

DRAWING THE LINE: THE LEGAL, ETHICAL AND PUBLIC POLICY IMPLICATIONS OF REFUSAL CLAUSES FOR PHARMACISTS

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INTRODUCTION

The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.¹

—Justice Sandra Day O'Connor

In February 2005, an incident in Chicago involving a pharmacist, two women and their prescriptions for emergency contraception triggered a firestorm of reaction that continues unabated. The pharmacist refused to fill the women's prescriptions for the emergency birth control pill known as Plan B, stating that to do so would violate her religious beliefs.² The governor of Illinois responded by issuing an emergency order on April 1, 2005, requiring Illinois pharmacies to fill all prescriptions for oral contraceptives without delay.³

The governor's order, which became permanent in August 2005,⁴ provoked lawsuits by a variety of groups, including the American Center for Law and Justice, an organization funded by evangelical preacher Pat Robertson,⁵ the

1. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 835 (1992).

2. See Jim Ritter, *Planned Parenthood Protests over Morning-After Pill; Downtown Pharmacist Wouldn't Sell Emergency Contraceptive*, CHI. SUN-TIMES, Mar. 23, 2005, at 10; PLANNED PARENTHOOD FED'N OF AM., A BRIEF HISTORY OF EMERGENCY HORMONAL CONTRACEPTION 2 (2005) (explaining that Plan B is a contraceptive hormone packet developed specifically for emergency use in order to prevent pregnancy, approved by the FDA in 1999).

3. Emergency Amendment to Pharmacy Practice Act of 1989, 29 Ill. Reg. 5586 (Apr. 1, 2005) (codified at ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005)).

4. *Id.*

5. See Press Release, American Center for Law and Justice, ACLJ Files Suit Against Illinois Governor over Directive Discriminating Against Pro-Life Pharmacists (Apr. 13, 2005), available at <http://www.aclj.org/News/Read.aspx?ID=1475>; Jim Suhr, *Robertson Group Sues over Contraception-Dispensing Law*, BOSTON GLOBE, Dec. 21, 2005,

Center for Law and Religious Freedom, an arm of the Christian Legal Society,⁶ and Americans United for Life, an anti-abortion organization.⁷ By January 2006, three bills had been introduced in the Illinois legislature to override the new regulation and permit pharmacists to refuse to dispense emergency contraception if doing so violated their religious or personal beliefs.⁸

The issue of refusal clauses for pharmacists has been brewing for some time.⁹ The media began to document the growing number of pharmacists across the country refusing to fill prescriptions for birth control pills and emergency contraception after an organization known as Pharmacists for Life began a formal campaign in September 2004, encouraging pharmacists to refuse to dispense contraceptives.¹⁰ Reports of pharmacists refusing to fill such prescriptions continued throughout 2005.¹¹ Then on August 24, 2006, in an unexpected turn of events, the Food and Drug Administration ("FDA") reversed its controversial decision to deny approval of Plan B¹² for over-the-counter sale.¹³ This reversal is

http://www.boston.com/news/nation/articles/2005/12/21/robertson_group_sues_over_contraception_dispensing_law?mode=PF.

6. Press Release, Christian Legal Society, Center for Law & Religious Freedom Sues Illinois Governor over "Emergency Rule" Targeting Pro-Life Pharmacists (Apr. 15, 2005), available at <http://www.clsnet.org/clrfPages/>.

7. See Gretchen Ruethling, *Illinois Pharmacist Sues over Contraceptive Rule*, N.Y. TIMES, June 10, 2005, at A1; Mary Massingale, *Pharmacists Seek Injunction; Claim Governor's Emergency Contraception Rule Violates Their Rights*, ST. J.-REGISTER (Springfield, Ill.), Sept. 15, 2005, at 19; Mary Massingale, *Governor, Agency Sued Over Contraceptive Rule*, ST. J.-REGISTER (Springfield, Ill.), Dec. 21, 2005, at 11.

8. Kaiser Family Foundation, *Three Bills Introduced in Illinois That Would Allow Pharmacists To Refuse to Fill EC Prescriptions; Gov. Says He Would Veto Measures*, Jan. 27, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=35034. As of September 2006, H.B. 4230, 94th Gen. Assemb., Reg. Sess. (Ill. 2005), H.B. 4246, 94th Gen. Assemb., Reg. Sess. (Ill. 2005), and H.B. 4346, 94th Gen. Assemb., Reg. Sess. (Ill. 2006), have been referred to the Illinois House Rules Committee.

9. See, e.g., Jeff Stryker, *Emergency Birth Control: Access Issues*, N.Y. TIMES, Mar. 11, 2003, at F5 (reporting that at least fourteen states considered emergency contraception legislation in 2003); Tresa Baldas, *Fighting Refusal to Treat*, NAT'L L.J., Mar. 7, 2005, at 1 (noting that in 2004, fourteen states introduced thirty-seven bills that would allow pharmacists to refuse to fill prescriptions on the basis of personal or moral convictions).

10. See, e.g., Editorial, *Moralists at the Pharmacy*, N.Y. TIMES, Apr. 3, 2005, § 4, at 12 (noting that over 180 incidents of pharmacist refusals occurred over a six-month period in 2004).

11. See, e.g., Ellen Goodman, *Pharmacists Dispensing More Than Medicine*, MIAMI HERALD, Apr. 13, 2005, at A23 (stating that in six months time there were 180 reports nationwide of pharmacists declining to fill prescriptions); Jim Ritter, *Planned Parenthood Protests Over Morning-After Pill; Downtown Pharmacist Wouldn't Sell Emergency Contraception*, CHI. SUN-TIMES, Mar. 23, 2005, at A10; Stacy Forster, *Pharmacist Rebuked; He Refused to Refill Birth Control Prescription*, MILWAUKEE J.-SENTINEL, Apr. 14, 2005, at B1.

12. FDA Denies Family Planning, Health Groups' Request To Allow Nonprescription Sales of Plan B, Daily Women's Health Policy Report, June 13, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=37830. For an in-depth look at the controversy surrounding the FDA's delay in approving Plan B for over-

unlikely, however, to reduce the incidence of pharmacist refusals.¹⁴ The FDA's approval limits the sale of Plan B without prescription to women over the age of eighteen.¹⁵ It requires pharmacies to stock Plan B behind the counter and pharmacists to confirm that each customer is eighteen or over before selling it without a prescription.¹⁶ As a result of the publicity surrounding the FDA's decision, awareness of the availability of Plan B has grown, and it is likely the number of interactions between women seeking access to Plan B, with or without a prescription, and pharmacists refusing to dispense it will increase.

the-counter use, see Michele Kort, *Denial by Delay: The Endless, Frustrating Saga of Plan B*, Ms., Jan. 1, 2006, at 12. In June of 2006, depositions of FDA officials confirmed that in 2005 former FDA Commissioner Lester Crawford took the unusual move of blocking out senior officials from the decisionmaking process regarding Plan B. Andrew Bridges, *Former Chief: FDA Meant to OK Plan B*, USA TODAY, June 13, 2006, http://www.usatoday.com/news/health/2006-06-13-fda-plan-b_x.htm.

13. See Press Release, U.S. Food and Drug Administration, 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), available at <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html> (last visited Aug. 29, 2006) [hereinafter FDA Press Release]. Reaction to the FDA's approval has been mixed, illustrating a continuing conflict. Proponents applaud the decision generally yet question its impact and express frustration over the politics leading to approval and the limitation that young women under 18 still need to have a prescription to access Plan B. See Press Release, Planned Parenthood Federation of America, Emergency Contraception OTC (Aug. 24, 2006), available at <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/emergency-contraception-otc.htm> (last visited Sept. 2, 2006); Press Release, Center for Reproductive Rights, Lawsuit by Center for Reproductive Rights Exposes High-Level FDA Cover-up (Aug. 24, 2006), available at http://www.reproductiverights.org/pr_06_0824FDACoverUp.html (last visited Sept. 4, 2006). For the view against emergency contraception, see Deirdre A. McQuade, United States Conference of Catholic Bishops, Why "Plan B" Won't Reduce Abortions (Aug. 25, 2006), <http://www.nccbuscc.org/prolife/publicat/lifeissues/082506.htm> (criticizing FDA approval and arguing that emergency contraception will not reduce the number of abortions performed and that emergency contraception is a potential abortifacient).

14. See Carol M. Ostrom, *Ruling Likely to Increase Access to Plan B Here*, SEATTLE TIMES, Aug. 25, 2006, at A7 (stating that while a policy director at Planned Parenthood of Washington believes that the FDA decision will likely improve access to Plan B, the decision will allow pharmacists who object to dispensing emergency contraception on personal moral grounds to continue to refuse).

15. *Id.*; see also Press Release, American College of Obstetricians and Gynecologists, Statement of the ACOG on the FDA's Approval of OTC Status for Plan B[®], Aug. 24, 2006, available at http://www.acog.org/from_home/publications/press_releases/nr08-24-06.cfm (last visited Sept. 12, 2006) (calling the FDA's decision to restrict OTC status to women over 18 a "missed opportunity" to prevent teenage pregnancy).

16. Press Release, *supra* note 15.

Presently three states, Arkansas,¹⁷ Mississippi¹⁸ and South Dakota,¹⁹ have adopted or expanded refusal clause statutes to cover pharmacists. A fourth, Georgia, has adopted regulations providing that a pharmacist's refusal to fill a prescription is not unprofessional conduct.²⁰ As of September 2006, eighteen states were considering forty bills that would permit health care providers, including pharmacists, to refuse to provide medical care that conflicts with religious or personal beliefs.²¹

The proponents of broad refusal clauses frame the debate as a contest between religious freedom and reproductive rights.²² Within that construct, they diminish the issue of reproductive rights to what they regard as a "lifestyle choice."²³ Thus, access to contraception becomes merely an elective option,²⁴ rather than a basic health care need essential for a woman's health and dignity during her reproductive years.²⁵ Given that paradigm, it is easy to see how "freedom of religion" trumps a "lifestyle choice" in the minds of the state legislators who enact these statutes.²⁶

17. ARK. CODE ANN. § 20-16-304 (2005) (originally enacted as 1973 Ark. Acts. No. 235).

18. Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. §§ 41-107-3, 41-107-5 (2004)

19. S.D. CODIFIED LAWS § 36-11-70 (2005) (originally enacted as 1998 S.D. Sess. Laws. Ch. 226).

20. See GA. COMP. R. & REGS. 480-5-.03(n) (2005) ("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 moral beliefs."); Elvia Diaz, *'Conscience' Bill for Pharmacists Vetoed; Pharmacists Can't Deny Service on Religious or Moral Basis*, ARIZ. REPUBLIC, Apr. 14, 2005, at A1 (reporting that the Governor of Arizona vetoed a bill that would have allowed pharmacists, health professionals and anyone employed by a health professional to decline to dispense prescription contraception, including emergency contraception, if they opposed its use for moral or religious reasons).

21. Twenty-nine of these bills apply specifically to pharmacists. See *infra* text accompanying notes 67-72.

22. Although the broadest statutes cover the right to die, physician-assisted suicide, stem cell research and other issues, reproductive rights was the original impetus for such laws and still remains the primary focus. See generally Bryan A. Dykes, *Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers*, 36 GA. L. REV. 565, 579 (2002); see also *infra* notes 400-402 and accompanying text.

23. See, e.g., R. Alta Charo, *The Celestial Fire of Conscience - Refusing to Deliver Medical Care*, 352 N. ENGL. J. MED. 2471, 2473 (2005) (criticizing health care professionals who abandon their obligation to provide reproductive medical care and claim such treatments are merely "lifestyle choices").

24. See *infra* notes 269-270 and accompanying text.

25. See Rebecca Cook, *Human Rights and Reproductive Self-Determination*, 44 AM. U.L. REV. 975 (1995) [hereinafter Cook, *Human Rights*] (noting that the right to decide whether or not to reproduce is a fundamental human right that has become an integral part of modern woman's struggle to assert her dignity and worth as a human being).

26. See *infra* text accompanying notes 228-231 (reviewing the history of equating birth control with promiscuity in women).

The terminology used to describe the legislation illustrates the tensions within the debate. Proponents refer to a law permitting pharmacists to refuse to dispense contraception as a “conscience clause,”²⁷ claiming pharmacists are entitled to the right of conscientious objection to protect their religious beliefs. In contrast, opponents often use the term “refusal clause,” to highlight the fact these statutes authorize a health care provider to refuse to fill an otherwise legal or ethical duty.²⁸ In this Article, the term “refusal clause” is used because it more accurately reflects the action taken by the pharmacist, as well as the impact of that action on a patient trying to obtain access to a legal medication. Use of this term should not be construed as a trivialization of religious freedom. On the contrary, this Article argues that the religious and moral beliefs of all those involved in the controversy must be taken into account to reach a proper balance of the rights at stake.

Pharmacist refusal clauses do create a clash of constitutional rights, pitting the religious freedom claims of pharmacists against the reproductive rights claims of their women customers. What is ignored when the debate is framed as an issue of religious freedom versus lifestyle choice, however, is the fact that refusal clauses effectively coerce non-consenting third parties into a course of action based on religious beliefs they do not share.²⁹ Religious freedom is without substance unless individuals are free to act consistently with their own conscience regarding doctrines of faith they do not hold.³⁰ When pharmacists use refusal clauses to deny women access to contraception, the imposition of their religious beliefs on others who do not share them has implications beyond issues of conscience and morality. Not only does it interfere with the woman’s constitutionally protected right to determine whether and when to have a child,³¹ with potentially disastrous consequence to her health and well-being, but it also has implications for the web of individuals, including her existing children, spouse, partner, or parents, who are intimately engaged in her life.

27. The terms “conscience clause” and “refusal clause” are often used interchangeably. They are given to a law that allows entities or individuals to refuse to treat, counsel, refer or insure certain health services they otherwise have a duty to provide based on religious or moral objections. AM. CIVIL LIBERTIES UNION, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 6 (2002), available at <http://www.aclu.org/FilesPDFs/ACF911.pdf> [hereinafter ACLU RELIGIOUS REFUSALS]. “[The] duty may arise from a state constitution, a statute or regulation, a series of court decisions, an employment relationship, a contract, a professional ethical obligation, or any other source.” *Id.*

28. *Id.*

29. See Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625, 682 (2003).

30. See Cook, *Human Rights*, *supra* note 25, at 1012.

31. See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (holding that married couples have the right to make decisions regarding contraception).

The controversy over abortion rights distorts and overshadows the debate about pharmacist refusal clauses.³² It obscures the fact that access to contraception does not implicate the government's interest in potential life recognized by the Supreme Court since *Roe v. Wade*.³³ It also fails to take into account the qualitative difference in the role a pharmacist plays in the provision of health care from that of physicians and other health care practitioners.³⁴ Separating out the narrower issue of the right of a pharmacist to deny access to contraceptives provides an opportunity to illuminate some of the underlying issues typically ignored in the larger debate.

This Article takes the position that refusal clauses for pharmacists are indefensible from a legal, ethical and public policy perspective. Using the methodology of feminist legal theory as a framework,³⁵ it addresses the unacknowledged assumptions and unspoken biases underpinning the "religious freedom versus lifestyle choice" debate, highlighting the particular, contextualized circumstances under which pharmacists attempt to impose their religious convictions upon women seeking to purchase contraceptives. Application of feminist methodology to the issue requires a nuanced approach that takes into account and balances the rights of all those involved, pharmacists and women patients alike. This framework supports the conclusion that pharmacist refusals should be permitted only under the most narrow circumstances.

