States between 1994 and 2000. Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 294, 300 (2002).

46. NARAL, *supra* note 2, at 1.

47. Herbe, *supra* note 8, at 80.

48. *Id.* at 85.

49. *Id.*

50. *Id.* at 86. This is the official position of the American Medical Association and is consistent with various medical dictionary definitions of conception. *Id.*

51. *Id.* at 85.

52. *Id.* at 86.

fectively terminates a human life and is believed to be an early form of abortion.⁵³ Although this belief is predominantly advocated by the Roman Catholic Church, the Church's views on when life begins resonate with the beliefs of many Americans, Catholic or otherwise.⁵⁴ For example, Pharmacist for Life International (PFLI) is a professional organization of pharmacists that has taken the definitive stance that life occurs at fertilization, from the moment the egg unites with the sperm.⁵⁵ According to PFLI, this theory is supported by the following reasoning: when a human egg and a human sperm unite, they form a cluster of cells that can only be called human.⁵⁶ From this point on, this cluster of cells only receives three additional things from its mother—a place to live, food, and oxygen—none of which could be argued to magically convert a nonhuman to a human.⁵⁷ Therefore, life begins at the moment of fertilization when this “human” cluster of cells is formed, and because EC can destroy this cluster, EC is actually an abortifacient.⁵⁸

For many pharmacists, this point of view is questionable, and we may never reach clear consensus on the exact moment when life begins. But what is clear is that the pharmacy profession is composed of qualified professionals on both sides of the EC debate who cannot be expected to agree on or hold the same viewpoint.⁵⁹ If a pharmacist strongly believes that by dispensing EC she is passively supporting abortion or destroying human life, that pharmacist faces the dilemma of choosing between her conscience and her responsibility to her patients, and some pharmacists will ultimately conclude that moral beliefs should override professional obligations.⁶⁰ Protection of the right of a pharmacist, as an autonomous individual, to exercise her conscience is a legitimate objective.⁶¹

53. *Id.* at 85.

54. *Id.* at 87. This position is the official teaching of the Roman Catholic Church; however, it is also claimed to be confirmed by scientific evidence from modern genetics. *Id.* at 86.

55. ABORTIFACIENT FAQs, *supra* note 33, at 1. Not surprisingly, PFLI, composed of more than sixteen thousand pharmacists and their supporters, adamantly defends pharmacist refusal clauses, stating that pharmacists can “refuse to cooperate knowingly with the evils of contraception, abortion, euthanasia and assisted suicide, among others, in violation of their sincerely held religious moral or ethical beliefs.” STAMPS, *supra* note 5. According to PFLI, it is not an inconvenience to refuse to refer a patient to another pharmacist because “the pharmacist is doing the woman and her preborn child a favor in terms of physical and spiritual health.” *Id.*

56. ABORTIFACIENT FAQs, *supra* note 33, at 1.

57. *Id.*

58. *Id.* PFLI also takes the radical stance that oral contraceptives, even in their regular doses, are also abortifacients. *Id.*

59. Letter from Michael Patton, Executive Dir., Ill. Pharmacists Ass'n, John A. Gans, Pharm.D., Executive Vice President, Am. Pharmacists Ass'n, and Henri R. Manasse, Jr., Ph.D., Sc.D., Executive Vice President and Chief Operating Officer, Am. Soc. of Health-System Pharmacists, to Rod R. Blagojevich, Governor, State of Illinois (Apr. 5, 2005), available at http://www.aphanet.org/AM/Template.cfm?Section=Search&Section=Practice_Workforct&Template=/CM/ContentDisplay.cfm&ContentFileID=468.

60. Herbe, *supra* note 8, at 87.

61. See generally *id.* Herbe actually argues for the enactment of pharmacist refusal clauses even more protective of pharmacists' right to refuse than current pharmacist refusal clauses. *Id.* at 100.

3. *EC: Over-the-Counter Status*

Originally, the FDA classified both emergency contraception plans Preven and Plan B as prescription drugs.⁶² In April 2003, Women's Capital Corporation, the initial marketer of Plan B, submitted the first application to the FDA for EC to receive over-the-counter (OTC) status.⁶³ "In February 2004, Barr Laboratories acquired Plan B and continued to support the OTC application."⁶⁴ The American Medical Association and various other medical groups also supported this application, lobbying the FDA and insisting that, "[e]mergency contraception is safer than aspirin, meets all of the FDA's requirements for over-the-counter status, and is up to 95 percent effective if used within the first 24 hours after unprotected sex."⁶⁵ The FDA delayed its decision on whether to grant OTC status to EC several times, partly due to opposition from the Bush administration.⁶⁶ Finally, on August 24, 2006, the FDA approved Plan B for OTC sales, albeit only for women eighteen and older, who must show proof of age before purchasing Plan B.⁶⁷

The FDA's decision, however, represents only a partial victory for pro-choice advocates. Despite scientific evidence that the drug is just as safe for use by women under eighteen, the FDA's decision leaves women under eighteen subject to the ordinary difficulties of obtaining a prescription and vulnerable to the possibility of a pharmacist refusing to fill that prescription.⁶⁸ Additionally, there are indications that some states may attempt to require that all women must have prescriptions to obtain EC.⁶⁹ Therefore, even after the FDA's decision, the debate over EC and

Although this note does not agree with Herbe's ultimate conclusion, his arguments in favor of protecting the interests of pharmacists are still important to consider and relevant to finding an adequate alternative solution that balances all competing interests involved.

62. *Id.* at 80.

63. PHARMACY ACCESS P'SHIP, EC OVER-THE-COUNTER (OTC) STATUS (2007), <http://www.pharmacyaccess.org/ECOTCStatus.htm>.

64. *Id.*

65. FEMINIST DAILY NEWS WIRE, FDA DELAYS DECISION ON EMERGENCY CONTRACEPTION (2005), <http://feminist.org/news/newsbyte/uswirestory.asp?id=9237>. As one commentator noted:

[W]hether a drug should be reclassified from prescription-only to OTC status centers around the second prong of the definition of prescription drugs in 21 U.S.C. § 353(b)(1), which provides that "[a] drug intended for use by man which . . . because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug."

Heather M. Field, *Increasing Access to Emergency Contraceptive Pills Through State Law Enabled Dependent Pharmacist Prescribers*, 11 UCLA WOMEN'S L.J. 141, 192-93 (2000). Drugs that do not implicate these safety concerns do not have to be classified as prescription-only. *Id.*

66. *See, e.g.*, Herbe, *supra* note 8, at 82.

67. Press Release, U.S. FDA, FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older; Prescription Remains Required for Those 17 and Under (Aug. 24, 2006), <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html>.

68. NAT'L WOMEN'S LAW CTR., PHARMACY ACCESS TO EMERGENCY CONTRACEPTION 1 (2006), http://www.nwlc.org/pdf/FSDirectAccess_08.24.06.pdf [hereinafter PHARMACY ACCESS].

69. *Id.* In Michigan and Missouri, bills were introduced (even before the FDA granted OTC status to EC for women eighteen and older) to prohibit the distribution of emergency contraception without a prescription. *Id.* at n.5.

when human life begins remains an important aspect of the debate surrounding pharmacists' right to refuse to dispense prescription contraceptives.

III. ANALYSIS

Pharmacist refusal clauses allow pharmacists with moral objections to oral or emergency contraception to refuse to fill a prescription on the sole basis of their personal beliefs. However, an analysis of pharmacist refusal clauses reveals several inherent flaws. First, pharmacist refusal clauses unreasonably expand the original purpose of refusal clauses. Additionally, state pharmacist refusal clauses, as enacted, fail to adhere to the professional guidelines and ethical code set forth by the American Pharmacist Association. Finally, these clauses are sexually discriminatory, and the addition of transfer provisions is not an adequate solution. All of these factors contribute to the failure of pharmacist refusal clauses to strike the correct balance between the competing rights of pharmacists and patients.