Part I of the Article examines the history and development of refusal clauses at the state and federal levels and surveys the current landscape of pharmacist refusal clauses nationwide. Part II describes the context in which the debate over pharmacist refusal clauses is taking place, analyzing other controversial issues such as mandating insurance coverage for contraception, the expansion of the Catholic health care system nationwide, and the mislabeling of emergency contraception as an abortifacient. Part III applies the methodology of feminist legal theory to the debate over pharmacist refusal clauses, demonstrating the *necessity of contraception as basic health care for women*. It also examines the religious arguments against contraception through the lens of gender and highlights the bioethical requirement that women be treated as rational moral agents when making decisions about their reproductive health. Part IV discusses the role of pharmacists in the provision of health care, looking specifically at the

32. See Clark, *supra* note 29, at 658. One commentator has referred to it as a proxy for the abortion wars. Charo, *supra* note 23, at 3.

33. 410 U.S. 113, 163 (1973) (holding that the state's interest in potential life becomes compelling at the viability of the fetus); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (concluding that the right to privacy prevents government from imposing an "undue burden" on the decision whether to have an abortion).

34. Despite the recent expansion of the pharmacist's role by pharmacy associations to include "pharmaceutical care," both legally and ethically the pharmacist's primary duty is to dispense medications prescribed by physicians. See *infra* Part IV.

35. For an overview of feminist legal theory and scholarship, see generally Katherine Bartlett, *Feminist Legal Methods*, 103 HARV. L. REV. 829 (1990); Linda E. Fisher, *I Know It When I See It, or What Makes Scholarship Feminist: A Cautionary Tale*, 12 COLUM. J. GENDER & L. 439 (2003); Martha L. A. Fineman, *Feminist Theory and Law*, 18 HARV. J.L. & PUB. POL'Y 349 (1995).

legal and ethical obligations of pharmacists. Part V then examines the constitutional issues raised by refusal clauses for pharmacists, analyzing the impact of the First and Fourteenth Amendments on the validity of refusal clauses. Finally, Part VI sets forth a public policy proposal, recommending that an individual pharmacist have the right to refuse to dispense contraception only if the contraception can be obtained from another pharmacist immediately, thus ensuring that there is no infringement upon the woman's right to procreative self-determination in accordance with her own religious and moral principles.

I. THE NATURE OF PHARMACIST REFUSAL CLAUSES IN THE UNITED STATES

A. History and development of refusal clauses

When refusal clauses covering reproductive health services first emerged at the time of the Supreme Court's decision in *Roe v. Wade*, they typically provided narrow exemptions permitting certain individuals and institutions to refuse to perform abortions and sterilizations.³⁶ In 1973, the same year *Roe v. Wade* was decided, Congress enacted the first federal refusal statute, known as the Church Amendment.³⁷ The Church Amendment was a direct response to the decision in *Taylor v. St. Vincent's Hospital*, in which the U.S. District Court for Montana issued a preliminary injunction requiring St. Vincent's, a Catholic hospital, to provide sterilizations.³⁸ Among other things, the Church Amendment provided that receipt of federal funds did not require an individual or entity to perform abortions or sterilizations if to do so would be contrary to the "religious beliefs or moral convictions" of the individual or entity.³⁹

Following Congress's lead, many states enacted refusal clauses covering abortion and sterilization procedures in the years immediately following *Roe v. Wade*. By 1978, nearly all states had adopted refusal clauses pertaining to abortion, while several had enacted clauses that also included sterilization and

36. See Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP. ON PUB. POL'Y, Aug. 2005, at 7 (examining the evolution of refusal clauses since *Roe*, and suggesting that recent refusal clauses attempt to create a right not just to withdraw but to obstruct care).

37. Act of June 18, 1973, Pub. L. No. 93-45, Title IV, § 401, 87 Stat. 95 (1973) (codified at 42 U.S.C. Section 300a-7 (2005)) (sponsored by Senator Frank Church).

38. 369 F. Supp. 948 (D. Mont. 1973), *aff'd*, 523 F.2d 75 (9th Cir. 1975). Citing religious grounds, St. Vincent's Hospital refused to perform a sterilization procedure on Mrs. Taylor. *Id.* at 949. The Taylors obtained an injunction requiring the hospital to perform the procedure, arguing that the hospital, which received federal funding, was a state actor. *Id.* at 950. Shortly afterwards, Congress passed the Church Amendment, and the court dissolved its prior injunction, holding that under the Amendment, the receipt of federal funds could not be used to find state action. *Id.* at 951.

39. 42 U.S.C. § 300a-7(e) (2005); see also Rachel Benson Gold & Adam Sonfield, *Refusing to Participate in Health Care: A Continuing Debate*, GUTTMACHER REP. ON PUB. POL'Y, Feb. 2000, at 8 (noting that the statute does not offer criteria for determining when a health care facility, a corporate entity, may claim a religious or moral belief).

contraception.⁴⁰ Many of these statutory provisions seemed to be more about disapproval of abortion in general than about protecting religious freedom.⁴¹ Of the forty-two statutes permitting facilities to refuse to perform abortions, twenty-nine “allowed any health care facility to refuse,” fifteen referred to private medical facilities, and only the California statute required that the facility “be organized and operated by a religious institution.”⁴²

After the initial wave of legislation, the issue of refusal clauses remained dormant for about twenty years.⁴³ While an occasional case arose from the refusal of a hospital or doctor to perform a necessary medical procedure, it was most often decided on theories of informed consent, negligence, or medical malpractice.⁴⁴ However, the issue gained renewed attention beginning in the mid-1990s with the managed care explosion⁴⁵ and the emergence of Catholic hospitals as a significant power in the provision of health care.⁴⁶ Media attention erupted when insurance companies provided coverage for Viagra (the male impotence pill), while maintaining a forty-year policy of refusing to cover prescription oral contraceptives.⁴⁷ After the FDA approved emergency contraception by prescription in 1998,⁴⁸ state and federal legislators opposed to contraception turned their attention back to the issue of refusal clauses. As a result of this “second wave of refusal clauses,”⁴⁹ by September of 2006, forty-seven states and the District of Columbia had laws permitting doctors and hospitals (as well as other individuals

40. See generally Gold & Sonfield, *supra* note 39, at 9 (summarizing federal and state policies permitting nonparticipation in reproductive health care).

41. See Clark, *supra* note 29, at 646 n.98.

42. *Id.*

43. See ACLU RELIGIOUS REFUSALS, *supra* note 27, at 1.

44. See, e.g., *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 245 (Ct. App. 1989) (holding that if providing rape victims with information about emergency contraception was the standard of care in the medical community, a hospital's failure to do so would constitute malpractice).

45. See Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. IV, § 1852(j)(3)(B), 111 Stat. 251, 295 (1997) (codified at 42 U.S.C. § 1396n (b)(4) (2005)) (extending federal refusal clauses to cover Medicaid managed care plans, exempting managed care organizations from providing family planning services to Medicaid patients, despite a statutory entitlement to receive such services).

46. See LIZ BUCAR, CATHOLICS FOR A FREE CHOICE, CAUTION: CATHOLIC HEALTH RESTRICTIONS MAY BE HAZARDOUS TO YOUR HEALTH 1 (1999), available at <http://www.catholicsforchoice.org/topics/healthcare> (reporting 127 mergers and affiliations between Catholic and non-Catholic hospitals between 1990 and 1998, almost half of which resulted in the elimination of all or some reproductive health services).

47. See Debra Baker, *Viagra Spawns Birth Control Issue*, A.B.A. J., Aug. 1998, at 36 (quoting the co-founder for the Center for Reproductive Law and Policy: “This is a problem that is so obvious it got hidden. Because women were denied coverage for so long, no one ever questioned it. Viagra demonstrates the inequities.”)

48. See PLANNED PARENTHOOD FED’N OF AM., *supra* note 2, at 2 (examining FDA’s continuing and historical reluctance to approve emergency contraception pills for use and over-the-counter sale).

49. See ACLU RELIGIOUS REFUSALS, *supra* note 27, at 1.

and entities) to refuse to provide a range of reproductive health services to women.⁵⁰

B. Current landscape of refusal clauses for pharmacists

Arkansas enacted the earliest refusal clause covering pharmacists in 1973 as part of the Arkansas Family Planning Act.⁵¹ It is still in effect today. Despite a broad public policy statement supporting access to contraceptives,⁵² the statute permits a pharmacist or physician to refuse to “furnish any contraceptive procedures, supplies or information,” without requiring the refusal to be based on religion, conscience or moral convictions.⁵³ South Dakota became the first state in the *Roe v. Wade* era to enact a pharmacist refusal clause dealing with reproductive health issues.⁵⁴ The 1998 statute is abortion-focused, providing that no pharmacist is required to dispense medication if there is “reason to believe that the medication will be used to: 1) cause an abortion, or 2) destroy an unborn child.”⁵⁵ The statute also protects pharmacists from damages claims arising out of a refusal exercised under its provisions.⁵⁶

In 2001, Georgia addressed the issue of pharmacist refusals by incorporating a refusal provision into its administrative code as part of the regulations promulgated by the Georgia State Board of Pharmacy.⁵⁷ The Code of Professional Conduct promulgated by the Georgia State Board of Pharmacy provides that a pharmacist’s refusal to fill any prescription based on “professional

50. See generally NARAL PRO-CHOICE AM., WHO DECIDES? THE STATUS OF WOMEN’S REPRODUCTIVE RIGHTS IN THE UNITED STATES (15th ed. 2006), available at http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/about-who-decides/welcome.html.

51. See ARK. CODE ANN. § 20-16-301 to -305 (2005).

52. See ARK. CODE ANN. § 20-16-302 (referencing the social, economic, and environmental harms associated with continuing population growth, and the lack of access to contraceptive-related resources within the state, and expressing an intent to eliminate restrictions preventing access to contraceptive procedures).

53. See ARK. CODE ANN. § 20-16-304(4) (explaining that the statute does not prohibit a “a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information”); ARK. CODE ANN. § 20-16-304(5) (protecting private and public institutions from liability for refusing to provide contraceptive procedures, supplies and information because of a religious or conscientious objection).

54. See S.D. CODIFIED LAWS § 36-11-70 (2005). Mississippi also enacted a refusal clause covering pharmacists in 1998, but it was part of the state’s Uniform Health-Care-Decisions Act, which deals primarily with patient consent and advanced health directives regarding end of life issues. MISS. CODE ANN. §§ 41-41-201 to -229 (2005).

55. S. D. CODIFIED LAWS § 36-11-70 (2004); see also S. D. CODIFIED LAWS § 22-1-2(50) (2005) (defining “unborn child” as “an individual organism of the species homo sapiens from fertilization until live birth”).

56. S. D. CODIFIED LAWS § 36-11-70.

57. See GA. COMP. R. & REGS. 480-5-.03 (2005).

judgment or ethical or moral beliefs” is not unprofessional conduct.⁵⁸ Thus, a refusal does not subject a pharmacist to disciplinary action under the Code.⁵⁹

Most recently, in July 2004 Mississippi passed a sweeping refusal clause known as the Mississippi Health Care Rights of Conscience Act.⁶⁰ The statute broadly defines a health care provider as “any individual who may be asked to participate in any way in a health care service,” and lists seventeen categories of covered providers, including pharmacists and pharmacy employees.⁶¹ The statute defines “conscience” as “the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer.”⁶² The statute establishes the right of a health care provider not to participate in any health care service that violates his or her conscience, and immunizes him or her from civil, criminal, and administrative liability.⁶³

It should be noted that there are no provisions in the Mississippi statute, or in the refusal clauses adopted in Arkansas, North Dakota or Georgia, that provide protection for the patient. Not one of these refusal clauses requires an objecting pharmacist to refer the patient to another pharmacist or health care provider, or to transfer a prescription to another pharmacy. On the contrary, the existing refusal clauses fail to address the needs of patients in any way, despite the ethical obligation of pharmacists to place the needs of their patients first.⁶⁴

A number of state legislatures have considered pharmacist refusal clauses during the past five years,⁶⁵ but it was not until 2005 that this legislative activity garnered widespread national attention.⁶⁶ During January 2006 alone, legislatures in eight states considered bills specifically targeting pharmacists.⁶⁷ Bills such as

58. GA. COMP. R. & REGS. 480-5-.03(n).

59. GA. COMP. R. & REGS. 480-5-.03(o).

60. MISS. CODE ANN. §§ 41-107-1 to -13 (2004).

61. MISS. CODE ANN. § 41-107-3(b).

62. MISS. CODE ANN. § 41-107-3(h).

63. MISS. CODE ANN. § 41-107-5. It also makes it unlawful discrimination to take any employment action in response to a refusal based on conscience, MISS. CODE ANN. § 41-107-5(3), and creates a right of action for damages and injunctive relief, including treble damages for pain and suffering, for a health care provider harmed by a violation of the statute. MISS. CODE ANN. § 41-107-11.

64. See *infra* text accompanying notes 325–343.

65. For example, in 2001 seven states considered a total of eleven bills that would have allowed pharmacists to refuse to dispense certain drugs, including contraceptives, if they objected on moral or religious grounds. NARAL FOUND., THE CONTRACEPTION REPORT: A STATE-BY-STATE REVIEW OF ACCESS TO CONTRACEPTION xiv (2001).

66. See generally NAT'L WOMEN'S LAW CTR., DON'T TAKE “NO” FOR AN ANSWER: A GUIDE TO PHARMACY REFUSAL LAWS, POLICIES AND PRACTICES (2005) http://www.nwic.org/pdf/8_2005_Donttaken1.pdf [hereinafter NAT'L WOMEN'S LAW CTR., GUIDE] (surveying laws and pharmacy licensing regulations pertaining to a pharmacist's right to refuse or duty to dispense medication).

67. See Nat'l Conference of State Legislatures, Pharmacist Conscience Clauses and Legislation: Update Jan. 2006, <http://www.ncsl.org/programs/health/conscienceclauses.htm>; Rob Stein, *Health Workers' Choice Debated; Proposals Back Right Not to Treat*, WASH. POST, Jan. 30, 2006, at A1.

those in New Hampshire, Missouri, Georgia, Wisconsin, and West Virginia would permit a pharmacist to refuse to dispense prescriptions specifically for contraceptives or abortifacients, without any reference to religious beliefs, moral beliefs, or conscience.⁶⁸ Bills currently pending in Illinois, Tennessee, and North Carolina would permit pharmacists to refuse to dispense prescriptions specifically for contraceptives or abortifacients on the basis of religious or moral beliefs.⁶⁹ Additionally, proposed legislation in at least five states includes pharmacists or the dispensation of prescriptions among the list of health care professionals or activities protected by a refusal clause.⁷⁰ Like the four refusal clauses already in place, none of these bills require referrals or transfers, and none provide adequate protection for the patient.⁷¹ In contrast, legislatures in four states have introduced bills that would require pharmacists to fill prescriptions for contraceptives.⁷² At the federal level, two laws are pending which would require pharmacists to fill prescriptions.⁷³

68. See H.B. 1492, 159th Leg., 2d Sess. (N.H. 2006); S.B. 609, 93d Gen. Assemb., 2d Reg. Sess. (Mo. 2006) (applying to drugs that a pharmacist believes in good faith would “contribute to death of a human being by abortion or otherwise”); S.B. 123, 148th Gen. Assemb., Reg. Sess. (Ga. 2006); S.B. 155, 97th Leg., Reg. Sess. (Wis. 2006); H.B. 2042, 79th Leg. (W. Va. 2005) (applying to drugs that can be used as abortifacients or “part of an abortion-related procedure”).

69. See H.B. 4346, 94th Gen. Assemb. (Ill. 2006); H.B. 1383, 104th Gen. Assemb. (Tenn. 2005); H.B. 1407, Gen. Assemb., 2005 Reg. Sess. (N.C. 2005).

70. S.B. 938, 93d Leg., 1st Reg. Sess. (Mich. 2005); H.B. 183, 68th Biennial Sess. (Vt. 2005); H.B. 469, 126th Gen. Assemb., Reg. Sess. (Ohio 2006); Assemb. No. 2016, 212th Leg. (N.J. 2006); H.B. 1654, 59th Leg., Reg. Sess. (Wash. 2005)

71. See NAT’L WOMEN’S LAW CTR., GUIDE, *supra* note 66, at 5.

72. S.B. 1518, 47th Leg., 2d Reg. Sess. (Ariz. 2006); Assemb. No. 3772, 212th Leg. Sess. (N.J. 2006); S.B. 5664, Reg. Sess. (N.Y. 2006); H.B. 2311, 2005 Gen. Assemb., Reg. Sess. (Pa. 2005–2006). Additionally, Massachusetts and North Carolina each have a pharmacy-board policy that requires pharmacists to ensure that valid prescriptions are filled in a timely manner. See N.C. Bd. of Pharmacy, Conscience Concerns in Pharmacist Decisions (Apr. 2005), <http://www.ncbop.org/LawsRules/ConscienceClause.pdf>; 247 MASS. CODE REGS. 9.01 (2005). Illinois has a regulation which requires pharmacies to fill valid contraception prescriptions without delay. See *supra* text accompanying notes 2–8.

73. See, e.g., Compassionate Care for Female Sexual Assault Survivors Act, H.R. 4113, 107th Cong. (2002) (proposing that Catholic hospitals receiving federal funds be required to provide survivors of sexual assault with emergency contraception); Emergency Contraception Education Act, H.R. 3887, 107th Cong. (2002), S. 1990, 107th Cong. (2002) (proposing the allotment of funds for an educational campaign about emergency contraception). Both bills, while supported by many Americans, sparked strong political opposition from pro-life forces and did not pass. Sally Peters, *Voter Support for EC*, 37 OB. GYN. NEWS 30 (Nov. 1, 2002). *But see* Consolidated Appropriations Act of 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809 (2004) (prohibiting the government from penalizing health care entities or providers for refusing to “provide, pay for, provide coverage of, or refer for abortions”).

II. THE CONTEXT FOR THE DEBATE OVER PHARMACIST REFUSAL CLAUSES

The debate over pharmacist refusal clauses takes place in the context of a broader conflict over contraception and abortion, and ultimately over the role of religion and women in a pluralistic society. This conflict is at the heart of a range of controversial issues, including states' attempts to mandate insurance coverage for prescription contraception,⁷⁴ and the nationwide expansion of Catholic health care systems through mergers and acquisitions.⁷⁵ It is also at the center of efforts in a number of states to require Catholic hospitals to provide emergency contraception to rape victims treated in their emergency rooms,⁷⁶ and efforts to obtain approval from the Food and Drug Administration for over-the-counter sale of emergency contraception.⁷⁷ These issues are fueled by a debate over whether emergency contraception is birth control or an abortifacient.⁷⁸ Each of these issues impacts the debate over pharmacist refusal clauses differently and will be explored below.

A. Mandating insurance coverage for prescription contraception

In 1998, thirty-eight years after the FDA first approved oral contraceptives for prescription use,⁷⁹ only fifteen percent of traditional insurance indemnity plans covered all of the prescription contraceptives most commonly used by women, and forty-nine percent of plans covered none of them.⁸⁰ Ironically,

74. See generally Breena M. Roos, Note, *The Quest for Equality: Comprehensive Insurance Coverage of Prescription Contraceptives*, 82 B.U. L. REV. 1289, 1301–05 (2002) (tracing the movement's evolution and noting that in 2002, at least twenty states had laws requiring employers or insurance companies to provide group health insurance coverage for contraception).

75. See BUCAR, *supra* note 46, at 1 (reporting that, from 1990–1999, thirty-four states experienced a Catholic/non-Catholic hospital merger or affiliation, with 127 total mergers taking place).

76. See CATHOLICS FOR A FREE CHOICE, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 5 (2002), http://www.catholicsforchoice.org/topics/healthcare/documents/2002secondchancedenied_001.pdf [hereinafter SECOND CHANCE DENIED] (finding that twenty-three percent of Catholic hospitals will provide emergency birth control to rape victims); see also *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 245 (Ct. App. 1989) (finding Catholic Hospital could be held liable for refusing to give a rape survivor information about emergency contraception and refusing to refer the woman to a location where she could obtain the medication).

77. See *supra* note 13.

78. See Rachel Benson Gold, *The Implications of Defining When a Woman Is Pregnant*, GUTTMACHER REP. ON PUB. POL'Y, May 2005, at 7.

79. See PLANNED PARENTHOOD FED'N OF AM., *supra* note 2 (summarizing the history of emergency contraception in the United States).

80. See Sylvia Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 372 (1998) (listing common types of prescription contraception at the time, including oral contraceptive pills, diaphragms, intrauterine devices (IUDs), and Norplant).

it was the development of a drug for male impotence, Viagra,⁸¹ which sparked a national campaign to mandate insurance coverage for female contraceptives.⁸² In March 1998, the Pfizer drug company introduced Viagra to the market.⁸³ Less than two months later, almost half of all Viagra prescriptions were covered by insurance plans.⁸⁴ In response to the outcry by women's health advocates, the insurance industry argued that prescription contraception was not necessary to treat a medical condition, while Viagra was treatment for the medical condition of impotence.⁸⁵ A spokesperson for the Health Insurance Association of American was quoted at the time as saying, "there is a clear distinction between Viagra, . . . approved for a medical dysfunction, and contraception . . . a 'lifestyle drug.'"⁸⁶ Despite the pervasiveness of this view,⁸⁷ within a year after Viagra received FDA approval, legislatures in twenty states had introduced bills requiring private health plans to include contraceptive pills and devices for women.⁸⁸

At the federal level, Congress mandated in 1998 that the Federal Employee Health Benefits Program ("FEHBP") provide federal employees with coverage for all FDA-approved methods of contraception.⁸⁹ The measure included a provision, however, which allowed non-compliance by five named religious health plans, as well as any other existing or future plan that objected on the basis of its "religious beliefs."⁹⁰ Likewise, the federal Medicaid program, while mandating coverage for family planning services,⁹¹ does not require managed care organizations serving Medicaid patients⁹² to provide such services.⁹³ In response,

81. See Lisa Hayden, Note, *Gender Discrimination Within the Reproduction Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 172 (1999).

82. See *id.*

83. See Amy Goldstein, *Viagra's Success Fuels Gender Bias Debate; Birth Control Advocates Raise Issue*, WASH. POST, May 20, 1998, at A1.

84. See Hayden, *supra* note 81, at 180 (recounting that, while no suit had yet been filed on behalf of women seeking coverage for contraception, two months after FDA approved Viagra, a class of men filed suit in New York, demanding insurance coverage for the drug because it treated a "vital human function"); see also Baker, *supra* note 47, at 44 (quoting Professor Sylvia Law's explanation that the issue of insurance coverage for contraception had not been litigated on behalf of women primarily because public interest groups spent most of their time litigating abortion-related cases).

85. See Baker, *supra* note 47, at 36.

86. *Id.*

87. See Hayden, *supra* note 81, at 182-85 (deconstructing the logic of insurer's medical necessity/lifestyle choice dichotomy).

88. See *id.* at 173 (discussing efforts by states to cover prescription contraception in wake of Viagra approval). In 1998, Maryland was the first state to require that health insurance companies providing coverage for prescription drugs and devices also cover contraceptives. Marc Kaufman, *More Health Plans Cover Birth Control*, WASH. POST, June 14, 2004, at A2.

89. Treasury and General Government Appropriations Act, 1999, Pub. L. No. 105-277, §§ 101(h), 656, 112 Stat. 2681, 2681-530 (1999).

90. *Id.*; see also Gold & Sonfield, *supra* note 39, at 10.

91. See 42 U.S.C. § 1396d(a)(4)(c) (2005).

92. Medicaid covers over seven million women of reproductive age, almost all of whom receive their health care through some type of managed care arrangement. Alan

legislation known as the Equity in Prescription Insurance and Contraceptive Coverage Act ("EPICC"), was first introduced in 1997⁹⁴ and has been introduced in each Congress since then.⁹⁵ EPICC would require all private, employment-based health insurance plans providing prescription coverage to also cover all FDA approved prescription contraceptive drugs or devices.⁹⁶ Although EPICC has stalled in Congress, it has provided a model for many of the recently passed state statutes mandating contraceptive coverage.

Since 1998, twenty-two states have enacted contraceptive equity laws requiring private insurance companies to provide coverage for prescription contraceptives if other prescriptions are covered.⁹⁷ Of those, seventeen have refusal clauses permitting entities or individuals to avoid the mandate.⁹⁸ Only eight of the statutes that have refusal clauses provide some definition of religious employer or organization.⁹⁹ In the first case to challenge a contraceptive equity law, *Catholic Charities of Sacramento, Inc. v. Superior Court*, the Supreme Court of California upheld the California Women's Contraceptive Equity Act

Guttmacher Inst., *Medicaid: A Critical Source of Support for Family Planning in the United States*, Apr. 2005, at 1, <http://www.guttmacher.org/pubs/medicaid-IB-Gold.pdf>.

93. See 42 U.S.C. § 1396n(b)(4).

94. Equity in Prescription Insurance and Contraceptive Coverage Act of 1997, S. 743, H.R. 2174, 105th Cong. (1997) [hereinafter EPICC 1997].

95. See Equity in Prescription Insurance and Contraceptive Coverage Act of 2005, S. 1214, 109th Cong. (2005) (referred to the Committee on Health, Education, Labor and Pensions on June 9, 2005); Equity in Prescription Insurance and Contraceptive Coverage Act of 2003, S. 1396 & H.R. 2727, 108th Cong. (2003); Equity in Prescription Insurance and Contraceptive Coverage Act of 2001, S. 104 & H.R. 1111, 107th Cong. (2001); Equity in Prescription Insurance and Contraceptive Coverage Act of 1999, S. 1200 & H.R. 2120, 106th Cong. (1999).

96. See EPICC 1997, *supra* note 94. The bill would also require coverage of incidental costs related to prescription contraception, such as initial doctor visits and annual follow up visits. *Id.* It failed to pass the 108th Congress as an amendment to the partial-birth-abortion act, but was reintroduced in the 109th Congress by its original sponsor, Senator Olympia Snow. S. 1214.

97. See generally Ctr. for Reprod. Rights, *Contraceptive Equity Laws in The States* (Aug. 2005), http://www.crlp.org/st_equity.html (citing Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Missouri, Nevada, New Hampshire, New Mexico, New York, North Carolina, Rhode Island, Texas, Vermont, and Washington).

98. The states with refusal clauses are: Arizona, Arkansas, California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Missouri, Nevada, New Mexico, New York, North Carolina, Rhode Island, and Texas. *Id.* Georgia, New Hampshire, Vermont and Washington have no refusal clause, *id.*, while Iowa has a provision that permits an individual policy holder to reject contraceptive coverage, but does not exempt religious or other organizations. IOWA CODE § 514C.19(6) (2005).

99. Nevada and Texas permit employers who are affiliated or associated with religious organizations to avoid the mandate. See NEV. REV. STAT. §§ 689A.0415(5), 689A.0417(5), 689B.0376(5), 689B.0377(5) (2006); TEX. INS. CODE ANN. § 1369.108 (2005). Massachusetts and Connecticut exempt a "church-affiliated organization" or a "qualified church-controlled organization" as defined by federal law. CONN. GEN. STAT. § 38a-503e(f) (2006); MASS. GEN. LAWS ch. 176G, § 40(c) (2005).

(“WCEA”),¹⁰⁰ rejecting Catholic Charities’ constitutional challenge under the Establishment and Free Exercise Clauses.¹⁰¹ The refusal clause in the California statute defined a “religious employer” as an entity that meets four specific criteria, one of which is to have as its purpose the “inculcation of religious values”¹⁰² Upholding the trial court’s denial of declaratory and injunctive relief, the California Supreme Court dismissed the contention that the WCEA was too narrowly drawn and impermissibly interfered with matters of religious doctrine and internal church governance.¹⁰³

The legal issues raised in the WCEA challenge are similar to those raised in opposition to statutes requiring pharmacists to dispense contraceptives, including claims of First Amendment protections. Likewise, refusal clauses exempting religious hospitals from providing the full range of reproductive health care services implicate many of the same issues.

B. Expansion of Catholic health care systems and the distribution of emergency contraception

Hospitals run by several religious denominations restrict medical services.¹⁰⁴ For example, Seventh Day Adventist hospitals and some Baptist hospitals do not provide abortion services and stress “abstinence only” birth control.¹⁰⁵ Jewish hospitals do not restrict medical services, but some Orthodox Jewish nursing homes restrict end of life directives.¹⁰⁶ However, the growing power of the nation’s Catholic hospitals and health care systems creates the largest threat to the availability of a full range of reproductive health care services for women.¹⁰⁷ This is particularly true in light of the numerous broad-based refusal clauses discussed above that permit entire health care systems to opt out of providing reproductive health services, counseling, and referrals.¹⁰⁸

100. CAL. HEALTH & SAFETY CODE § 1367.25 (West Supp. 2004) (enacted 1999) (mandating that all group and individual health and disability insurance policies covering prescriptions also cover prescription contraceptives).

101. 85 P.3d 67, 79-80, 83-89 (Cal. 2004), *cert denied*, 543 U.S. 16 (2004).

102. CAL. HEALTH & SAFETY CODE §§ 1367.25(b)(1)(A)–(D) (listing four criteria, including employment of people of the same beliefs, primarily serving people of the same beliefs, and falls under certain statutory classification of non-profit institutions).

103. *Catholic Charities*, 85 P.3d at 77.

104. See Susan B. Fogel & Lores A. Rivera, *Saving Roe is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L. J. 725, 732 (2004) (discussing the significant control which religiously-affiliated hospitals have in the marketplace); LOIS UTTLEY & RONNIE PAWELKO, NO STRINGS ATTACHED: PUBLIC FUNDING OF RELIGIOUSLY-SPONSORED HOSPITALS IN THE UNITED STATES, 24 (2002), http://www.mergerwatch.org/pdfs/bp_no_strings.pdf [hereinafter NO STRINGS ATTACHED].

105. See Fogel & Rivera, *supra* note 104, at 733.

106. See *id.* at 732.

107. See generally Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1113-14 (1996) (describing how selective cuts in health services in Catholic Hospitals disproportionately affect poor women of color, for whom the cuts function as “total barriers” to the receipt of reproductive health care).