A. *Expansion of the Original Purpose of Refusal Laws*

Healthcare professionals have been familiar with refusal clauses for quite some time, but not always in the context of birth control.⁷⁰ Refusal clauses were first introduced as a response to the Supreme Court's 1973 historic decision in *Roe v. Wade*, which legalized abortion nationwide.⁷¹ In the aftermath of *Roe*, Congress passed the Church Amendment, which allowed healthcare providers to refuse to provide abortion or sterilization based on religious beliefs.⁷² Within five years, most states had enacted similar laws.⁷³

Initially, these clauses applied to abortion services only, and in the majority of states, this is still true.⁷⁴ However, over the years, some states have gradually expanded the scope of refusal clauses to encompass the right to refuse access to assistive reproductive technologies, human embryonic or fetal research, in vitro fertilization, stem cell research, and contraceptives.⁷⁵ Now, some refusal clauses are broadly written to protect a wide variety of healthcare providers, including physicians, nurses, hospitals, clinics, universities, insurance companies, and most recently, pharmacists.⁷⁶ Additionally, these laws have expanded the list of specific

70. PLANNED PARENTHOOD, *supra* note 39, at 3.

71. *Id.*; see *Roe v. Wade*, 410 U.S. 113 (1973).

72. PLANNED PARENTHOOD, *supra* note 39, at 3.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

justifications a provider can use to refuse a service, ranging from particular religious beliefs to broader personal conscience or moral values.⁷⁷

Refusal clauses that permit pharmacists to refuse to dispense contraceptives based on moral beliefs unreasonably expand the initial purpose of refusal clauses, which was to allow doctors or nurses who actually performed abortion procedures to refuse to perform these services if they had a religious objection or thought the procedure was physically harmful to the mother or child.⁷⁸ Doctors, nurses, and pharmacists are a chain of providers that implement treatment plans for patients, and the assigned role of pharmacists is to provide the link between the doctors (or nurses) and the patients.⁷⁹ As this link, the pharmacist's duty is to *effectuate* treatment, which cannot be characterized in the same way as the doctor's duty to *initiate* treatment.⁸⁰ Unlike doctors or nurses, pharmacists do not select treatments or perform procedures; rather, their purpose is to *assist* individuals to make use of their medications.⁸¹ Without direct involvement in the selection of treatment, pharmacist refusal clauses are unnecessary to ensure that the treatment will not be harmful to the patient (the initial purpose of refusal clauses) because another healthcare professional has already determined that the patient's health will not be compromised by the contraceptives prescribed.⁸²

B. Professional Guidance from the American Pharmacist Association

1. APhA's "Pharmacist Conscience Clause"

The American Pharmacist Association (APhA) is the largest professional association of pharmacists in the United States.⁸³ APhA's mission is to provide information, education, and advocacy to help pharmacists work together to improve medication use and advance patient care.⁸⁴ State law governs the practice of pharmacy and sets forth regula-

77. *Id.*

78. MORRISON, *supra* note 9, at 3. Courts have not decided whether refusal clauses that applied only to abortion could possibly protect pharmacists who refuse to dispense birth control. *Id.* at 10. One case is pending in Ohio: Karen Brauer, president of PFLI, was fired from Kmart for refusing to dispense emergency contraception. Brauer claimed she was protected by a state conscience clause for abortion, and while the merits of her claims were not decided, the court could not rule out application of this clause. *Id.* The court concluded this clause could conceivably encompass "drugs which may currently be available . . . that could be prescribed and ingested with the intent to produce an abortion." *Id.* The court held that for purposes of her claim, it was Brauer's *subjective* belief that emergency contraception caused what she *believed* to be an abortion. *Id.* at 10. This is significant in light of the controversy surrounding emergency contraception and when human life begins. See *supra* Part II.C.2. The case was delayed due to Kmart's bankruptcy proceedings. MORRISON, *supra* note 9, at 10.

79. Brodsho, *supra* note 32.

80. *Id.*

81. MORRISON, *supra* note 9, at 3 ("While pharmacists are an important part of the delivery of health care, as the Preamble of the Code of Ethics for the American Pharmacists Association states, '[p]harmacists are health professionals who *assist* individuals in making the best use of medications.'").

82. See *id.*

83. American Pharmacists Association, About APhA, <http://www.aphanet.org>.

84. *Id.*

tions concerning pharmacies and pharmacists' rights and obligations.⁸⁵ Therefore, the recommendations of APhA are not binding as law.⁸⁶ However, APhA's adopted codes and policies are intended to provide guidance for acceptable standards of care and obligations for pharmacy professionals.⁸⁷ This type of guidance is often considered by state legislatures and state pharmacy boards when enacting pharmacy laws and regulations that do have legal effect.⁸⁸

APhA first issued guidance regarding pharmacist refusal clauses in 1998, when the APhA House of Delegates adopted a resolution titled "Pharmacist Conscience Clause."⁸⁹ The Pharmacist Conscience Clause provides: "APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."⁹⁰ The resolution was accompanied by an APhA Policy Committee Report (Committee Report), which describes the issues debated between members before adopting the Pharmacist Conscience Clause and attempts to explain the proper applicability of the resolution.⁹¹

A close review of the Committee Report reveals that APhA, through its Pharmacist Conscience Clause, intended to advocate the establishment of systems that, if correctly implemented, require neither the pharmacist nor the patient to abide by the other's beliefs.⁹² According to APhA staff counsel, a pharmacy's system is only effective when "it is seamless to the patient, and the patient is not aware that the pharmacist is stepping away from the situation. . . . [T]he patient gets the medication, and the pharmacist steps away from that activity—with no intersection between the two."⁹³

Unfortunately, the broad language "establishment of systems" provides little guidance as to the specific details and systems legislatures or pharmacies should use to reach this desired result.⁹⁴ The Pharmacist Conscience Clause has been interpreted to require, at a minimum, that a pharmacist must transfer a prescription that she refuses to fill on moral grounds to another pharmacist on duty, or to another pharmacy in the area if no other pharmacist is available.⁹⁵ However, APhA has clarified

85. MORRISON, *supra* note 9, at 4.

86. *Id.* at 8.

87. *Id.*

88. *Id.*

89. Teliska, *supra* note 15, at 237.

90. APhA 2004 HOUSE OF DELEGATES, REPORT OF THE POLICY REVIEW COMMITTEE 10 (2004) (retaining 1998 policy).

91. Teliska, *supra* note 15, at 237–38.

92. *Id.*

93. MORRISON, *supra* note 9, at 8 (quoting American Pharmacists Association, APhA Responds to Media Coverage (Aug. 5, 2005), <http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2689>).

94. Teliska, *supra* note 15, at 238.

95. MORRISON, *supra* note 9, at 8.

that this is just one possible interpretation, and in fact, several other methods exist that better serve both pharmacists' right to conscientious refusal and patients' best interests.⁹⁶ On the whole, APhA encourages regulations and laws that obtain the appropriate balance between respecting an individual pharmacist's right to exercise her conscience, yet still seeking to put patients' needs as a pharmacy's first priority.⁹⁷

Unfortunately, pharmacist refusal clauses, as enacted, entirely fail to attempt or achieve this desired result. Currently, South Dakota, Arkansas, Mississippi, and Georgia have pharmacist refusal laws that explicitly grant either pharmacists, pharmacies, or both, a broad right to exercise conscientious refusal.⁹⁸ A brief overview of these laws reveals several disturbing similarities.

The first so-called pharmacist refusal clause was passed in South Dakota in 1998 (ironically in the same year APhA introduced its Pharmacist Conscience Clause).⁹⁹ The South Dakota law allows pharmacists to refuse to fill prescriptions for any drug that the pharmacist *believes* could cause an abortion or destroy an unborn child.¹⁰⁰ Because "unborn child" is defined under South Dakota law to include a fertilized egg not yet implanted in the uterus, prescriptions for both oral and emergency contraception can be refused under this law, based solely on pharmacists' personal beliefs.¹⁰¹ The law is silent regarding patients' remedies if a pharmacist does refuse to fill a prescription, and the law does not require advance notice to patients that pharmacists have the option to refuse to fill a prescription.¹⁰² Under the South Dakota law, pharmacists do not even have the minimum duty to refer or transfer the patient to another pharmacist or pharmacy, much less ensure that the patient ultimately receives access to the refused prescription.¹⁰³

The Arkansas law, passed in 1973, allows pharmacists to refuse to provide contraceptive procedures, supplies, or information on the basis of religious or conscientious objection.¹⁰⁴ Since its passage, the Arkansas

96. Letter from John A. Gans, Pharm. D., Executive Vice President, Am. Pharmacists Ass'n, to James Oliphant, Editor in Chief, *Legal Times* (Aug. 22, 2005), <http://www.aphanet.org/AM/Template.cfm?Section=Search&Section=August6&template=/CM/ContentDisplay.cfm&ContentFileID=679>.