108. See *supra* Part I; see also Fogel & Rivera, *supra* note 104, at 743.

The Catholic health care system is the largest private, non-profit health care provider in the United States.¹⁰⁹ Each of the Nation's sixty Catholic health care systems is comprised of one or more hospitals, outpatient clinics, laboratories, physician groups and health maintenance organizations.¹¹⁰ Most of the hospital mergers that occur in today's health care market involve Catholic entities,¹¹¹ and about half result in a reduction or elimination of reproductive health services.¹¹² Many of the nonprofit hospitals acquired or merged with Catholic hospitals are located in rural or other economically underserved communities.¹¹³

The limits placed on the provision of health care by Catholic institutions are imposed by a document entitled the Ethical and Religious Directives for Health Care Services ("Directives"),¹¹⁴ first promulgated by the United States Conference of Catholic Bishops in 1994.¹¹⁵ The Directives are a sophisticated set of rules through which the Catholic clerical hierarchy asserts its authority over the business of Catholic health care.¹¹⁶ All Catholic health care services are required to adopt the Directives as policy;¹¹⁷ typically, a Catholic hospital board adopts the Directives as part of its corporate laws.¹¹⁸ The Directives require a bishop's

109. See Fogel & Rivera, *supra* note 104, at 730. According to the Catholic Health Association, as of 2005 there were 611 Catholic hospitals in the United States, an increase of 70 hospitals since 1997. See Catholic Health Association of the United States, Catholic Health Care in the United States 2 (Jan. 2005), <http://www.chausa.org/ABOUTCHA/FACTSHEET.PDF>.

110. See CATHOLICS FOR A FREE CHOICE, CATHOLIC HEALTH CARE UPDATE: THE FACTS ABOUT CATHOLIC HEALTH CARE IN THE UNITED STATES 1 (Sept. 2005) [hereinafter CFFC UPDATE], <http://www.catholicsforchoice.org/topics/healthcare/keypubs.asp#chcfacts>.

111. See *id.* at 6 (noting there were 171 mergers or acquisitions between 1990–2004).

112. See *id.* at 2 (noting that abortions are banned at Catholic-affiliated hospitals, and programs most likely to be eliminated include sterilizations, family planning programs, and emergency contraception for rape victims).

113. See NO STRINGS ATTACHED, *supra* note 104, at 31 (noting that forty-eight religious hospitals in the study's database were the sole providers of hospital care for more than seventy-five percent of population in the service area or were located forty-five miles away from another hospital, and an estimated twenty-eight percent of Catholic acute care hospitals are located in rural areas); Clark, *supra* note 29, at 639–40 (pointing out that in areas where a Catholic hospital is a "sole-provider," most of the population is not Catholic).

114. See COMM. ON DOCTRINE, NAT'L CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001), available at <http://www.nccbuscc.org/bishops/directives.shtml> [hereinafter DIRECTIVES].

115. See Arthur B. LaFrance, *Corporate Ethics and Governance in the Health Care Marketplace: Merger of Religious and Public Hospitals: Render Unto Caesar . . .*, 3 SEATTLE J. SOC. JUST. 229, 234 (2004).

116. See *id.* at 234–36 (explaining that the Directives are meant to prevent "market forces and the imperatives of competition" from causing Catholic health care institutions to "compromise their theological principles").

117. DIRECTIVES, *supra* note 114, at pt. I, No. 5; see also LaFrance, *supra* note 115, at 240 (suggesting that the Directives "transform [Catholic] teaching and principles from matters of individual adherence to matters of corporate and community policy").

118. See Clark, *supra* note 29, at 634–35 (explaining that the Church views the hospital as a corporation with civil law obligations and as a "moral person" under canon law).

approval for any partnership or merger,¹¹⁹ and require compliance by non-Catholic institutions that form new partnerships or merge with Catholic health care providers.¹²⁰ All physicians and other employees of the institution are required to comply with the Directives.¹²¹ Although the Directives acknowledge that many patients will not have the same religious or moral beliefs, they provide that patients who use Catholic health care “accept its public commitment to the Church’s understanding of and witness to the dignity of the human person.”¹²²

It is in the area of reproductive health that the Catholic religious doctrine underpinning the Directives has the greatest impact. Part IV of the Directives contains numerous restrictions on the provision of reproductive health care, including prohibitions against sterilization¹²³ and contraception.¹²⁴ Directive 45 unequivocally forbids abortion,¹²⁵ stating that abortion “includes the interval between conception and implantation of the embryo.”¹²⁶ In addition, the Directives prohibit artificial insemination by a spouse or donor,¹²⁷ in vitro fertilization,¹²⁸ surrogacy arrangements,¹²⁹ and the destruction of embryos.¹³⁰

While Catholic hospitals historically served communities who shared the religious beliefs underlying the policies set forth in the Directives,¹³¹ today they serve patients and employ health care professionals who come from many different

119. LaFrance, *supra* note 115, at 237 (Directive 68).

120. DIRECTIVES, *supra* note 114, at pt. I, No. 8. Further, the doctrine of “material cooperation” (which prohibits providing assistance for acts forbidden by Church teachings even without intending the act to take place) severely limits the ability of an entity merging with a Catholic hospital to create independent clinics or other facilities to provide prohibited services. *See* DIRECTIVES, *supra* note 114, at 29.

121. DIRECTIVES, *supra* note 114, at pt. I, No. 5.

122. *Id.* at pt. III, intro. The statement continues, “[the] professional-patient relationship is never separated, then, from the Catholic identity of the health care institution.” *Id.*

123. *See* DIRECTIVES, *supra* note 114, at pt. IV, No. 53. Directive 53 prohibits the performance of sterilization at Catholic hospitals, but permits the performance of procedures that “induce sterility” in certain medically necessary situations.

124. *See* DIRECTIVES, *supra* note 114, at pt. IV, No. 52. Acts of contraceptive intervention are prohibited that “either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible.” DIRECTIVES, *supra* note 114, at pt. I, intro. (quoting POPE PAUL VI, ENCYCLICAL LETTER 14: ON THE REGULATION OF BIRTH (HUMANAE VITAE) (1968)).

125. *Id.* at pt. IV, No. 45.

126. *See id.*

127. *See id.* at pt. IV, Nos. 40–41.

128. *See id.* at pt. IV, intro. (“Reproductive technologies that substitute for the marriage act are not consistent with human dignity.”).

129. *See id.* at pt. IV, No. 42.

130. *See id.* at pt. IV, No. 39, 51. This includes the use of embryonic stem cells for research or treatment. *Id.* at pt. V, No. 66.

131. *See* Leonard J. Nelson, III, *God and Woman in the Catholic Hospital*, 31 J. LEGIS. 69, 115–25 (2004) (discussing the evolving relationship between Catholic Hospitals and the Ethical and Religious Directives).

faiths as well as those who profess no faith at all.¹³² Catholic hospitals rarely disclose the religious restrictions on reproductive health services to consumers before the time of service, creating significant barriers to informed consent and effective decision-making by patients.¹³³ Furthermore, when a Catholic hospital is the sole provider in an area, particularly a poor, rural area, the burden falls upon low-income women who do not have the resources to travel long distances to obtain services from an alternative provider.¹³⁴ Catholic hospitals are non-profit corporations and receive tax exemptions and substantial financial support from federal and state governments.¹³⁵ However, most states and the federal government have adopted refusal clauses permitting these hospitals to refuse to provide necessary medical services, some of which cover entire corporate health systems.¹³⁶ Most of these refusal clauses also relieve covered institutions from the obligation to provide referrals or counseling to obtain restricted services from another source.¹³⁷

Perhaps the most controversial constraints which Catholic hospitals impose are restrictions on the distribution of emergency contraception to rape survivors seeking treatment at Catholic emergency rooms.¹³⁸ According to one extensive study, eighty-two percent of Catholic hospitals refuse to dispense emergency contraception to rape survivors.¹³⁹ Many also refuse to provide

132. See Clark, *supra* note 29, at 633.

133. See Fogel & Rivera, *supra* note 104, at 740. A national survey in 2000 by Catholics for Free Choice found that almost half of women stated they expected to have access to a full range of reproductive health services (excluding abortion) if treated in a Catholic hospital. See BELDEN RUSSONELLO & STEWART, RELIGION, REPRODUCTIVE HEALTH AND ACCESS TO SERVICES: A NATIONAL SURVEY OF WOMEN, CONDUCTED FOR CATHOLICS FOR A FREE CHOICE 13 (2006), <http://www.catholicsforchoice.org/topics/healthcare/documents/2000religionreproductivehealthandaccessstoservices.pdf>.

134. Fogel & Rivera, *supra* note 104, at 733.

135. See NO STRINGS ATTACHED, *supra* note 104, at 13, 65 (religious hospitals in general rely on Medicare and Medicaid for half of their revenues and use the proceeds of government-issued tax exempt bonds to get low-cost financing for construction, expansion, and even acquisition of nonsectarian hospitals).

136. See *supra* text accompanying notes 40–50 (summarizing refusal clauses nationwide).

137. Although the right to receive or impart information regarding sexual and reproductive health is essential to reproductive decisionmaking, and necessary for informed consent on the part of the patient, doctors in Catholic hospitals are prohibited from fulfilling this legal and ethical obligation. See Clark, *supra* note 29, at 685–87.

138. See BELDEN RUSSONELLO & STEWART, *supra* note 133, at 2 (finding that seventy-eight percent of American women believe Catholic hospitals should provide emergency contraception to victims of rape).

139. See BUCAR, *supra* note 46, at 9-10. Of the 589 Catholic hospitals surveyed, only nine percent provided emergency contraception; eighty-two percent refused to provide it, and nine percent had no policy. *Id.* This is so despite the fact that the Directives include an exception for rape victims to the blanket prohibition against artificial birth control, permitting distribution of emergency contraceptives under limited circumstances. See DIRECTIVES, *supra* note 114, at pt. III, No. 36.

information about its availability to rape victims.¹⁴⁰ These policies directly contravene the medically accepted standard of care for treatment of rape victims. Both the American Medical Association and the American College of Obstetricians and Gynecologists have adopted a protocol for emergency treatment of sexual assault victims that requires the transmission of information about and access to emergency contraception.¹⁴¹ Given the fact that 330,000 women are raped or sexually assaulted in the United States each year, resulting in 22,000 pregnancies,¹⁴² the efficacy of this protocol is obvious.¹⁴³

States have enacted legislation requiring hospitals to provide sexual assault survivors access to emergency contraception.¹⁴⁴ These laws fall into three categories: 1) statutes requiring hospitals to provide information about emergency birth control and dispense it on site at the victim's request;¹⁴⁵ 2) statutes requiring hospitals to provide information and a referral for the medication;¹⁴⁶ and 3) statutes

140. Such policies pose serious problems for rape victims in communities with only Catholic hospitals, particularly since seventy-five percent of "sole-provider" Catholic hospitals refuse to provide emergency contraception. BUCAR, *supra* note 46, at 10; *see also*, e.g., *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240 (Ct. App. 1989) (adjudicating a rape survivor's suit against a Catholic hospital for its refusal to provide information about emergency contraception).

141. AM. MED. ASS'N, POLICY H-75.985, ACCESS TO EMERGENCY CONTRACEPTION (2004) (advising that patients and doctors be educated on treatment option for sexual assault survivors, including emergency contraception); AM. COLL. OF EMERGENCY PHYSICIANS, POLICY NO. 400130, MANAGEMENT OF THE PATIENT WITH THE COMPLAINT OF SEXUAL ASSAULT (2002) ("A victim of sexual assault should be offered prophylaxis for pregnancy . . .").

142. *See* Felicia H. Stewart & James Trussell, *Prevention of Pregnancy Resulting from Rape: A Neglected Preventive Health Measure*, 19 AM. J. PREV. MED. 228, 228 (2000) (finding that approximately 330,000 women are sexually assaulted each year, resulting in 25,000 pregnancies, an estimated 22,000 of which could have been prevented if all women who were raped used emergency contraception in a timely manner).

143. For decades doctors provided regular contraceptives "off-label" for emergency use; on February 25, 1997, the FDA formally approved this use when it announced that six brands of oral contraceptive were safe and effective for use in emergency regimes. CTR. FOR REPROD. RIGHTS, EMERGENCY CONTRACEPTION: COMMON LEGAL QUESTIONS ABOUT PRESCRIBING, DISPENSING, REPACKAGING AND ADVERTISING 1 (2002), http://www.reproductiverights.org/pdf/pub_bp_ec_commonlegal.pdf.

144. *See*, e.g., CAL. PENAL CODE § 13823.11(e) (2005); N.J. REV. STAT. § 26:2H-12.6a (2005); N.M. STAT. § 24-10D-3 (2005); N.Y. PUB. HEALTH LAW § 2805-p (2005); WASH. REV. CODE ANN. § 70.41.350 (LexisNexis 2005).

145. *See*, e.g., CAL. PENAL CODE § 13823.11(e) ("Postcoital contraception shall be dispensed by a physician or other health care provider upon the request of the victim."); N.M. STAT. ANN. § 24-10D-1-5 (2005) ("[P]rovide each sexual assault survivor with . . . accurate and objective . . . information about emergency contraception; (2) . . . inform each sexual assault survivor of her option to be provided emergency contraception at the hospital; and (3) provide emergency contraception at the hospital to each sexual assault survivor who requests it.").

146. *See*, e.g., 410 ILL. COMP. STAT. § 70/2-2 (2005) ("[E]very hospital providing services to alleged sexual assault survivors . . . must [ensure] that each survivor of sexual assault will receive medically and factually accurate and written and oral information about emergency contraception . . . and a description of how and when victims may be provided

requiring hospitals to dispense the medication only when a victim requests it.¹⁴⁷ The impact of state refusal clauses on laws mandating access to emergency contraception for rape victims remains untested and will depend upon the scope of the specific refusal clause.¹⁴⁸

At the heart of the debate, however, is the issue of whether emergency contraception is an abortifacient as well as a method of contraception. Emergency contraception functions in several ways. It may prevent a pregnancy prior to fertilization by suppressing ovulation or by inhibiting the movement of the sperm or the egg.¹⁴⁹ It also may work to disrupt the movement of a fertilized egg through the fallopian tube or prevent a fertilized egg from implanting in the uterine wall.¹⁵⁰ Within the medical community, it is undisputed that emergency contraception has no impact on an established pregnancy.¹⁵¹ However, there are significant differences between the medical and religious definitions of conception and pregnancy.¹⁵² Based on this distinction, Pharmacists for Life and others claim the protection of refusal clauses when they decline to dispense emergency contraception as well as ordinary birth control pills.

emergency contraception . . ."); 77 ILL. ADMIN. CODE tit. 77, § 545.95 (2005) (requiring an "appropriate referral to a physician licensed to practice medicine in all its branches").

147. See S.C. CODE ANN. § 16-3-1350 (2005) (stating that exams of sexual assault victims "must include medication for pregnancy prevention if indicated and if desired"); OR. ADMIN. R. § 137-084-0010 (2005) (indicating that the state will pay for emergency contraception dispensed to victims of sexual assault).

148. Most of the states that have enacted emergency contraception laws have refusal clauses that extend only to procedures such as abortion, sterilization and artificial insemination. See, e.g., MD. CODE ANN., HEALTH-GEN. § 20-214 (West 2005); N.M. STAT. ANN. § 24-8-6 (West 2005); see also *supra* note 50, discussing scope and nature of refusal clauses nationwide. Compare FLA. STAT. § 381.0051(6) (2005) (establishing the right of physicians or other persons to refuse to furnish contraceptives for medical or religious reasons), with Health Care Right of Conscience Act, 745 ILL. COMP. STAT. 70/4 (2002) (exempting health care providers from performing any medical treatment that is "contrary to [his/her] conscience").

149. See AM. PHARMACEUTICAL ASS'N, SPECIAL REPORT: EMERGENCY CONTRACEPTION, THE PHARMACIST'S ROLE 1 (2000) [hereinafter APHA SPECIAL REPORT], available at http://www.pharmacist.com/pdf/emer_contra.pdf (summarizing the ways in which emergency contraception may prevent pregnancy, namely by inhibiting ovulation, fertilization, transport of the fertilized egg to the uterus, and implantation).

150. See CTR. FOR REPROD. RIGHTS, GOVERNMENTS WORLDWIDE PUT EMERGENCY CONTRACEPTION INTO WOMEN'S HANDS, A GLOBAL REVIEW OF LAWS AND POLICIES 3 (2004), http://www.crlp.org/pdf/pub_bp_govtswwec.pdf (confirming that emergency contraception acts like other hormonal contraceptives, acting to delay or prevent ovulation).

151. See generally Am. Coll. of Obstetricians and Gynecologists, *Emergency Oral Contraception*, ACOG PRACTICE BULLETIN. No. 25 (2001); Charlotte Ellerston et al., *Modifying the Yuzpe Regimen of Emergency Contraception: A Multicenter Randomized Controlled Trial*, 101 OBSTETRICS AND GYNECOLOGY 1160 (2003).

152. See Elizabeth Spahn & Barbara Andrade, *Mis-Conceptions: The Moment Of Contraception In Religion, Science, and Law*, 32 U.S.F. L. REV. 261, 292-96 (1998) (decrying the religiously motivated skewing of "objective scientific evidence" by those furthering the erroneous theory of conception as a "moment," which confuses conception, the implantation of a fertilized egg, with fertilization).

C. Emergency birth control and Catholic teachings on conception

The definitions of fertilization,¹⁵³ conception,¹⁵⁴ and pregnancy are not in dispute within the medical community. The American Medical Association, the American College of Obstetrics and Gynecology, the Food and Drug Administration, the World Health Organization and the International Federation of Gynecology and Obstetrics all define the onset of pregnancy as the implantation of the fertilized egg (blastocyst) in the woman's uterus.¹⁵⁵ Since emergency contraception acts prior to implantation, each of these organizations has approved the use of emergency contraception as a contraceptive and have not categorized it as an abortifacient.¹⁵⁶ Within medical science it is also undisputed that emergency contraception cannot interfere with an established pregnancy; it has no effect on a developing embryo once implantation occurs.¹⁵⁷ As a result, the governments of numerous countries with restrictive abortion laws, including predominantly Catholic countries such as Brazil and Columbia, have approved the use of emergency contraception.¹⁵⁸

In contrast to the medical community, the Catholic Church and other conservative Christian denominations¹⁵⁹ hold as a matter of religious belief that

153. See Gold, *supra* note 78 (criticizing anti-abortion groups' attempts to enforce a definition that pregnancy begins at fertilization, thus outlawing contraception, despite the long-standing recognition by the scientific community and federal-policy that pregnancy begins at implantation).

154. See *id.* at 7 (stating that the American College of Obstetricians and Gynecologists defines conception as implantation, as a "pregnancy is considered to be established only when the process of implantation is complete").

155. See Spahn & Andrade, *supra* note 152, at 266 (discussing scientific and Catholic definitions of pregnancy, and citing a definition of conception as "the onset of pregnancy, marked by implantation of the blastocyst"); see also 45 C.F.R. 46.202(f) ("Pregnancy encompasses the period of time from implantation until delivery."); see also COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, PREEMBRYONIC RESEARCH: HISTORY, SCIENTIFIC BACKGROUND, AND ETHICAL CONSIDERATIONS 95-96 (2004), http://www.acog.org/from_home/publications/ethics/ethics092.pdf (explaining the medical view that a fertilized egg is still preembryonic even after implantation and noting that sixty percent of fertilized eggs do not survive long enough to cause a woman to miss a period and that up to seventy-eight percent of fertilized eggs do not result in live births.)

156. See Gold et al., *Provision of Emergency Contraception to Adolescents*, 35 J. ADOLESCENT HEALTH 66 (2004); January W. Payne, *Is Plan B 'Unsafe'? Current Research Does Not Support Fears of Day-After Pill Dangers*, WASH. POST, Sept. 6, 2005, at F1.

157. See CTR. FOR REPROD. RIGHTS, EMERGENCY CONTRACEPTION (EC): A SAFE AND EFFECTIVE WAY TO PREVENT UNPLANNED PREGNANCY (2005).

158. See CTR. FOR REPROD. RIGHTS, *supra* note 150, at 3, 7 (reporting that many countries, including France, the U.K., China, and Tunisia, permit emergency contraception to be available over the counter without a prescription; see also R. v. Sec'y of State for Health, [2002] EWHC (Admin) 610, [386] (Eng.) (concluding that emergency contraception cannot induce a miscarriage).

159. See William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455, 502-07 (2001) (explaining that the teachings of the Baptist, Seventh Day Adventist and Eastern Orthodox religions prohibit abortion under most circumstances).

life begins at conception, which they define as the moment of fertilization and the beginning of pregnancy.¹⁶⁰ Thus, they believe that any intervention that interferes with or prevents the implantation of a fertilized egg in the uterine wall is an abortion.¹⁶¹ As a result, it is the official doctrine of the Catholic Church that emergency contraception, as well as other forms of birth control such as IUDs and certain oral contraceptives, are abortifacients and constitute the immoral taking of a human life.¹⁶² It is also the official position of numerous anti-abortion organizations such as Pharmacists for Life, National Right to Life Campaign and American Life League that pregnancy begins at fertilization and emergency birth control is an abortifacient.¹⁶³ While many of these organizations claim to be non-sectarian, it is clear from a review of their literature that their position on emergency contraception (and abortion) is based on religious teaching.¹⁶⁴ As will be discussed below, it is also clear that stereotyped views of women's roles and female sexuality play an important part in the positions and practices of these organizations.

The certitude of beliefs grounded in religious faith makes it difficult, if not impossible, to reach a compromise with individuals who hold those beliefs.¹⁶⁵ No argument grounded in medical science that emergency contraception is not an abortifacient will sway individuals who believe the contrary, based on their religious doctrine.¹⁶⁶ While members of all faiths are entitled to have their beliefs

160. See Sacred Congregation for the Doctrine of Faith, *The Declaration on Procured Abortion*, 4 ORIGINS 186, 186 (1974) (stating that, once fertilized, an ovum begins "the life of a new human being with his [sic] own growth" separate from the life of the mother); see also, Am. Life League, What Part of 'Emergency Contraception' is Not Abortion?, <http://www.all.org/article.php?id=10149> (last visited Aug. 27, 2006) ("[P]regnancy begins at fertilization . . . Any 'treatment' that destroys the living human being at any point after fertilization is abortion. . .").

161. See DIRECTIVES, *supra* note 114, at Directive no. 45 ("Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo."); *id.* at Directive no. 36.

162. See Congregation for the Doctrine of Faith, *Respect for Human Life (Donum Vitae)* (Feb. 22, 1987), available at <http://www.cin.org/vatcong/donumvit.html> (postulating that "from the moment of conception, the life of every human being is to be respected in an absolute way"); see also *supra* notes 128-130 (explaining that the Catholic Church prohibits all forms of "artificial" birth control).

163. See Am. Life League, *supra* note 160.

164. See, e.g., Ann E. Freedman, *Sex Equality, Sex Differences, and the Supreme Court*, 92 YALE L.J. 913, 915 (1983). ("The subordination of women has traditionally been justified by arguments drawn from biology or nature, in turn often equated with divine command.").

165. See Bassett, *supra* note 159, at 492-94, 528 (stressing that Catholic health care providers have a duty to respect Church teaching, and rejecting referral solutions as morally illicit cooperation).

166. Yet as Professor Rebecca Cook noted in a lecture for The Academy of Human Rights and Humanitarian Law, "theo-physiology" cannot be permitted to supplant medical science. Rebecca Cook, *Lecture Before the Academy on Human Rights and Humanitarian Law*, American University: Advancing the Women's Human Rights Agenda:

respected, a pluralistic society cannot as a matter of public policy permit members of any religion to impose their beliefs on those who do not share them, especially when to do so denies others access to necessary health care.¹⁶⁷ This becomes apparent with the application of feminist methodology, which reveals the misogynist underpinnings of the history of these beliefs.

III. APPLYING FEMINIST METHODOLOGY TO PHARMACIST REFUSAL CLAUSES

Feminist legal methodology emerged in the early 1990s from a rich body of legal scholarship that had been sparked by the second wave of the women's movement of the 1960s.¹⁶⁸ Despite the variety and diversity of feminist perspectives that developed under the rubric of feminist legal theory,¹⁶⁹ at their core each recognizes that women live gendered lives,¹⁷⁰ and that women's lives are shaped by experiences within societies whose ideologies and institutions (including law) are founded upon and incorporate gendered assumptions.¹⁷¹ Feminist legal theory challenges the claims to objectivity and assumptions of gender neutrality inherent in legal tradition, and has had “. . . a visible and

Legal, Political and Social Approaches (June 9, 2005) (referencing *R. v. Sec'y of State for Health*, [2002] EWHC (Admin) 610, [386] (Eng.)).

167. See, e.g., *Pichon and Sajous v. France*, App. No. 49853/99, <http://www.echr.coe.int> (2001) (holding that pharmacists “cannot give precedence to their religious beliefs and impose them on others as justification for refusal to sell [contraceptives]”).

168. See generally Martha Albertson Fineman, *Feminist Legal Theory*, 13 AM. U.J. GENDER SOC. POL'Y & L. 13 (2005).

169. See, e.g., Mary Becker, *Patriarchy and Inequality: Towards a Substantive Feminism*, 1999 U. CHI. LEGAL F. 21, 33 (1999) (discussing “liberal feminists,” who focus on principles of equality and sameness, and argue that individuals are offered the same choices regardless of sex); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 27 (1988) (advocating a “cultural feminist” perspective, theorizing that women have a deep connection to human life through experiences such as motherhood and are fundamentally different from men); CATHARINE A. MACKINNON, *FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW* 37 (1987) (advocating a “dominance” approach, which challenges the social and legal treatment of gender, focusing on inequality and the social subordination of women by men); see generally Fisher, *supra* note 35; Bartlett, *supra* note 35 (analyzing feminist legal theories and epistemologies).

170. Women's lives are also shaped by race, ethnicity, disability, sexual orientation, poverty, caste, etc. See, e.g., Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 585 (1990) (criticizing the belief that a woman's experience can be defined independently of such social factors as race, class, and sexual orientation).

171. See Fineman, *supra* note 168, at 13 (“Of course, when we speak of feminism, it is necessary to clearly state that there are many differences within feminism—difference in approach, emphasis and objectives—that make sweeping generalizations difficult.”) Yet a shared goal of feminist legal theorists is to improve women's material, political and psychological well-being. See Carrie Menkel-Meadow, *Mainstreaming Feminist Theory*, 23 PAC. L. J. 1493, 1496 (1992).

immediate impact on law over the past several decades."¹⁷² It has shaped the development of contemporary legal thought, and today is an essential component of any serious theoretical legal project.¹⁷³

Feminist legal scholars, recognizing that traditional legal methods and rules "overrepresent and enforce existing power structures,"¹⁷⁴ developed new methodologies for addressing the ways in which truth is apprehended within the law.¹⁷⁵ These methodologies expand the legal inquiry to include facts and perspectives which have historically been ignored.¹⁷⁶ In the context of reproductive rights, feminist methods can be applied to scrutinize current and proposed laws to determine how they serve, advance, or retard women's reproductive self-determination.¹⁷⁷ One of the classic formulations of feminist methodology posited by Katherine Bartlett sets forth three features of the practice:

- (1) identifying and challenging those elements of existing legal doctrine that leave out or disadvantage women and members of other excluded groups (asking the "woman question");
- (2) reasoning from an ideal in which legal resolutions are pragmatic responses to concrete dilemmas rather than static choices between opposing, often mismatched perspectives (feminist practical reasoning); and
- (3) seeking insights and enhanced perspectives through collaborative or interactive engagements with others based upon personal experience and narrative (consciousness-raising).¹⁷⁸

Others have used similar formulations of these basic concepts.¹⁷⁹ For example, in applying feminist methodology to an analysis of reproductive rights as international human rights, Rebecca Cook looked first at the history of sex and

172. Fineman, *supra* note 168, at 14; *see also* Menkel-Meadow, *supra* note 171, at 1504 (stating that early legal cases brought by feminists focused on enforcing legal rights and advocating for gender-neutral laws).

173. *See, e.g.,* Ann Shalleck, *Institutions and the Development of Legal Theory: The Significance Of The Feminism And Legal Theory Project*, 13 AM. U. J. GENDER, SOC POL'Y & LAW 7 (2005) (discussing the role of Feminism and Legal Theory Project as a feminist institution).

174. Bartlett, *supra* note 35, at 832.

175. *Id.*

176. *See id.*; Christine A. Littleton, *Feminist Jurisprudence: The Difference Method Makes*, 41 STAN. L. REV. 751, 764 (1989) (reviewing CATHARINE A. MACKINNON, *FEMINISM UNMODIFIED* (1987)) ("Feminist method starts with the very radical act of taking women seriously, believing that what we say about ourselves and our experience is important and valid, even when, (or perhaps especially when) it has little or no relationship to what has been or is being said *about us*.").

177. *See* Cook, *Human Rights*, *supra* note 25, at 985.

178. Bartlett, *supra* note 35, at 831.

179. *See, e.g.,* Catharine MacKinnon, *From Practice to Theory, or What is a White Woman, Anyway?*, 4 YALE J.L. & FEMINISM, 13, 14 (1991) (focusing on consciousness raising as the fundamental feminist method). Others have identified narrative and storytelling as an essential feminist method, particularly in terms of analyzing domestic violence. *See, e.g.,* Jane C. Murphy, *Lawyering for Social Change: The Power of the Narrative in Domestic Violence Law Reform*, 21 HOFSTRA L. REV. 1243, 1259 (1993); Leigh Goodmark, *Telling Stories, Saving Lives: The Battered Mothers' Testimony Project, Women's Narratives, and Court Reform*, 37 ARIZ. ST. L.J. 709, 757 (2005).

gender discrimination and the treatment of women as reproducers,¹⁸⁰ then posed the woman question to analyze existing international legal instruments and determine their impact on women's rights to reproductive self-determination.¹⁸¹

Applying feminist methodologies to the analysis of pharmacist refusal clauses reveals the fallacy of the religious freedom versus lifestyle argument. It does so by exposing the unspoken assumptions about female sexuality and contraception that underpin the argument. A more accurate characterization of the conflict may be obtained by examining the history of the legal treatment of women and contraception, asking the woman question to explore the impact of contraception on women's lives, and looking at the context in which refusal clauses are exercised for both the woman and the pharmacist. Rather than a struggle between religious freedom and a lifestyle choice, the conflict is based on the need to balance a pharmacist's right to exercise personal belief against a woman's right to exercise personal belief *and* to access necessary health care.¹⁸² Put in this light, the balance tips in favor of protecting women's right to obtain and use contraception, precluding the use of refusal clauses by pharmacists except in the most limited circumstances.