97. *Id.*

98. REFUSALS 101, *supra* note 3, at 3.

99. Teliska, *supra* note 15, at 241.

100. S.D. CODIFIED LAWS § 36-11-70 (2006) ("No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to: (1) Cause an abortion; or (2) Destroy an unborn child as defined in subdivision 22-1-2(50A); or (3) Cause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.").

101. *Id.* § 22-1-2(50A) ("Unborn child," an individual organism of the species homo sapiens from fertilization until live birth"); Teliska, *supra* note 14, at 241.

102. *Id.* § 36-11-70.

103. *Id.* The statute specifically provides: "No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist." *Id.*

104. ARK. CODE ANN. § 20-16-304(4)-(5) (West 2006). The law reads:

legislature appears to have ignored the subsequent guidance provided by APhA, because the law has not been amended to impose any duty on the pharmacist or pharmacy to refer or transfer contraception prescriptions that are refused, nor to establish any other alternative methods for guaranteeing patients access to their prescriptions.¹⁰⁵ The law affirmatively protects pharmacists and pharmacies from liability for refusing to fill prescriptions for contraceptives, so women in Arkansas have no legal recourse if they are ultimately harmed by a pharmacist's refusal.¹⁰⁶

Georgia's law is actually a regulation, passed in 2001, and is broader than the South Dakota and Arkansas laws in that it allows pharmacists to refuse to fill any prescription at all based on personal beliefs, specifically stating that it is "not unprofessional conduct" to do so.¹⁰⁷ But similar to the laws in South Dakota and Arkansas, there is no duty to provide notification of this right to potentially affected patients and no duty to refer or transfer the refused prescriptions.¹⁰⁸

In 2004, the Mississippi legislature passed The Mississippi Health Care Rights of Conscience Act (the Act), campaigned for and praised by Mississippi Governor Haley Barbour as the "single most expansive conscience exception law in the nation."¹⁰⁹ The Act broadly allows any person, including pharmacists, who furnishes or assists in furnishing health-care procedures, to refuse to participate in any healthcare service they oppose on moral, ethical, or religious grounds without incurring any liability for doing so.¹¹⁰ The Act also prohibits many of the alternative actions employers could potentially take to guarantee patients' access to legal prescriptions, including a prohibition against reassigning workers to different shifts based on their beliefs.¹¹¹

Furthermore, although the Act prevents pharmacists from discriminating based on specific patient characteristics such as race, ethnicity, or religion, the list of protected characteristics does not include marital

(4) Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information; and (5) No private institution or physician, nor any agent or employee of such institution or physician, nor any employee of a public institution acting under directions of a physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or physician shall be held liable for the refusal.

Id.

105. *Id.* § 20-16-304.

106. *Id.*

107. GA. COMP. R. & REGS. 480-5-.03(n) (2006) ("It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or oral beliefs."); NAT'L WOMEN'S LAW CTR., LAWS AND BILLS GOVERNING PHARMACIST REFUSALS—MAP OF THE UNITED STATES 2 (2006), <http://www.nwlc.org/pdf/NWLPharmacyRefusalsMapJuly2006.pdf> [hereinafter LAWS AND BILLS].

108. LAWS AND BILLS, *supra* note 107, at 2.

109. Ronald L. Scott, *Health Care Providers' Right to Refuse to Treat Patients*, U. HOUSE HEALTH L. PERSP., Apr. 27, 2005, at 3, available at <http://www.law.uh.edu/healthlaw/perspectives/april2005/HCPRighttoRefusetotreatPatients.pdf>.

110. The Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. § 41-107-5 (2005).

111. Sonfield, *supra* note 32, at 3.

status, implying that a pharmacist could refuse to fill a single woman's birth control prescription simply because the pharmacist did not believe in sex outside of marriage.¹¹² Not surprisingly, the Mississippi legislature also paid little attention to APhA's recommendations, as the Act does not require pharmacists to refer or transfer refused prescriptions, nor must pharmacists provide any information about other ways a patient may be able to access the prescription.¹¹³ Effectively, the Mississippi law appears to assert that patients have no enforceable right to access basic reproductive healthcare, or, even more disturbingly, that female reproductive healthcare is not really "health care" at all.¹¹⁴

The South Dakota, Arkansas, Georgia, and Mississippi refusal laws make no reference to the needs of the patient, place no affirmative duty on the refusing pharmacist or pharmacy to ensure that patients receive timely access to legal prescriptions, and provide no legal remedies when a woman is denied access to birth control. These laws are proof that state pharmacist refusal clauses, which do nothing more than protect pharmacists' right to refuse, fail to accomplish the fair and seamless result advocated by the APhA's Pharmacist Conscience Clause.

2. *APhA's Code of Ethics*

APhA's widely accepted professional standard of care was first established in 1994, when APhA created and adopted a Code of Ethics (the Code) that is intended to guide pharmacists in their relationships and responsibilities to patients, other healthcare professionals, and society.¹¹⁵ Legislatures and private pharmacies are not bound by the Code, and there are no means of legal enforcement.¹¹⁶ However, similar to the Pharmacist Conscience Clause, the Code is often used as guidance by state pharmacy boards, which develop binding regulations for state-licensed pharmacists to follow.¹¹⁷

The Code is another useful illustration of why pharmacy refusal clauses violate the acceptable standard of care expected of pharmacists. The Code contains eight principles of appropriate pharmaceutical behavior, with one consistent theme: the primary focus of the profession is the patient.¹¹⁸ The first principle of the Code describes the pharmacist-patient relationship as a "covenant" in which the pharmacist has a

112. *Id.* at 3.

113. Teliska, *supra* note 15, at 244; *see also* The Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. § 41-107-5.

114. Sonfield, *supra* note 32, at 2-3.

115. AM. PHARMACISTS ASS'N, CODE OF ETHICS (2004), <http://www.aphanet.org/Am/Template.cfm?Section=Search&template=ICM/HTMLDisplay.cfm&ContentID=2809> [hereinafter CODE OF ETHICS].

116. Teliska, *supra* note 15, at 236.

117. In fact, at least one state board, South Carolina, has codified the Code of Ethics, giving it the force of law. S.C. CODE ANN. § 40-43-86 (2005); MORRISON, *supra* note 9, at 6.

118. *See* CODE OF ETHICS, *supra* note 115.

“moral obligation” to the patient and promises to help individuals “achieve optimum benefit from their medications.”¹¹⁹ The second principle highlights the importance of focusing on the patient’s needs, stating that a pharmacist “places concern for the well-being of the patient at the center of the professional practice.”¹²⁰

The third and fourth principles address the responsibility of pharmacists to avoid discrimination in the administration of their duties. The third principle states that pharmacists have a duty to “respect[] personal and cultural differences among patients.”¹²¹ The fourth principle affirms this responsibility by providing that a pharmacist should “avoid[] discriminatory practices . . . that impair professional judgment, and actions that compromise dedication to the best interests of patients.”¹²² The seventh principle summarizes the underlying motivation of each principle of the Code, stating: “The primary obligation of a pharmacist is to individual patients.”¹²³

Pharmacist refusal clauses violate almost every principle of this Code. The first and second principles indicate that pharmacists have a moral obligation to put the needs of the patients first and at the center of their practice. This would seem to prohibit pharmacists from allowing their personal beliefs to interfere with these needs, yet this is permitted by pharmacist refusal clauses nevertheless.¹²⁴ Pharmacist refusal clauses also allow pharmacists to subordinate women’s health needs to their own personal beliefs, which violates the third and fourth principles because this compromises pharmacists’ dedication to their patients and disrespects and discriminates against patients’ personal beliefs.¹²⁵ Finally, under these refusal clauses a pharmacist’s primary obligation is to her own moral beliefs, rather than to individual patients, in violation of the concept of the entire Code as summarized in the seventh principle.¹²⁶

Regardless of an individual pharmacist’s personal beliefs, the pharmacy profession’s main ethical responsibility is to guarantee patients access to lawfully prescribed medication.¹²⁷ Pharmacist refusal clauses, such as the laws in South Dakota, Arkansas, Georgia, and Mississippi, which protect pharmacists’ personal beliefs at the expense of compromising patients’ access to legal prescriptions, violate the accepted pharmaceutical standard of care and ethical code by removing patients from the focus of the pharmacy profession.

119. *Id.*

120. *Id.* § II.A.

121. *Id.* § III.A.

122. *Id.* § IV.A.

123. *Id.* § VII.A.

124. *See* Teliska, *supra* note 15, at 236–39.

125. *See id.* at 237.

126. *See id.* at 238–39.

127. *See* MORRISON, *supra* note 9, at 3.

C. *Sex Discrimination*

APhA's Code of Ethics amplifies the widely recognized, fundamental principle that discrimination in professional practices is unacceptable.¹²⁸ Pharmacist refusal clauses are sexually discriminatory for several reasons. First, only prescriptions for oral or emergency contraception, prescriptions used solely by women and usually sought at the pharmacy only by women, are subject to refusals based on pharmacists' personal beliefs.¹²⁹ Similarly, women alone are at risk of pregnancy and subject to the possible physical health consequences of an unplanned pregnancy as a result of not being able to fill their prescriptions in a timely manner.¹³⁰ Only women have certain conditions such as amenorrhea and endometriosis that are managed or treated with oral contraceptives.¹³¹ Furthermore, only women face the potential costs of an additional doctor's visit, transportation, and time necessary to either fill a transferred prescription or replace a prescription if a pharmacist refuses to return it.¹³² Finally, in the majority of reported cases, only women suffer the humiliation and degradation of being lectured or turned away by a pharmacist.¹³³ Because these laws affect a group of people composed entirely of one sex, they are sexually discriminatory.

This argument can be analogized to a similar argument that supports insurance coverage for contraceptives.¹³⁴ Recently, the Equal Employment Opportunity Commission (EEOC), the administrative agency charged with interpreting national employment antidiscrimination laws, affirmed that employer insurance plans that include coverage for prescription drugs but exclude contraceptives are a form of sex discrimination.¹³⁵ The Pregnancy Discrimination Act (PDA) explicitly requires the equal treatment of women "affected by pregnancy, childbirth, or related medical conditions" in employment.¹³⁶ The EEOC rationalized that because contraceptives are a means by which a woman controls her ability to become pregnant, prescription contraceptives fall within the scope of the PDA.¹³⁷ Therefore, employer policies that provide insurance coverage for prescription drugs but exclude contraceptives (only available for women) are sexually discriminatory against women.¹³⁸ According to the

128. See CODE OF ETHICS, *supra* note 115.

129. MORRISON, *supra* note 9, at 5.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*; U.S. Equal Employment Opportunity Commission, *Commission Decision on Coverage of Contraception* (Dec. 14, 2000), <http://www.eeoc.gov/policy/docs/decision-contraception.html> [hereinafter EEOC].

136. Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (codified at 42 U.S.C. § 2000e(k) (2000)).

137. EEOC, *supra* note 135.

138. *Id.*

EEOC, refusal to offer insurance coverage for contraceptives is, by definition, a sex-based exclusion:¹³⁹ “Because 100 percent of the people affected . . . are members of the same protected group—here, women—[refusing to offer contraceptive coverage] need not specifically refer to that group in order to be facially discriminatory.”¹⁴⁰

Likewise, one hundred percent of the patients directly affected by pharmacist refusal clauses are women.¹⁴¹ The fact that pharmacist refusal clauses do not specifically refer to women as a group does not save these clauses from being facially sexually discriminatory.¹⁴² Women have a widely accepted right to be free of any discrimination based on sex, and this protection should extend to all aspects of healthcare, arguably one of the most important and vital aspects of women’s lives.¹⁴³ Pharmacist refusal clauses, which undermine this protection, are sexually discriminatory and violate women’s basic rights as equal members in our society.

Although there are no reported cases involving sex discrimination claims in pharmacy practice, state laws and pharmacy regulations that prohibit sex discrimination should protect women from pharmacist refusals laws.¹⁴⁴ Most state constitutions have equal protection guarantees giving protection against sex discrimination, and some states have enacted Equal Rights Amendments to their constitutions giving heightened protection against sex discrimination.¹⁴⁵ Beyond state constitutions, some state statutes specifically prohibit discrimination on the basis of sex when providing pharmaceutical services.¹⁴⁶

In addition to constitutional and statutory guarantees, state pharmacy boards prohibit sex discrimination as well. The National Association Boards of Pharmacy’s Model “Pharmacy Patient’s Bill of Rights” (Model Bill of Rights) asserts that patients have the right not to be discriminated against on the basis of sex.¹⁴⁷ At least one state, North Dakota, has adopted the Model Bill of Rights as law.¹⁴⁸ Pharmacist refusal

139. *Id.*

140. *Id.*

141. MORRISON, *supra* note 9, at 5.

142. *See supra* text accompanying note 140.

143. *See* discussion of the various roles birth control plays in the lives on American women *supra* Part II.

144. MORRISON, *supra* note 9, at 5.

145. *Id.* at 5–6. State constitutions with their own Equal Rights Amendment include: Alaska, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Louisiana, Maryland, Maine, Montana, New Hampshire, New Jersey, New Mexico, Pennsylvania, Texas, Utah, Virginia, Washington, and Wyoming. *Id.* at 11 n.21.

146. *Id.* at 5; *see, e.g.*, IOWA ADMIN. CODE r. 657-8.11(6) (2005) (“It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.”).

147. MORRISON, *supra* note 9, at 8.

148. N.D. ADMIN. CODE § 61-04-07 (2005); MORRISON, *supra* note 9, at 6. The relevant provision provides that patients have the right: “2. To be treated with dignity, consistent with professional standards, regardless of manner of payment, race, sex, age, nationality, religion, disability, or other discriminatory factors.” N.D. ADMIN. CODE § 61-04-07.

clauses are sexually discriminatory, and this type of discrimination should not be tolerated or endorsed by state legislatures or pharmacy boards, which claim to offer heightened protection against sex discrimination.

D. Transfer Provisions—an Inadequate Solution

Pharmacist refusal laws, as currently enacted, do not even offer the minimal protection of requiring pharmacists who refuse to fill legal prescriptions on the basis of personal or moral beliefs to transfer or refer the prescription to another pharmacist or pharmacy.¹⁴⁹ However, such proposed transfer provisions, although they admittedly attempt to balance the competing rights of pharmacists and patients, are still an inadequate compromise.¹⁵⁰

First, transfer provisions do nothing to correct the sexually discriminatory nature of refusing to fill a legal prescription for birth control.¹⁵¹ Pharmacists who are required to transfer or refer contraceptive prescriptions are still only required to transfer women's prescriptions, so these provisions run into the same discrimination problems as discussed above. Second, for many pharmacists, referring or transferring a prescription is merely passive participation in the same activity the pharmacist personally opposed and refused to perform in the first place.¹⁵² Therefore, even if a pharmacy refusal clause contains a transfer provision, the dilemma of whether to fill a prescription is simply transformed into a dilemma over whether to transfer the prescription, a dilemma which is equally troubling for the pharmacist and equally potentially harmful for the patient.¹⁵³ Therefore, transfer provisions are still not guaranteed to lead to the seamless vision of APhA, in which the patient gets the medication and the pharmacist steps back, without any interaction between the two.¹⁵⁴

Moreover, commentators' examples of transfer provisions that require the refusing pharmacist to refer the prescription to another pharmacist on duty presume that there are always two pharmacists working side by side on any given shift and that if one pharmacist refuses to fill a prescription, the other pharmacist will always be available and willing to

149. See *supra* Part III.B.1.

150. MORRISON, *supra* note 9, at 6.

151. *Id.*

152. Herbe, *supra* note 8, at 89. Pharmacists for Life International (PFLI) asserts that pharmacists should not only have the right to refuse, but the right to refuse to transfer prescriptions as well. Rob Stein, *Pharmacists' Rights at Front of New Debate: Because of Beliefs, Some Refuse to Fill Birth Control Prescriptions*, WASH. POST, Mar. 28, 2005, at A10. According to Karen Brauer, president of PFLI, "[A transfer] is like saying, 'I don't kill people myself but let me tell you about the guy down the street who does' [I]t's the same thing." *Id.*

153. Herbe, *supra* note 8, at 89. There have been reported cases of pharmacists refusing to fill a prescription based on moral beliefs in which the pharmacists also further refused to transfer the prescription to another pharmacist or pharmacy at the patient's request. Morrison, *supra* note 9, at 6.