A. Women's right to contraception through the lens of gender

Feminist legal theory has exposed the law's male-centered bias by illustrating the fallacy of its claims to objectivity and neutrality. As one commentator has noted,

Law as an institution—its procedures, structures, dominant concepts and norms—was constructed at a time when women were systematically excluded from participation. Insofar as women's lives and experiences became the subject of law, they were of necessity translated into law by men. Even social and cultural institutions that women occupy exclusively, such as "motherhood," were as legally significant categories . . . defined, controlled and given legal context by men. Male norms and male understandings fashioned legal definitions of what constituted a family, who had claims and access to jobs and education, and ultimately, how legal institutions functioned to give or deny redress for alleged and defined harms.¹⁸³

In the legal discourse surrounding women's historical role as the bearers of men's children and the keepers of men's homes, women's voices have not been heard. As a result, the particular injustices that women have suffered have been invisible and unrecognized, often rationalized as a natural consequence of

180. Cook, *Human Rights*, *supra* note 25, at 986–87. Such an historical analysis helps to reveal the origins of stereotypes and assumptions that often remain unspoken within but continue to influence the modern debate.

181. *Id.*

182. *Id.* at 1012 (asserting that a health care professional bears the burden of justifying a conscientious objection to certain reproductive services, and may have to, out of respect for an individual's right to access reproductive care, voluntarily abstain from working in professions linked with reproductive care).

183. See Fineman, *supra* note 35, at 350–51.

women's innate characteristics, particularly their physiology and biology.¹⁸⁴ In law, as in the rest of society, women's biology has been their destiny.

The legal treatment of contraception reflects these biases.¹⁸⁵ In the nineteenth century, contraception was linked to female sexual promiscuity and was chargeable as the crime of obscenity and immorality.¹⁸⁶ Most opponents of birth control at that time did not distinguish between contraception and abortion: Both were considered immoral and murderous.¹⁸⁷ The prevalent belief was that if women could enjoy sexual relations without fear of pregnancy or sexually transmitted diseases, "sexual morality and family security would be in jeopardy."¹⁸⁸ The cost to women's health from early and excessive childbearing, and their premature deaths due to labor, pregnancy, and close birth spacing, were explained through fate, destiny and divine will.¹⁸⁹ By the late nineteenth century, the federal Comstock Law criminalized the distribution or possession of material that would prevent conception or cause abortion,¹⁹⁰ and a physicians' campaign to outlaw abortions resulted in an unprecedented enactment of laws in most states prohibiting all abortions.¹⁹¹ It was not until the mid-twentieth century that these laws were successfully challenged.¹⁹²

184. See Cook, *Human Rights*, *supra* note 25, at 985. For a detailed history of attitudes towards women, motherhood, and reproduction in the United States, see Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 280–323 (1992) (arguing that claims about women's bodies often express judgments about women's roles, combining religion and physiology to justify paternalistic regulation of women's conduct).

185. Criminalization and regulation of contraception is a relatively modern phenomenon; traditional forms of contraception, from condoms to abortion, were widely practiced by women throughout history. Linda Gordon, *Woman's Body, Woman's Right: Birth Control in America*, in FEMINIST JURISPRUDENCE: TAKING WOMEN SERIOUSLY 501 (Mary Becker et al. eds., 2d. ed. 2001).

186. See JAMES C. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800–1900* 196 (1978) (discussing the regulation of female sexuality in the nineteenth century).

187. See Linda Gordon, *Why Nineteenth-Century Feminist Did Not Support "Birth Control" and Twentieth-Century Feminists Do: Feminism, Reproduction and the Family*, in RETHINKING THE FAMILY 140–54 (Barrie Thorne & Marilyn Yalom eds., 1982).

188. See Rebecca J. Cook, *International Protection of Women's Reproductive Rights*, 24 N.Y.U. J. INT'L L. & POL. 645, 645–46 (1992) [hereinafter Cook, *International Protection*].

189. See *id.* at 645.

190. An Act for the Suppression of, Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use, ch. 258, 17 Stat. 598-99 (1873).

191. See MOHR, *supra* note 186, at 147–70 (explaining that under common law, abortion was legal until "quickenning," when a woman could detect fetal movement, and chronicling the "physician's crusade"); Siegel, *supra* note 184, at 301–04 (positing that the physicians redirected the focus of the common law from the woman's experience to scientific evidence, supporting legislative views of women's use of abortion and birth control as selfish "derogations of maternal duty").

192. See *Roe v. Wade*, 410 U.S. 113, 154 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

Even after the United States Supreme Court declared laws prohibiting contraception unconstitutional in *Griswold* and *Eisenstadt*,¹⁹³ and made abortion legal in *Roe v. Wade*,¹⁹⁴ women's access to contraception and other reproductive health care remained limited by socio-economic status, age, geographic location, and other factors.¹⁹⁵ For example, not only did employment-based health insurance plans exclude contraception from coverage;¹⁹⁶ they excluded vaginal deliveries and neonatal care as well.¹⁹⁷ Even after the Pregnancy Discrimination Act was passed in 1978,¹⁹⁸ it took twenty-three years for advocates to bring an action challenging the exclusion of contraception in insurance plans.¹⁹⁹ The limited amount of funding dedicated to contraceptive research has restricted the number of contraceptive options available to women,²⁰⁰ and some products that were developed were rushed to the market before their safety could be confirmed, damaging women's health.²⁰¹ In addition, women's childbearing potential was used as an excuse to exclude women from clinical research.²⁰² In clinical studies for medical conditions men and women share, as well as medical conditions only women experience, women were repeatedly excluded or seriously underrepresented.²⁰³ Thus, while for many years the law remained blind to the fact

193. *Griswold*, 381 U.S. at 486; *Eisenstadt*, 405 U.S. at 455.

194. 410 U.S. at 154.

195. See, e.g., *Rust v. Lawson*, 500 U.S. 173, 216–18 (1991) (Blackmun, J., dissenting) (arguing that the government's refusal to fund abortions coerces childbirth by effectively denying poor women the chance to choose to terminate a pregnancy); Martha Davis et al., *Four Cornerstones to Ending Women's Poverty*, 7 GEO. J. ON POVERTY L. & POL'Y 199, 211 (2000) (discussing reproductive rights as an issue of class and race).

196. See *supra* Part II.A.

197. See Law, *supra* note 80, at 375.

198. Pub. L. No. 95-555, 92 Stat. 2076 (codified as 42 U.S.C. § 2000e(k) (2000)) (stating that discrimination on the basis of pregnancy, childbirth, or related medical conditions is discrimination on the basis of sex).

199. See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1277 (W.D. Wash. 2001) (concluding that an employer's exclusion of contraception from insurance coverage was sex discrimination in violation of Title VII); see also Comm'n Decision on Coverage of Contraception, 2000 WL 33407187, at *2–3 (Equal Employment Opportunity Comm'n Dec. 14, 2000) (holding that the denial of benefits for contraception is discrimination on the basis of a women's ability to become pregnant and is thus prohibited by the Pregnancy Discrimination Act).

200. See William M. Brown, *Déjà Vu All Over Again: The Exodus from Contraceptive Research and How to Reverse It*, 40 BRANDEIS L.J. 1, 30–38 (2001) (suggesting that the unwillingness of companies to research and develop new forms of contraception stems from a fear of liability, perceived links with abortion, stringent FDA requirements, and limited profits because most insurers do not cover contraceptives).

201. See *id.* at 10 n.55, 11–12 (discussing the Dalkon Shield, a hastily marketed contraceptive device that prompted a huge number of lawsuits when it was discovered to cause deaths, miscarriages, and other injuries).

202. See generally Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women's Health Care*, 32 HOUS. L. REV. 1201, 1206 (1996) (discussing legal and medical harms of excluding women from clinical research).

203. A shocking example of the exclusion of women from clinical studies was a project to examine the impact of obesity on breast and uterine cancer. The study participants were all men. *Id.* at 1207.

that only women can get pregnant,²⁰⁴ the medical establishment was obsessed with women's possible pregnancy,²⁰⁵ and gender bias pervaded the delivery of health care, particularly reproductive health care.²⁰⁶

Society's contempt of women's right to reproductive self-determination and the law's trivialization of women as merely childbearers both have roots deeper than the Comstock Law and the anti-abortion statutes of the nineteenth century. The present day conservative view that associates birth control with sexual promiscuity can be traced to the historical treatment of female sexuality by the Christian religion, and to the tremendous influence of the Catholic Church on contemporary religious doctrine about contraception and abortion.²⁰⁷ These influences can be seen directly in the action of Pharmacists for Life and individual pharmacists who refuse to fill prescriptions for birth control pills and emergency contraception.

B. The underpinnings of Catholic teaching on contraception and abortion

The doctrine of the modern Catholic Church prohibiting contraception, which is shared by other conservative Christian denominations,²⁰⁸ cannot be separated from its centuries old anti-sexuality ethic²⁰⁹ or its teachings on abortion

204. See Siegel, *supra* note 184, at 268–73 (criticizing the Supreme Court's ignorance of the "fact that the capacity to gestate distinguishes the sexes *socially*: Judgments about women's capacity to bear children play a key role in social definitions of gender roles and thus in the social logic of 'discrimination based on gender as such'") (emphasis added).

205. See Rothenberg, *supra* note 202, at 1217–18 (arguing that the medical community's obsessive exclusion of women from medical research on the basis of potential for pregnancy reinforces harmful gender stereotypes, placing a higher value on a woman's ability to reproduce than on women's health in general).

206. See *id.* at 1210–18.

207. See BEVERLY WILDUNG HARRISON, OUR RIGHT TO CHOOSE: TOWARD A NEW ETHIC OF ABORTION 130, 145 (1983) (remarking that the Protestant Reformation had little impact on the Christian treatment of abortion, as the reformers strongly enforced and extended theological emphasis on the centrality of marriage and the role of procreation in sexuality).

208. On June 6, 2006, the Vatican's Pontifical Council for the Family issued "Family and Human Procreation," a document summarizing the Catholic Church's opposition to contraception, and reaffirming the principles set out in the 1968 "Humane Vitae." Maria Sanminiatielli, *Vatican Reiterates Family Stance*, BOSTON GLOBE, June 7, 2006, http://www.boston.com/news/world/articles/2006/06/07/vatican_reiterates_family_stance/. The document also condemned in vitro fertilization, artificial insemination, the use of embryos, and same-sex marriage. *Id.* Additionally, the document states that abortion "constitute[s] a violation of the fundamental right to life." Joseph Mallia, *Vatican: Traditional Family at Risk*, NEWSDAY, June 7, 2006, at A3.

209. HARRISON, *supra* note 207, at 128 (quoting a female theologian's description of the theological animus toward sexual pleasure "imposed upon Catholics by exclusively male and predominately celibate theologians for almost 19 centuries" as a "stunning impoverishment of life" that precluded any connection between sexual pleasure and the expression of love). Although in 1968 Pope Paul VI stated that a purpose of sexual intercourse in marriage was to express marital love, the ban on "artificial abortion" remained. *Humanae Vitae*, *supra* note 124, at 11.

and the "sanctity of the unborn." Nor can it be separated from its relegation of women to the role of mother and homemaker.²¹⁰ In an exhaustive analysis of the historical treatment of abortion in Christianity, theologian Beverly Harrison found that

[a]bortion, when condemned, was usually one act in an anathematized continuum: illicit sex or adultery (genital sexual activity not aimed at procreation), contraception (because it facilitated sex for another purpose), and abortion. In the writings of some of the ascetic "fathers," prostitution was sometimes linked with contraception and abortion because all were equally onerous violations of woman's God-given vocation. Nearly all extant early Christian objections to abortion, when any moral reasons were enunciated, either directly condemn wanton women (those who seek to avoid pregnancy) or denounce the triad of adulterous, pleasure-oriented sex, contraception, and abortion. These were undifferentiated elements in a disparaging attitude to nonprocreative functional sexuality and a negativity to "promiscuous" women, grounded in what was, within Christianity, the antisensual spirituality of its most ascetic, frequently celibate theologians. . . . [A]ny woman [not celibate] who refused childbearing was thereby a murderer.²¹¹

Harrison points out that the prohibitions eliding contraception, abortion and promiscuity in women were in place long before the concept of "ensoulment" was developed in Catholic doctrine.²¹²

I have been unable to identify any examples of moral reasoning in premodern Christian history which exhibit clear-cut and direct support for the contemporary moral claim that because the fetus is a human being we are obligated to defend its life. . . . Only after the equation of abortion and homicide was well established by rhetorical denunciation of all nonprocreative sex as murder, a connection made inevitable by treating procreation as the divinely ordained purpose of sex, did Christian theologians begin to theorize about when the prohibition against abortion should appl[y] Discussions of the moral value of fetal life, as such, are simply not present, because the shape of the emerging teaching on sexuality never encouraged a focus on that question.²¹³

210. As Pope John Paul II pronounced in 1979, "if men are by temperament more apt to deal with matters outside the home . . . women have, generally speaking, more understanding and tact for comprehending and resolving the delicate problems of domestic life . . . Certain domestic work must be seen not as an implacable and inexorable imposition, as slavery, but as a free choice, conscious and willing, which fully realizes a woman's nature, and fulfills their needs." HARRISON, *supra* note 207, at 277, n.17.

211. HARRISON, *supra* note 207, at 130.

212. *See id.* at 121-22 (noting that theologians and Church historians question the present assumption about the consistency of Catholic doctrine on abortion throughout Catholic history).

213. *Id.* at 131, 137 (emphasis in original).

For this reason, many premodern theologians who addressed abortion, such as Augustine, permitted the practice until a later point in pregnancy.²¹⁴ It was not until the late nineteenth century, when Pope Pius IX designated conception as the moment of hominization,²¹⁵ that is, when life begins, that the Catholic teaching on abortion was standardized.²¹⁶

The issue of ensoulment is key to understanding the absolutist position of the Catholic Church on abortion. Law professor David Richards, arguing that “fetal personhood” is a religious doctrine that would violate the Establishment Clause if adopted by any state or the federal government, has pointed out that “ensoulment” creates a metaphysical person out of an embryo which, biologically, has merely the potential to become a human being.²¹⁷ Professor Richards stated,

The implicit premises, which naturally bridge the gap from potentiality to actuality, surely are specifically religious or metaphysical assumptions about the fetus at all points having an individual soul: the soul requiring baptism for release from original sin (so that killing prior to birth has disastrous religious consequences for the soul); the radical innocence of the life; the moral obligation for sexual activity to lead to procreation (which leads to anticontraceptive policies as morally obligatory); the naturalness of the maternal burdens of birth; the historical association of the Church’s adoption of the potentiality view with the dating of the Immaculate Conception with its associated model of ideal maternity and the like. From the religious perspective of vital belief in these assumptions, abortion in the potentiality stage is as wrongful, perhaps more wrongful, than ordinary homicide: the fetus is radically innocent and vulnerable, the woman murderously unnatural in her betrayal of her role as mother.²¹⁸

As Richards observed, only a religious or metaphysical belief (that the embryo/fetus at all points has a soul) can bridge the gap from potential human being to actual human being and impose a prohibition against abortion even when

214. See *id.*; see also John A. Balint, *Ethical Issues In Stem Cell Research*, 65 ALB. L. REV. 729, 735 (2002) (noting that Catholic scholars St. Augustine and St. Thomas Aquinas followed Aristotle’s view that that human life begins with ensoulment at about forty days of gestation).

215. See *The Declaration on Procured Abortion*, *supra* note 160, at 12 (defining fertilization as conception, the moment that life begins). *But see* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 155 (presenting the contrary medical view).

216. See HARRISON, *supra* note 207, at 123.

217. See David A. J. Richards, *Constitutional Privacy, Religious Disestablishment and the Abortion Decisions*, in ABORTION: MORAL AND LEGAL PERSPECTIVES 148, 171 (Jay L. Garfield & Patricia Hennessey eds., 1986) (asserting that the religiously-based argument that after fertilization, a genetic individual exists and is a “life” subject to the legal proscription of murder, is not reasonable absent other implicit premises). Notably, two years after this article, Missouri adopted a fetal personhood doctrine in its preamble to the state’s statute governing unborn children and abortions, MO. REV. STAT. § 1.205 (2006). The Supreme Court upheld the statute in *Webster v. Reproductive Health Services*, 492 U.S. 490, 506–07 (1989), but failed to address the Establishment Clause issues.

218. Richards, *supra* note 217, at 171.

necessary to save the life of the mother,²¹⁹ an extraordinary obligation of sacrifice to demand of pregnant women.

Rebecca Cook has noted that certain religious hierarchies, accustomed to instructing individuals on their duties and demanding obedience to divine will as they interpret it, cannot protect or even recognize the right of women, as free and rational persons, to reproductive self-determination.²²⁰ Individuals who do not share the beliefs of such religious organizations should not be required to guide their moral conduct in accordance with those assumptions.²²¹ Privileging the religious beliefs of one group over another violates the basic tenets of a pluralistic society.²²² This is so whether those beliefs are imposed through exclusions to prescription coverage in insurance policies, exclusions of medical procedures from health services provided by hospitals, or the refusal of pharmacists to dispense legally prescribed medication. The application of feminist methodologies makes evident that the impact of these policies on the ability of women to exercise reproductive self-determination is quite restrictive.

C. Asking “the woman question”

Asking “the woman question” means examining how the law fails to take into account the experiences and values more typical of women than men, or how existing legal standards and concepts might disadvantage women.²²³ It challenges the prevailing presumptions about women’s reality and exposes flawed factual assumptions about women.²²⁴ In the area of reproductive rights, the woman question cannot be answered without investigating the context in which women in different socioeconomic, educational, and cultural communities can avail themselves of reproductive options.²²⁵ Any law affecting reproductive rights, such as a refusal clause for pharmacists, must be scrutinized to determine its impact on women’s reproductive self-determination.²²⁶

219. See *id.* The mother, already baptized, is sacrificed to allow for the possible redemption of the fetus by baptism should it live.

220. See Cook, *Human Rights*, *supra* note 25, at 978 (describing the emerging perception that international human rights instruments and institutions can provide the means for powerless and disenfranchised groups to claim and enforce equality).

221. See Richards, *supra* note 217, at 173.

222. See *infra* text accompanying notes 449–465.

223. Bartlett, *supra* note 35, at 837–38 (“Women have long been asking the woman question in the law. The legal impediments to being a woman were, early on, so blatant that the question was not so much whether women were left out, but whether the omission was justified by women’s different roles and characteristics.”).

224. See Cook, *International Protection*, *supra* note 188, at 675; see also REBECCA J. COOK ET AL., *REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW* 67-68 (2003) (discussing feminist bioethics, which criticizes the failure of traditional bioethical discussion of contraception to take into account the impact of unwanted pregnancies on woman’s lives) [hereinafter COOK, *REPRODUCTIVE HEALTH*].

225. See Cook, *Human Rights*, *supra* note 25, at 987.

226. Claims that reproductive rights are fundamental to human dignity are rarely questioned when applied to men; legal attempts to control men’s bodies through regulation of their reproductive capacities, such as through castration, have long been condemned.

A subset of questions should be asked when posing the woman question in the controversy over pharmacist refusal clauses: What assumptions are made about those whom the law affects? Whose point of view do those assumptions reflect? Whose interests are invisible or peripheral? What excluded viewpoints might be identified and taken into account?²²⁷

The assumptions made about those whom the law affects—the women who are denied access to prescription birth control or emergency contraception when a pharmacist exercises the right of refusal—have been discussed at length above. Refusing pharmacists are likely to believe that such women are promiscuous at best,²²⁸ and potential murderers at worst.²²⁹ Deeply held religious and societal beliefs about women's appropriate role as mothers and the inappropriateness of sexual behavior but for marital procreation underlie these opinions. While these extreme views are not shared by all, the lingering effects of Christianity's misogynist and anti-sexual ethical underpinnings still influence many people's perceptions about the legitimacy of women's claims to a right to contraception.²³⁰ Even the colloquial name given to emergency contraception, "the morning-after pill," suggests using it is a way to avoid the possible consequences of casual sex. Thus, century old stereotypes about female sexuality and women's role in a patriarchal society are reflected in the assumptions underlying pharmacist refusal clauses. The "point of view" is that of those who would deny women the right of reproductive self-determination, those who fail to take seriously the moral independence of women as free and rational agents able to make responsible decisions about their reproductive capacities.²³¹

Cook, *International Protection*, *supra* note 188, at 658; *see also, e.g.*, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942) (holding that the forced sterilization of certain criminals unconstitutionally infringed on the fundamental rights to marriage and procreation).

227. *See Bartlett, supra* note 35, at 846–48 (noting that asking the woman question does not require a decision in favor of a woman, but rather requires the decision maker to search for gender bias and to make a decision in light of that bias).

228. *See, e.g.*, Matt Pommer, *UW Birth Control Help 'Outrages' Rep*, CAPITAL TIMES, Mar. 16, 2005, at 3A (quoting Wisconsin State Rep. Dan LeMahieu's reaction to the University of Wisconsin's provision of emergency contraception: "I am outraged that our public institutions are giving young college women the tools for having promiscuous sexual relations.").

229. *See, e.g.*, Judith Davidoff, *Now It's The Pill They're After: Right-to-Life Movement Calls It Chemical Abortion*, CAPITAL TIMES, Aug. 1, 2005, at 1A (recounting how a pharmacist refused to fill a woman's prescription for emergency contraceptives and called her a "baby-killer").

230. *See Siegel, supra* note 184, at 293, 325 (comparing modern contraceptive laws to those advocated by physicians in the nineteenth century, which relied on science and biblical authority to condemn women participating in non-procreative sex as sinners who shirk "those responsibilities for which [they were] created").

231. As Erdman and Cook recently noted, "Women were and continue to be viewed as incapable of responsibly engaging in sexual intercourse and deciding the course of their reproductive care." Joanna N. Erdman & Rebecca J. Cook, *Protecting Fairness in Women's Health: The Case of Emergency Contraception*, in JUST MEDICARE: WHAT'S IN, WHAT'S OUT, WHO DECIDES 155 (Colleen M. Flood ed., 2006). Many advocates of pharmacist refusal clauses view women as defenseless and ignorant, either being misled into

Pharmacist refusal clauses make the interests of women who wish to avoid the consequences of unintended pregnancy invisible and peripheral. When the views of these women are identified and taken into account, it becomes clear that access to contraception is essential health care for women in their reproductive years.²³² Empirical evidence is frequently used in legal analysis to demonstrate inequities not obvious from *a priori* reasoning; it often highlights the harmful consequences of facially neutral or even benevolent laws.²³³ In the case of women's reproductive rights, empirical studies illustrate the negative effects of laws limiting access to contraception on women's reproductive health and the well-being of their families.²³⁴

Empirical studies consistently establish women's need for access to contraception and other reproductive health care in their reproductive years.²³⁵ In the United States, sixty-two million women are in their childbearing years.²³⁶ Forty-three million women (seven in ten) are sexually active and do not want to become pregnant; of these, eighty-nine percent use some form of contraceptive.²³⁷ The typical woman in the United States uses contraceptives for two or three decades of her life in order to achieve her goal of two children; without contraception, the average fertile woman would become pregnant twelve to fifteen times during those years.²³⁸ Approximately thirty-eight million women in the United States use some form of birth control; the most common methods are birth

taking Plan B, or not intelligent enough to make their own choices about sexuality. *See, e.g.*, Alan Burkhart, *The Morning After Pill – Legality vs. Morality*, THE CONSERVATIVE VOICE, Aug. 21, 2005, at <http://www.theconservativevoice.com/articles/article.html?id=7625> (“And please ladies . . . tell me why you're allowing yourself to be put in such a situation?”).

232. *See infra* notes 254–269.

233. *See Cook, International Protection, supra* note 188, at 676 (discussing the importance of empirical evidence, citing a commentator's warning that “[w]hen justice is blind to the fruits of scientific and social science research, . . . rules of law are divorced from the empirical world. Courts are thus rendered impotent in the exercise of their duty to safeguard fundamental constitutional guarantees, for rights may be violated in innumerable ways not apparent by speculation”).

234. *See id.* at 675; Siegel, *supra* note 184, at 373–77 (explaining that motherhood “forced” on a woman because of laws restricting her reproductive freedom affects her ability to plan her life and career and may lead her and her children to live in poverty).

235. *See* Alan Guttmacher Inst., *Facts in Brief: Contraceptive Use*, http://guttmacher.org/pubs/fb_contr_use.html (2005) [hereinafter *Contraceptive Use*].

236. *See id.* (reporting sixty-two percent of the 62 million women of childbearing age (15–44) currently use contraception; thirty-one percent do not need contraception because they are infertile, pregnant, post-partum, trying to become pregnant, have never had sexual intercourse or are not sexually active).

237. *See* Dep't of Health and Human Servs., Ctrs. for Disease Control and Prevention, *Unintended Pregnancy Prevention: Contraception*, <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/contraception.htm> (2006) [hereinafter *Pregnancy Prevention*] (discussing the use of currently available methods of contraception in the U.S.).

238. *See* NARAL, *INSURANCE COVERAGE FOR CONTRACEPTION: A PROVEN WAY TO PROTECT AND PROMOTE WOMEN'S HEALTH*, http://www.prochoiceamerica.org/issues/birth_control/insurance-coverage/insurance-coverage-contraception.html (2006) (asserting that contraception is basic health care).

control pills, tubal sterilization, male condoms, and vasectomy.²³⁹ Yet each year nearly half of all pregnancies in the United States are unintended, and almost one in two American women experience an unintended pregnancy at some point in their lives.²⁴⁰

The consequences of unintended pregnancy are serious and life-altering, particularly for women who are young or unmarried, have recently given birth, or already have the number of children they want.²⁴¹ Unintended pregnancies may result in low birth weight babies and infants with serious medical conditions.²⁴² Lack of prenatal care, along with poor birth spacing or giving birth before or after one's child-bearing prime, each pose health risks for the woman and her newborn.²⁴³ The cost to teenagers who become pregnant is even greater. As noted by the Centers for Disease Control and Prevention, "Teen mothers are less likely to complete high school, more likely to be single parents, and more likely to live in poverty than other teens."²⁴⁴ Infants born to teen mothers are more likely to suffer from low birth weights and higher mortality rates than those born to adult women.²⁴⁵ When an unintended pregnancy interferes with a young woman's education, it can have lifelong implications for her employment prospects and ability to support herself and her family.²⁴⁶ These consequences fall disproportionately upon African-American and Hispanic teenagers compared to white teens.²⁴⁷

Unplanned pregnancy increases a woman's risk of physical abuse and abandonment by her partner and an infant's risk of physical abuse and death before his or her first birthday.²⁴⁸ "Pregnancy produces tremendous burdens on a

239. Contraceptive Use, *supra* note 235, at 1 tbl.1 (reporting that in 2002, over 11.5 million women in the U.S. used birth control pills, about 10 million used female sterilization to control their fertility, and indicating how age and race are significant factors in the choice of method, with women who are over thirty or of African American or Hispanic descent more likely to choose sterilization).

240. See Adam Sonfield, *Preventing Unintended Pregnancy: The Need and the Means*, GUTTMACHER REP. ON PUBLIC POL'Y, Dec. 2003, at 7 (stating that about half of the approximately 3.95 million unintended pregnancies a year in the U.S. are terminated by abortion, and half of all unintended pregnancies stem from the seven percent of at-risk women who do not use some type of contraceptive method).

241. See *id.* at 1.

242. The U.S. infant mortality and morbidity rates are higher than those of virtually all other developed countries and even those of many developing countries. CENT. INTELLIGENCE AGENCY, *THE WORLD FACT BOOK: RANK ORDER, INFANT MORTALITY RATE*, <https://www.cia.gov/cia/publications/factbook/rankorder/2091rank.html> (2006).

243. See Sonfield, *supra* note 240, at 7.

244. See Dep't of Health and Human Servs., Ctrs. for Disease Control and Prevention, Adolescent Reproductive Health, <http://www.cdc.gov/reproductivehealth/AdolescentReproHealth/index.htm> (2006) [hereinafter CDC Teen Pregnancy].

245. See Law, *supra* note 80, at 365-66 (describing the adverse effects of unwanted pregnancy on children and adolescents); see also PLANNED PARENTHOOD, *PREGNANCY AND CHILDBEARING AMONG U.S. TEENS* (2005).

246. See Sonfield, *supra* note 240, at 7.

247. See CDC Teen Pregnancy, *supra* note 244.

248. See INST. OF MED., *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 1* (Sarah S. Brown & Leon Eisenberg eds., 1995).

woman's body and life, and an infant makes even greater demands on the mother and family."²⁴⁹ When a woman and family plan a child, they are better prepared to make the necessary sacrifices to meet the infant's needs. When the pregnancy is unintended, however, it is much more difficult for everyone involved to respond to the demands of pregnancy and infancy.²⁵⁰ In addition, economic pressures are very real; to be able to provide for a child in today's world requires a genuine measure of economic security, which many women, and particularly teenage girls, do not have.²⁵¹

All of these concerns are heightened when a woman seeks emergency contraception, especially given the limited period of time in which the medication is effective.²⁵² A woman uses emergency contraception when she believes she is likely to become pregnant unless she takes immediate steps to prevent conception. This could be the result of any number of circumstances, including an unintended, unprotected sexual encounter, the failure of other forms of contraception, or rape. The woman could be a married, middle-aged mother of four or a single teenager or young adult; she could be poor or middle-class, educated or uneducated. She could have a medical condition that makes pregnancy life-threatening or a danger to her health;²⁵³ she may recently have given birth, or she may be involved in an abusive relationship. These and countless other details of a woman's life are not apparent to the pharmacist when a woman attempts to purchase emergency contraception. But a delay of twenty-four or thirty-six hours could result in an unintended pregnancy and the other harmful consequences to the woman and those involved in her life discussed above.