154. See *supra* Part III.B.1.

step in and fill the prescription.¹⁵⁵ Pharmacists, however, may not always have this option, especially during shifts where it is unnecessary or uneconomical to have more than one pharmacist on duty.¹⁵⁶ This is likely to be the case during late night shifts at twenty-four-hour pharmacies (ironically, the time when emergency contraceptives may be needed most).¹⁵⁷

Transfer provisions that impose a duty on the refusing pharmacist to transfer the prescription to another pharmacy are just as problematic. Even in large cities, there may be certain times of day when few pharmacies are open and transportation is not routinely available.¹⁵⁸ Women in states with large rural and low-income populations are at the greatest disadvantage because they often have fewer choices of pharmacies, fewer financial resources, and even less access to transportation.¹⁵⁹ States that are home to large rural and low-income populations include South Dakota and Mississippi, two of the states which have already enacted pharmacist refusal laws.¹⁶⁰ Therefore, it appears that pharmacist refusal clauses have been enacted in states where they will cause the most damage to women's healthcare.¹⁶¹

An analysis of the current situation in South Dakota illustrates the point that even if transfer provisions were added to the state's pharmacist refusal clause, South Dakota women could still face many obstacles in obtaining their prescriptions. The women in South Dakota are disadvantaged by the state's size and demographics: South Dakota's small population in a mid-sized state creates an extremely rural population consisting of only 9.9 persons per square mile, as compared with the United States average of 79.6.¹⁶² There is also a large low-income population in the state, illustrated by the fact that out of the 81,890 women in South Dakota in need of contraceptive services, over half (47,370) of these women require public financial assistance to meet those needs.¹⁶³ As a final obstacle, according to the South Dakota chapter of Planned Parenthood, many communities in South Dakota only have one pharmacy.¹⁶⁴ Collectively, these statistics indicate that even if a referral or transfer provision was added to the South Dakota law, it would likely still be an inadequate method of guaranteeing that South Dakota women receive timely access to birth control because many women would be un-

155. MORRISON, *supra* note 9, at 7.

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. Teliska, *supra* note 15, at 243.

161. *Id.*

162. *Id.* at 245.

163. *Id.* at 246.

164. *Id.* at 245.

able to afford to go to another pharmacy or find an alternative pharmacy within their means of travel and transportation.¹⁶⁵

Imposing a duty to transfer, although a step in the right direction, is an inadequate solution because it neither allows pharmacists to meaningfully exercise their conscience, nor guarantees that patients receive timely access to their prescriptions. Therefore, “refuse and refer” policies still fail to strike the appropriate balance of rights that both pharmacists and patients deserve.

IV. RECOMMENDATIONS

Rather than enacting new pharmacist refusal clauses or adding transfer provisions to current laws, legislation and alternative policies must be adopted that allow individual pharmacists to exercise their moral beliefs, while ensuring that patients still receive the minimal standard of pharmaceutical professional care and that women are never denied access to legally prescribed birth control. In order to accomplish this objective, legislatures should pass “duty to dispense” laws. State pharmacy boards should interpret professional obligations to prohibit obstruction of prescription contraceptives and discipline pharmacists who impede access to these prescriptions. States should offer the option of collaborative practice agreements, which give pharmacists the chance to volunteer to become qualified to independently prescribe EC. Finally, the pharmaceutical community should implement new, innovative procedures and policies and provide patients with notice of any obstacles to obtaining prescription contraceptives.

A. *Legislative Solutions: “Duty to Dispense” Legislation*

The first step towards protecting women’s constitutional right to birth control and patients’ right to lawful prescriptions is the initiation of new legislation on the federal and state level. Lawmakers must enact “duty to dispense” laws, which not only impose an explicit duty on pharmacies to truly guarantee patients’ timely access to all legal prescriptions, but also provide meaningful alternatives beyond transfer provisions or “refuse and refer” policies and impose sanctions for individual pharmacists who violate these duties.

1. *Federal Legislation: Access to Legal Pharmaceuticals Act*

The Access to Legal Pharmaceuticals Act (ALPhA) was a proposed federal bill that would have imposed upon pharmacies an express “duty to dispense” all legal prescriptions, including contraceptives, for the pharmacies that choose to carry contraception. ALPhA was introduced

165. See *id.* at 245–46.

into the Senate and the House of Representatives on April 14, 2005.¹⁶⁶ The bill garnered 128 cosponsors but, unfortunately, did not get out of the House Subcommittee on Health.¹⁶⁷ However, an analysis of this bill is helpful as a model to guide future federal legislation.

ALPhA began by stating the proposed findings of Congress: an individual's right to religious beliefs is a fundamental right; an individual's access to legal contraception is a fundamental right; and the right to religious beliefs cannot impede the right to legal contraception.¹⁶⁸ ALPhA would have protected an individual's right to legal contraceptives by requiring pharmacies to ensure that if a pharmacist has a personal objection to filling a legal prescription for birth control, another pharmacist employed by the pharmacy who had no personal objection would fill the prescription.¹⁶⁹ Refusing to refer or, at the patient's wish, transfer the prescription would have been prohibited under ALPhA.¹⁷⁰ Additionally,

166. Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005). ALPhA was introduced into the Senate by Sen. Frank Lautenberg (D-N.J.) and into the House of Representatives by Reps. Carolyn Maloney (D-N.Y.), Christopher Shays (R-Conn.), Debbie Wasserman Schultz (D-Fla.), and Joseph Crowley (D-N.Y.). Press Release, Representative Debbie Wasserman Schultz, *supra* note 1.

167. The Library of Congress, THOMAS, H.R. 1652 Bill Summary & Status, <http://thomas.loc.gov/cgi-bin/bdquery/z?d109:h.r.01652>: (last visited Feb. 27, 2007).

168. Access to Legal Pharmaceuticals Act, H.R. 1652 § 2. This provision states:
The Congress finds as follows:

- (1) An individual's right to religious belief and worship is a protected, fundamental right in the United States.
- (2) An individual's right to access legal contraception is a protected, fundamental right in the United States.
- (3) An individual's right to religious belief and worship cannot impede an individual's access to legal prescriptions, including contraception.

Id.

169. *Id.* § 249(a)(1)–(2). This provision states:

(a) In General—A pharmacy that receives prescription drugs or prescription devices in interstate commerce shall maintain compliance with the following conditions:

(1) If a product is in stock and a pharmacist employed by the pharmacy refuses on the basis of a personal belief to fill a valid prescription for the product, the pharmacy ensures, subject to the consent of the individual presenting the prescription in any case in which the individual has reason to know of the refusal, that the prescription is, without delay, filled by another pharmacist employed by the pharmacy.

(2) Subject to subsection (b), if a product is not in stock and a pharmacist employed by the pharmacy refuses on the basis of a personal belief or on the basis of pharmacy policy to order or to offer to order the product when presented a valid prescription for the product—

(A) the pharmacy ensures that the individual presenting the prescription is immediately informed that the product is not in stock but can be ordered by the pharmacy; and

(B) the pharmacy ensures, subject to the consent of the individual, that the product is, without delay, ordered by another pharmacist employed by the pharmacy.

Id.

170. *Id.* § 249(a)(3)(A)–(D). This provision states:

(3) The pharmacy does not employ any pharmacist who engages in any conduct with the intent to prevent or deter an individual from filling a valid prescription for a product or from ordering the product (other than the specific conduct described in paragraph (1) or (2)), including—

(A) the refusal to return a prescription form to the individual after refusing to fill the prescription or order the product, if the individual requests the return of such form;

(B) the refusal to transfer prescription information to another pharmacy for refill dispensing when such a transfer is lawful, if the individual requests such transfer;

(C) subjecting the individual to humiliation or otherwise harassing the individual; or

pharmacists would not have been allowed to prevent or deter an individual from filling a legal prescription, nor harass, humiliate, or intentionally breach the confidentiality of an individual filling a legal prescription for birth control.¹⁷¹ ALPhA also would have required that the prescription be filled without delay, which meant in a time frame consistent with the amount of time it would take the pharmacy to fill any other nonobjectionable prescription.¹⁷² Finally, any pharmacy violating the provisions of ALPhA would have been liable to the United States for a civil penalty, and the bill would have authorized individuals to commence a private cause of action against the pharmacy to obtain appropriate relief, including actual and punitive damages.¹⁷³

In short, ALPhA's provisions would have achieved the goal of striking the important balance between protecting an individual's access to legal contraception and other medications and respecting an individual pharmacist's right to personal and religious beliefs.¹⁷⁴ Although it retained some components of a refusal clause, it would have imposed an explicit duty on the pharmacy, but not individual pharmacists, to make sure a pharmacist's right to refuse never interfered with the dispensation of legal prescriptions. Ideally, individual pharmacists will never have to choose between their moral beliefs and the needs of the patient if the pharmacy acts in an appropriate manner. The passage of a federal "duty to dispense" law similar to ALPhA would be a significant victory in the battle over reproductive healthcare and pharmacist refusal clauses, fi-

(D) breaching medical confidentiality with respect to the prescription or threatening to breach such confidentiality.

Id.

171. *Id.*

172. *Id.* § 249(d)(8). This provision states;

(d) DEFINITIONS—For purposes of this section:

(8) The term 'without delay', with respect to a pharmacy filling a prescription for a product or ordering the product, means within the usual and customary timeframe at the pharmacy for filling prescriptions for products for the health condition involved or for ordering such products, respectively.

Id.

173. *Id.* § 249(c)(1)–(3). This provision states:

(c) ENFORCEMENT—

(1) CIVIL PENALTY—A pharmacy that violates a requirement of subsection (a) is liable to the United States for a civil penalty in an amount not exceeding \$5,000 per day of violation, not to exceed \$500,000 for all violations adjudicated in a single proceeding.

(2) PRIVATE CAUSE OF ACTION—Any person aggrieved as a result of a violation of a requirement of subsection (a) may, in any court of competent jurisdiction, commence a civil action against the pharmacy involved to obtain appropriate relief, including actual and punitive damages, injunctive relief, and a reasonable attorney's fee and cost.

(3) LIMITATIONS—A civil action under paragraph (1) or (2) may not be commenced against a pharmacy after the expiration of the five-year period beginning on the date on which the pharmacy allegedly engaged in the violation involved.

Id.

174. See AM. ASS'N OF UNIV. WOMEN, PROTECT ACCESS TO LEGAL PHARMACEUTICALS (2005), http://www.aauw.org/issue_advocacy/actionnetwork/activations/05_0504.cfm.

nally reaching the correct balance between pharmacists' right to conscience and women's right to birth control.¹⁷⁵

2. State Legislation

In addition to federal legislation, states legislatures should take the initiative to pass "duty to dispense" laws that protect women's access to birth control.¹⁷⁶ Five states—California, Illinois, Nevada, Maine, and New York—have laws or regulations that place a duty on either pharmacists, pharmacies, or both to ensure that prescriptions for contraception are filled without delay.¹⁷⁷

The Illinois Pharmacy Practice Act (Pharmacy Practice Act) should be used by state legislatures as a model for future state laws because it places the duty on the pharmacy, rather than the pharmacist, to fill all prescriptions without delay, thus attempting to consider and respect the beliefs of individual pharmacists. In April 2005, in response to a growing number of reported cases of pharmacists in Illinois refusing to fill birth control prescriptions, Illinois Governor Rod Blagojevich issued an emergency order clarifying the responsibility of all licensed retail pharmacies in Illinois to fill all legal prescriptions for FDA-approved contraceptives without delay or hassle.¹⁷⁸ On August 16, 2005, legislators serving on the Joint Committee on Administrative Rules in Illinois voted to make the emergency rule a permanent rule promulgated under the Illinois Pharmacy Practice Act.¹⁷⁹ Governor Blagojevich emphasized the fundamental, rather than political, purpose of the new law: "[F]illing prescriptions for birth control is about protecting a woman's right to have access to medicine her doctor says she needs. Nothing more. Nothing less."¹⁸⁰

The Illinois model is even more protective than ALPhA would have been of a woman's right to access contraceptives in a timely fashion. When a pharmacy is confronted with a legal prescription for birth control, there are certain steps it must follow: if the contraceptive is in stock,

175. There has been other federal legislative activity in this area. Senator Barbara Boxer introduced the Pharmacy Consumer Protection Act into the Senate, which would amend the Social Security Act to require a pharmacy that receives payments or has contracts under the Medicare and Medicaid programs to ensure all valid prescriptions are filled without delay. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005). Also, Representative Carolyn McCarthy introduced a bill into the House to amend the Public Health Service Act with respect to the responsibilities of a pharmacy when a pharmacist employed by the pharmacy refuses to fill a valid prescription for a drug on the basis of moral beliefs. H.R. 1539, 109th Cong. (2005).

176. In fact, in 2006, legislators in eleven states—Arizona, Maryland, Michigan, Minnesota, Missouri, New York, New Jersey, Ohio, Pennsylvania, West Virginia, and Wisconsin—introduced bills that would place a duty on pharmacists or pharmacies to fill prescriptions for all contraceptives. RE-FUSALS 101, *supra* note 3, at 3.

177. *Id.*

178. Press Release, Illinois Office of the Governor, State Commission Gives Permanent Approval to Gov. Blagojevich's Emergency Rule Protecting Illinois Women's Right to Birth Control (Aug. 16, 2005), <http://www.idfpr.com/NEWSRSL/081605JCARContraceptivePermRule.pdf>.

179. *Id.*

180. *Id.*

the pharmacy must dispense the contraceptive without delay; if the contraceptive is not in stock, the pharmacy must either provide a suitable medical alternative, order the drug from their supplier, or, at the request of the patient, transfer the prescription to a local pharmacy of the patient's choice or return the unfilled prescription to the patient.¹⁸¹ The law encompasses all FDA-approved contraceptives, including EC.¹⁸² The Illinois rule indirectly leaves room for an individual pharmacist to refuse to dispense a prescription based on personal beliefs by placing the ultimate responsibility on the pharmacy, rather than the pharmacist, to ensure that patients have access to prescriptions without delay.¹⁸³

When the emergency order was first issued, Illinois pharmaceutical organizations lobbied Governor Blagojevich to rescind the order for various reasons, including the allegation that the law interfered with the Provision of Pharmaceutical Care contained in the Illinois Pharmacy Practice Act, which specifically requires pharmacists to conduct prospective drug utilization review.¹⁸⁴ However, this concern was addressed by the Illinois Department of Financial and Professional Regulation, which issued guidance regarding the emergency order and expressed the opinion that the emergency order did not contradict or override any drug review requirements.¹⁸⁵ This opinion is supported by the permanent law, which contains a provision explaining that nothing in the new law should prevent a pharmacist's screening for potential drug therapy problems due to the existing considerations, not relating to moral or personal beliefs, already outlined in the Pharmacy Practice Act.¹⁸⁶ It is too soon to analyze the full effect of the new law, but women in Illinois are already

181. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1) (2006). This rule, the Duty of Division 1 Pharmacy to Dispense Contraceptives, states:

1) Upon receipt of a valid, lawful prescription for a contraceptive, a pharmacy must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient's agent without delay, consistent with the normal timeframe for filling any other prescription. If the contraceptive, or a suitable alternative, is not in stock, the pharmacy must obtain the contraceptive under the pharmacy's standard procedures for ordering contraceptive drugs not in stock, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. However, if the patient prefers, the prescription must be transferred to a local pharmacy of the patient's choice under the pharmacy's standard procedures . . . Under any circumstances an unfilled prescription for contraceptive drugs must be returned to the patient if the patient so directs.

Id.

182. *Id.* § 1330.91(j)(2) (2006) ("For the purpose of this subsection (j), the term 'contraceptive' shall refer to all FDA-approved drugs or devices that prevent pregnancy.").

183. *See id.* § 1330.91(j)(1).

184. Letter from Michael Patton, John A. Gans, and Henri R. Manasse, Jr. to Rod R. Blagojevich, *supra* note 59.

185. Illinois Department of Financial & Professional Regulation, Guidance Regarding the Emergency Rule (Apr. 7, 2005), <http://www.idfpr.com/emergencyruleguidance.asp>.

186. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(3). This provision states:

Nothing in this subsection [j] shall interfere with a pharmacist's screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interaction with nonprescription or over-the-counter drugs), drug-food interaction, incorrect drug dosage or duration of drug treatment, drug-allergy interactions or clinical abuse or misuse, pursuant to 25 ILCS 85/3(q).

Id.

choosing to exercise their newfound rights—within one month after becoming a permanent law, three individuals had filed complaints against Illinois retail pharmacies under the newest provision of the Illinois rule.¹⁸⁷

State laws must impose an *explicit* duty on pharmacies to fill all prescriptions. Currently, many state pharmacy laws have refusal clauses that permit refusals for medical or legal reasons.¹⁸⁸ Therefore, by omitting moral or religious beliefs from the enumerated reasons for referrals, these laws could be interpreted as implicitly prohibiting refusals for moral or religious reasons.¹⁸⁹ However, an implicit duty is not enough—states need to enact legislation that protects a pharmacist's right to exercise her conscience, while unequivocally placing a duty on pharmacies to put patients' needs first and guarantee access to birth control without delay.

B. State Pharmacy Boards

The responsibility of enforcing state pharmacy laws is often delegated to a state pharmacy board, which may be authorized to discipline pharmacists for certain acts or omissions.¹⁹⁰ State pharmacy boards should take a more active role to guarantee that patients receive prescription contraceptives. State pharmacy boards in New York, Oregon, and North Carolina have interpreted pharmaceutical professional duties and obligations to prohibit obstruction of prescriptions and to require pharmacies to provide timely access to contraceptives or meaningful referrals or transfers.¹⁹¹

For example, the North Carolina Pharmacy Board acknowledged that pharmacists have a right to avoid moral or ethical conflicts, but do not have the right to obstruct the dispensation of legal prescriptions based solely on these beliefs.¹⁹² The North Carolina Board places the obligation on the pharmacist with a moral or ethical conflict to nevertheless meet the needs of the patient by requiring that pharmacists who refuse to fill prescriptions still take proactive measures to ensure that patients obtain their medication.¹⁹³ Other state pharmacy boards should take simi-

187. Press Release, Illinois Department of Financial & Professional Regulation, Three Complaints Filed Against Pharmacies for Failure to Dispense Contraceptives (Sept. 15, 2005), <http://www.idfpr.com/newsrsls/091505PharmComplaints.asp>.

188. MORRISON, *supra* note 9, at 5.

189. *Id.*

190. Herbe, *supra* note 8, at 92.

191. LAWS AND BILLS, *supra* note 107, at 2.

192. MORRISON, *supra* note 9, at 7–8.

193. *Id.* at 8. The Massachusetts Board of Pharmacy has taken a similar stand: in response to an inquiry about pharmacists' refusals, the Board issued a letter that concluded pharmacists were required to fill all valid prescriptions, including EC (pursuant, of course, to a review for drug contradictions and similar concerns). *Id.*

larly definitive positions, taking the initiative to file suits and impose sanctions for violations of these positions.

In addition to acting on its own initiative, when a state pharmacy board is notified that a pharmacist has failed to comply with her professional obligations, the board should take strong actions against the pharmacist so as to deter others from acting similarly in the future. State pharmacy boards should follow the precedent of a recent decision issued by the Wisconsin State Pharmacy Board. In 2004, a woman filed a complaint before an Administrative Law Judge (ALJ) against Neil Noesen, a pharmacist who had refused to fill or transfer her legal prescription for birth control.¹⁹⁴ After a hearing, the ALJ found that Noesen had violated state regulations prohibiting unprofessional conduct by pharmacists and had acted in a manner that could endanger the health of patients or the public.¹⁹⁵ The ALJ recommended that Noesen receive a reprimand, pay for the costs of the proceeding, and be required to file a plan specifying steps he would take to ensure patients' access to lawful medication in the future as a condition of retaining his pharmacy license.¹⁹⁶ The Wisconsin State Pharmacy Board unanimously accepted these sanctions on April 13, 2005.¹⁹⁷

Disciplinary actions such as the sanctions imposed on Noesen are an appropriate response because they acknowledge that a violation has occurred without imposing a disproportionate monetary penalty. Additionally, not only do these sanctions attempt to prevent the disciplined pharmacist from acting in a similar manner again, but they also serve as a deterrent for other pharmacists who might otherwise choose to disregard state laws regarding ethical obligations and pharmacist refusals in the future.

C. Collaborative Practice Agreements and Pharmacy Access

States have the responsibility to decide which healthcare professionals, including pharmacists, have authority to prescribe EC.¹⁹⁸ Although the majority of states limit the general duties of a pharmacist to dispensing EC, a handful of states currently allow pharmacists to independently prescribe EC through collaborative practice agreements.¹⁹⁹ Collaborative practice agreements are voluntary arrangements between a pharmacist and a physician that permit the pharmacist to dispense EC directly to pharmacy customers without an advance prescription from a

194. *Id.* at 7.

195. Noesen, No. LS0310091PHM (Wisc. Pharm. Examining Bd. Feb. 28, 2005), available at <http://www.naralwi.org/assets/files/noesendecision&finalorder.pdf>.

196. MORRISON, *supra* note 9, at 7.

197. *Id.* Noesen is appealing the decision. *Id.*

198. Herbe, *supra* note 8, at 80–81.

199. *Id.* at 81. Currently, pharmacists may initiate emergency contraceptive therapy in collaboration with healthcare prescribers ("collaborative practice agreements") in Alaska, California, Hawaii, Maine, New Mexico, and Washington. PHARMACY ACCESS, *supra* note 68, at 1.

physician.²⁰⁰ The agreements are subject to carefully outlined guidelines and limitations detailed in the state's pharmacy regulations.²⁰¹ Participation is voluntary, and pharmacists who choose to participate must complete a training course.²⁰²

More states should offer pharmacy access to EC through collaborative practice agreements as a means of giving pharmacists the individual choice to help women under the age of eighteen obtain timely access to contraceptives without an advanced prescription, while still allowing those pharmacists who have a moral or personal objection to EC to choose not to participate. The success of the pharmacy access model, in those states that offer it, shows that these agreements work effectively to help women prevent unintended pregnancies.²⁰³ For example, by the end of the second year after Washington began allowing the use of collaborative practice agreements, almost twelve thousand women received EC.²⁰⁴ Six months later, the Washington State Department of Health linked a statewide drop in abortion rates to increased use of contraception, in particular emergency contraception.²⁰⁵ Women have expressed satisfaction with the process as well. In a 2006 study of women who obtained EC directly from pharmacists in California, the overwhelming majority of women were satisfied with their experiences, reporting that pharmacy access was faster and more convenient than seeking a prescription from a doctor, and one quarter of all respondents even stated that they were "more comfortable" going to a pharmacist instead of a physician.²⁰⁶

Another way states can facilitate pharmacy access to contraceptives is to establish some type of written protocol, drafted and approved by the state's pharmacy board, that gives pharmacists the ability to dispense EC without an advance prescription or collaborative agreement with a physician, under certain conditions.²⁰⁷ For example, New Mexico law provides this option, giving pharmacists who satisfactorily complete an EC training course the authority to independently dispense EC directly to female customers, without a prior agreement with a participating physician.²⁰⁸ This is yet another means by which state pharmacy boards can take a more active role in ensuring that all women have access to EC while giving pharmacists an option to become more active as well.

With the FDA's recent decision to make EC available as an OTC medication for women eighteen and older, collaborative practice agreements may not be as significant or necessary for many American women.

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*; see also Field, *supra* note 65, at 231–32 (providing an overview of the Washington law and arguing that this law should be used as a model in other states to enact similar legislation).

206. PHARMACY ACCESS, *supra* note 68, at 2.

207. *Id.*

208. *Id.* at n.7 (citing N.M. CODE R. § 16.19.26 (Weil 2006)).

However, until the FDA approves EC for OTC use for all ages and state-level threats to eliminate OTC status cease, collaborative practice agreements, or written protocol establishing pharmacy access, offer effective solutions to ensure that young patients seeking EC receive timely access to this essential form of contraception.²⁰⁹

D. New Procedures and Policies

The pharmaceutical community should also implement new, innovative procedures and policies that will accommodate pharmacists' personal beliefs while ensuring that patients' needs are ultimately met. The American Medical Association (AMA) has adopted a helpful resolution (AMA Resolution), which proposes a different approach to balancing the competing interests of pharmacists and patients that shifts the focus from the pharmacy to the physician's office. The AMA Resolution advocates working together with state medical authorities to adopt legislation "in the absence of all other remedies . . . that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty mile radius who is able and willing to dispense that medication."²¹⁰ This solution would make it possible for a patient to circumvent the dual obstacles of private pharmacy policies and state pharmacist refusal laws by allowing a physician to step in and perform the professional duties of a pharmacist when the patient has no other means of receiving timely access to birth control. Few physicians would likely be included within the scope of the legislation, and stocking a minimal supply of birth control would likely impose nominal burdens on the affected physicians. This legislation would alleviate many of the burdens pharmacist refusal clauses place on low-income and rural women because these women would not have to spend the additional time and money tracking down a pharmacist outside of their local area.

Groups in the pharmaceutical community should also work towards the establishment of a public registry of pharmacies. Ideally, public registration can be made mandatory through state legislation, but at a minimum should be offered on a voluntary basis and maintained by a pharmaceutical group such as APhA. All private pharmacies would register and list their pharmacist refusal policies. This registry should be available to all groups affected by these policies, including patients, prospective employees, and physicians. Patients who have regular birth control prescriptions could use the registry to establish working relationships with pharmacies that have reputations for quickly and efficiently dispensing birth control. Pharmacists seeking employment could look for phar-

209. *Id.* at 2.

210. AM. MED. ASS'N, AMA POLICY: PRESERVING PATIENTS' ABILITY TO HAVE LEGALLY VALID PRESCRIPTIONS FILLED (2005), http://www.alphanet.org/AM/Template.cfm?section=search§ion=Practice_Workforce&template=/CM/ContentDisplay.cfm&ContentFileId=531.

macies with policies that allow them to exercise their conscience in a way they feel is meaningful. Physicians could utilize the registry to proactively direct patients with birth control prescriptions to fill prescriptions at contraceptive-friendly pharmacies with appropriate “duty to dispense” policies in place.

Private pharmacies should not merely be required to disclose to the public their pharmacist refusal policy, but they should also be required to disclose whether they even carry certain types of oral and emergency contraceptives. For example, in 2003, the New York City Council passed a provision requiring pharmacies not stocking EC to post a notice within the store that informs customers that EC is unavailable, and subjecting pharmacies that failed to do so to a \$700 fine.²¹¹ Requiring disclosure of whether pharmacies carry certain contraceptives will not only proactively direct patients to pharmacies that stock EC, but it may also lead to an increase in the amount of pharmacies that choose to stock EC, so that they will not lose the business of customers who may select their pharmacy based on the availability of these contraceptives.

Private pharmacies can also help. Private pharmacies have already developed a wide range of company policies that address pharmacists’ right to refuse prescriptions based on moral or religious beliefs.²¹² Pharmaceutical groups and patients need to keep pressure on pharmacies to reform and improve company policies that will increase access to contraceptives.²¹³ Private pharmacies should be encouraged to adopt “duty to dispense” policies that acknowledge that the primary responsibility of the pharmacy is to serve its customers.

Private pharmacy employers should engage in discussions with potential employees during the hiring process, explaining their policies, including any potential sanctions, and asking if the potential employee has a personal objection to a duty to dispense contraceptives. The pharmacy’s refusal policies should be clearly stated in the pharmacists’ employee handbook. As part of their employment contract, pharmacists should be required to state in writing their intent to refuse prescriptions for personal reasons and agree to abide by the pharmacy’s duty to dispense policies, or be subjected to termination.

211. Nicole Monastersky & Sharon Cohen Landau, *Future of Emergency Contraception Lies in Pharmacists’ Hands*, 46 J. AM. PHARM. ASS’N 84, 86, available at <http://pharmacyaccess.org/pdfs/JaphaCOMMMonasterskyLandau.pdf>.

212. Teliska, *supra* note 15, at 239.

213. Wal-Mart simply declines to carry emergency contraceptives, a policy reported to represent a “business decision, not a moral judgment.” Dana Canedy, *Wal-Mart Decides Against Selling a Contraceptive*, N.Y. TIMES, May 14, 1999, at C1. Walgreen’s and CVS pharmacies have instituted “refuse and refer” policies that require refusing pharmacists to transfer the prescription to another pharmacist on duty or the nearest pharmacy branch, but it is unclear how serious these policies are enforced. Teliska, *supra* note 15, at 239. Eckerd Pharmacy actually has a “duty to dispense” policy that prohibits pharmacists from declining to fill a prescription for moral or religious reasons. *Id.* at 240. However, Eckerd cannot be hailed as a haven for access to emergency contraceptives, as some Eckerd pharmacies decline to carry EC. *Id.*

When choosing to accommodate pharmacists' moral or religious beliefs, employers should only hire as many pharmacists whose beliefs prevent them from dispensing all legal prescriptions as the individual pharmacy can accommodate without imposing an undue burden on other coworkers or the pharmacy.²¹⁴ Pharmacies should never schedule a pharmacist who has a personal objection against dispensing birth control on a "one pharmacist shift" where the pharmacist could be placed in the dilemma of having to choose to dispense or transfer a prescription. All of these proposed solutions would achieve a better balance between pharmacists' right to refuse and women's right to legal birth control prescriptions than do pharmacist refusal clauses.

V. CONCLUSION

When a woman and her physician decide that a prescription for contraception is in her best health interests, legal, professional, and ethical obligations should prevent a pharmacist from being able to effectively override that determination. The right of a pharmacist to abide by her moral or religious principles when faced with a prescription that goes against those principles is an important right to protect. However, this right should never be allowed to infringe on a patient's right to access birth control, an equally important right that has significant implications for the majority of American women's reproductive health. Pharmacist refusal clauses acknowledge pharmacists' right to refuse at the expense of women's right to access contraceptives, inappropriately reconciling these rights. *Griswold v. Connecticut* may be forty years old, but the issues debated before the Supreme Court then have risen anew today, this time behind the pharmacy counter. Following in the footsteps of the *Griswold* Court, we must now reaffirm that women have the right to make their own family planning decisions, including the decision to use contraception. Legislatures, pharmacy boards, pharmacies, pharmacists, and patients must work together to put the needs of patients back where they belong—as the first priority of the pharmacy profession.

214. Opponents of "duty to dispense" or other hiring policies that expressly consider the religious beliefs of pharmacists have argued that these policies violate Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e (2000), which courts have interpreted to require an employer to accommodate an employee's religious belief, as long as that belief does not impose an "undue burden" on the employer's ability to run the business. MORRISON, *supra* note 9, at 10. However, considering courts' traditionally narrow view of the accommodations required by Title VII, hiring employees whose religious beliefs may impose an economic burden or impair the pharmacy's ability to serve its customers likely imposes an undue burden that a pharmacy is not required to accommodate. Sonfield, *supra* note 32, at 2; *see, e.g.,* *Hellinger v. Eckerd Corp.*, 67 F. Supp. 2d 1359, 1364–65 (S.D. Fla. 1999) (holding that Eckerd pharmacy did not have a duty to accommodate an applicant's refusal to sell condoms based on his religious beliefs because such an accommodation placed an undue burden on the pharmacy, which usually only staffed one pharmacist per shift).