As feminist legal theory highlights, a woman's decision to use contraception to control the number and spacing of her children is a morally responsible act, one that takes into account the multitude of factors that impact her ability to carry, give birth to, and raise a child at any given point in her life.²⁵⁴ Access to contraception is essential to a woman's reproductive health during the

249. Law, *supra* note 80, at 365. The birth of a child requires a person or persons to care continuously for the child, providing tangible material resources over time, energy-draining attention and physical and emotional support. HARRISON, *supra* note 207, at 173. As the court in *Erickson v. Bartell Drug Co.* noted, "The adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the 'marketplace and the world of ideas.'" 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (quoting *Stanton v. Stanton*, 421 U.S. 7, 14-15 (1975)).

250. See Law, *supra* note 80, at 365.

251. See HARRISON, *supra* note 207, at 245.

252. Emergency contraception is most effective if taken between twelve and twenty-four hours after unprotected intercourse. See PLANNED PARENTHOOD FED'N OF AM., *supra* note 2.

253. See Cook, *International Protection*, *supra* note 188, at 646-48 (discussing causes of maternal mortality).

254. As the trial court stated in *Erickson*, "Being pregnant, though natural, is not a state that is desired by all women or at all points in a woman's life." 141 F. Supp. 2d at 1273.

approximately thirty years she is capable of becoming pregnant.²⁵⁵ It is also one condition, among several, necessary to women's enjoyment of a healthy sexuality apart from its procreative consequences.²⁵⁶ Reproductive health has been defined as ". . . not merely the absence of disease or disorders of the reproductive process. Reproductive health . . . implies that people have the *ability* to reproduce, to regulate their fertility, and to practice and enjoy sexual relationships."²⁵⁷ Without access to contraception, "women are not free to make informed choices about their sexual and reproductive health. They are deprived of the power to define and direct their lives, and the capacity to shape their identity as human beings."²⁵⁸ Refusal clauses permitting pharmacists to decline to dispense contraceptives reflect the viewpoint of those who do not grasp the centrality of procreative choice to women's overall well-being.

D. Feminist practical reasoning

As formulated by Katherine Bartlett, feminist practical reasoning focuses on "specific, real life dilemmas posed by human conflict—dilemmas that more abstract forms of legal reasoning often tend to gloss over."²⁵⁹ Building upon the traditional mode of practical reasoning feminist practical reasoning brings to it the critical concerns and values reflected in other feminist methods, including the woman question.²⁶⁰ It approaches problems "not as dichotomized conflicts, but as dilemmas with multiple perspectives, contradictions and inconsistencies,"²⁶¹ and "challenges the legitimacy of the norms of those who claim to speak, through rules, for the community."²⁶² Bartlett states:

The "substance" of feminist practical reasoning consists of an alertness to certain forms of injustice that otherwise go unnoticed and unaddressed. Feminists turn to contextualized methods of reasoning to allow greater understanding and exposure of that injustice. Reasoning from context can change perceptions about the world, which then may further expand the contexts within which

255. See *id.* (stating that emergency contraception is essential to a woman's ability to protect herself from many physical and psychological harms); *Catholic Charities of Sacramento, Inc. v. Superior Court*, 90 Cal. App. 4th 425, 432 ("Women who cannot afford these additional costs [of contraceptives] must forgo using prescription contraceptive methods, which results in an increase in unwanted or unintended pregnancies. The average sexually active woman would have four pregnancies in five years if she did not use contraception."); see also Law, *supra* note 80, at 364–68.

256. See HARRISON, *supra* note 207, at 39 (emphasizing that without contraception, women are unable to enjoy sexuality free from the anxiety of unwanted pregnancy).

257. See Mahmoud F. Fathalla, *Reproductive Health: A Global Overview*, 626 ANNALS N.Y. ACAD. SCI. 1 (1991).

258. See Erdman & Cook, *supra* note 231, at 156.

259. See Bartlett, *supra* note 35, at 850.

260. *Id.* at 854–55.

261. *Id.* at 851.

262. *Id.* at 855.

such reasoning seems appropriate, which in turn may lead to still further changes in perceptions.²⁶³

Bartlett provides an example of this process in the shift from *Plessy v. Ferguson*²⁶⁴ to *Brown v. Board of Education*,²⁶⁵ in which what was “legally relevant” in race discrimination cases expanded to include the actual experiences of African-Americans and the inferiority implicit in segregation.²⁶⁶ It can also be seen in the decisions in both *Erickson v. Bartell* and *Catholic Charities*, in which the courts expanded the definition of legally relevant to include the recognition that contraception is essential health care for women.²⁶⁷

Applying feminist practical reasoning to the issue of pharmacist refusal clauses requires looking beyond the abstract dichotomy of religious freedom versus lifestyle choice to examine the specific real life issues at stake and the context in which the conflict arises. The abstract principle of protecting religious belief seems to justify a state law permitting pharmacists to refuse to fill prescriptions when to do so would violate their conscience.²⁶⁸ While current First Amendment jurisprudence does not require such protection under the Free Exercise Clause,²⁶⁹ the popular understanding of freedom of religion, held dear in American society, assumes that only a very compelling concern, certainly not an “elective” or “optional” lifestyle choice, could override a pharmacist’s right to exercise that religious freedom. Empirical studies and women’s accounts of the impact of unintended pregnancy tell a very different story, however, illuminating the serious, sometimes tragic consequences to infant and maternal health and the well-being of women and their families.²⁷⁰ Actual circumstances yield insights into the difficult problems that lack of access to contraception creates in the lives of women and their families.

263. *Id.* at 863.

264. 163 U.S. 537 (1896).

265. 347 U.S. 483 (1954).

266. *See* Bartlett, *supra* note 35, at 863.

267. *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1276–77 (W.D. Wash. 2001) (holding that it is sex discrimination to exclude contraception from a general prescription benefit plan because doing so leaves a “fundamental and immediate healthcare need uncovered”); *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 92 (Cal. 2004) (concluding that the state furthers a “compelling state interest of eliminating gender discrimination” by requiring employers to cover prescription contraceptives in their health benefit plans).

268. This analysis models Bartlett’s application of feminist practical reasoning to the issue of minors’ access to abortion. *See* Bartlett, *supra* note 35, at 852. *But see* COOK, REPRODUCTIVE HEALTH, *supra* note 224, at 113 (concluding that health-care providers, who may feel the need to express certain moral standards within their communities, must act as professionals when caring for a patient’s needs, “restrain any instincts they may have for moral condemnation, and act non-judgementally to discharge their legal responsibilities to those whose medical treatment they undertake”).

269. *See infra* Part V.A.

270. *See* Cook, *International Protection*, *supra* note 188, at 676–77 (asserting that empirical data on maternal and infant mortality rates signals that restrictions on reproductive care are dangerous and ineffective).

Taking into account women's lived experience, pharmacist refusal clauses harm women, especially when a pharmacist refuses to dispense emergency contraception. Three types of harm result from pharmacist refusal clauses. First, women are denied access to necessary medical care, and may suffer an unintended pregnancy as a consequence. Second, pharmacists are empowered to impose their own religious beliefs on others who do not share them. And third, pharmacist refusal clauses permit pharmacists to perpetuate and reinforce stereotypes about female sexuality and the role of women in society.

In any analysis, feminist practical reasoning requires a consideration of the various divergent perspectives and calls for a solution based on the contextual integration of these viewpoints.²⁷¹ To fully explore the appropriate balancing of the rights at issue in the debate over pharmacist refusal clauses, it is therefore necessary to examine not only the impact of pharmacists' refusals on women's lives, but also the context in which individual pharmacists seek to exercise the right of refusal. Such an exploration includes an analysis of the legal and ethical obligations of pharmacists as professionals and the impact of refusals on the proper fulfillment of those duties.

IV. THE ROLE OF PHARMACISTS IN THE PROVISION OF HEALTH CARE

Pharmacists, like lawyers and physicians, are trained professionals. "They complete a graduate program to gain expertise, obtain a state license to practice, and join a professional organization with its own code of ethics."²⁷² While traditionally pharmacists were viewed as "dispensers" of medication, in recent years pharmacy associations have advocated for an expanded role for pharmacists that is more active and patient-oriented.²⁷³

Nevertheless, the law has been reluctant to expand the nature of the pharmacist's legal obligation for two reasons: first, to protect pharmacists from

271. See Bartlett, *supra* note 35, at 886–87 (advocating the use of this analytic method to reveal and correct different forms of oppression).

272. See Julie Cantor & Ken Baum, *The Limits of Conscientious Objection: May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2008 (2004).

273. See RICHARD R. ABOOD & DAVID B. BRUSHWOOD, *PHARMACY PRACTICE AND THE LAW* 209 (1994) [hereinafter ABOOD & BRUSHWOOD] (discussing emerging trends in professional and legal liability); David B. Brushwood, *The Professional Capabilities and Legal Responsibilities of Pharmacists: Should "Can" Imply "Ought"?*, 44 DRAKE L. REV. 439, 443–45 (1995–1996) [hereinafter Brushwood, *Professional Capabilities*] (discussing how traditionally, pharmacists were only responsible for the proper processing of prescriptions, but noting a modern trend towards recognizing that a pharmacist owes a certain degree of care to the patient to catch potential drug abuse, warn of certain serious dangers, or provide correct advice once counseling is offered). In fact, nine states—Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Vermont and Washington—have existing laws allowing pharmacists to write prescriptions for Plan B directly; these state laws should be unaffected by the FDA ruling. See Press Release, Barr Pharmaceuticals, FDA Grants OTC Status to Barr's Plan B[®] Emergency Contraceptive (Aug. 24, 2006), available at <http://phx.corporate-ir.net/phoenix.zhtml?c=60908&p=irol-newsArticle&ID=899120> (last visited Sept. 5, 2006).

liability given their limited role in the provision of health care, and second, to preserve the integrity of the physician-patient relationship.²⁷⁴ It would be inappropriate to claim that pharmacists are mere automatons, particularly since the pharmacist owes the customer a professional duty of care.²⁷⁵ Ultimately, however, it is the physician's role to diagnose and prescribe a patient's medication, and the pharmacist's role to see that it is accurately filled and delivered to the customer.²⁷⁶ This duty must be carefully analyzed when balancing the rights of pharmacists to refuse to dispense contraception, with or without a prescription, against the rights of women to receive necessary health care.²⁷⁷

274. See *Chamblin v. K-Mart Corp.*, 612 S.E.2d 25, 27 (Ga. Ct. App. 2005) (declining to impose on pharmacists a legal obligation to warn of adverse drug effects because it would interject the pharmacist into the patient-physician relationship and the threat of liability would force the pharmacist to second guess every prescription); *Madison v. Am. Home Prods. Corp.*, 595 S.E.2d 493, 496 (S.C. 2004) (declining to hold pharmacist liable for drug defects because "the imposition of such duties would force pharmacists to refuse to stock necessary drugs because of risks involved, refuse to use less expensive generic drugs, or second guess the judgment of prescribing physicians").

275. See *Morgan v. Wal-Mart Stores, Inc.*, 30 S.W.3d 455, 461 (Tex. App. 2000) ("In filling and refilling prescriptions, pharmacists are required to exercise the high degree of care that a very prudent and cautious person would exercise under the same or similar circumstances in that business."); *Dooley v. Everett*, 805 S.W.2d 380, 385 (Tenn. Ct. App. 1990) (concluding that as a professional, a pharmacist has a duty to the patient to "exercise the standard of care required by the pharmacy profession in the same or similar communities").

276. See *Brushwood, Professional Capabilities*, *supra* note 273, at 443–45. The responsibility of technical accuracy is so well established that a pharmacist who errs in processing a physician's prescription may be held negligent as a matter of law, no matter how careful or attentive the pharmacist may have been to detail. *Id.* at 443–44. Likewise, an absence of error has immunized pharmacists from liability. *Id.*

277. In light of the FDA's approval of Plan B for over-the-counter sale, it is clear that the risks associated with emergency contraception are so minimal that women age eighteen and older can safely use it without consulting a physician. See FDA Press Release, *supra* note 13 (stating that if used as directed, Plan B is safe and effective); Sheryl Gay Stolberg, *F.D.A. Considers Switching Some Prescription Drugs to Over-the-Counter Status*, N.Y. TIMES, June 28, 2000, at A18 (stating that companies must submit drugs being considered for OTC status to formal FDA review); Julie Aker, *Getting Approval for an Rx-to-OTC Switch Involves Real-World Consumer Research*, APPLIED CLINICAL TRIALS, May 2, 2002, available at <http://www.actmagazine.com/appliedclinicaltrials/article/articleDetail.jsp?id=87117> (last visited Sept. 14, 2006) (stating that OTC status is awarded to drugs that pass "actual use" studies in which researchers see how consumers use any given drug under OTC conditions). Given the proven safety of this medication, a pharmacist should have no greater authority to interfere with a woman's decision to use non-prescription emergency contraception than to interfere with a woman's attempt to obtain prescription contraception. See *infra* text accompanying notes 278–287.

A. The legal role of the pharmacist

Although the role of the pharmacist has expanded in recent years,²⁷⁸ courts have been reluctant to expand the legal responsibility of pharmacists beyond that of accurately and efficiently dispensing drugs.²⁷⁹ The traditional view is that the pharmacist has three legal responsibilities: careful and proper storage, preparation, and dispensing of prescription drugs.²⁸⁰ As the conduit between the physician and patient, a pharmacist's most vital duty is to ensure the delivery of the correct drug and dosage to the patient, because any error in translation of the doctor's handwriting or mistake in labeling and dosage instructions could result in serious harm.²⁸¹ At the simplest level, a physician is responsible for making the correct drug choice for the patient (risk assessment) and the pharmacist is responsible for proper drug use (risk management).²⁸² The pharmacist has a duty to understand the risks that a particular drug may pose to a patient and to ensure proper drug usage.²⁸³ Courts generally have recognized a pharmacist's duty to exercise due care and diligence in the discharge of their professional duties.²⁸⁴

Courts also recognize that pharmacists have a final opportunity to catch any potentially dangerous errors or issues the physician may have missed, and several courts have acknowledged that pharmacists have an affirmative duty to notify a patient or prescribing physician of any clear errors before dispensing the drug.²⁸⁵ Thus, the pharmacist's role in accurately dispensing prescriptions also

278. The expanded practice is referred to as "pharmaceutical care," and includes drug therapy, disease management and patient counseling as well as dispensing. BUREAU OF HEALTH PROFESSIONS, DEP'T OF HEALTH AND HUMAN SERVS., THE PHARMACIST WORKFORCE: A STUDY OF THE SUPPLY AND DEMAND FOR PHARMACISTS 1 (Dec. 2000) [hereinafter PHARMACIST WORKFORCE], available at <http://bhpr.hrsa.gov/healthworkforce/reports/pharmacist.htm>.

279. *E.g.*, Allberry v. Parkmor Drug, Inc., 834 N.E.2d 199, 203 (Ind. Ct. App. 2005).

280. See 2-13 DRUG PRODUCT LIABILITY § 13.02 (2005) (explaining that the traditional duties of a pharmacist included storing, preparing or compounding, and dispensing prescription drugs); see also David B. Brushwood, *The Pharmacist's Duty Under OBRA-90 Standards*, 18 J. LEGAL MED. 475 (1997).

281. See 2-13 DRUG PROD. LIABILITY § 13.02 [4].

282. See ABOOD & BRUSHWOOD, *supra* note 273, at 212.

283. See *id.* at 213.

284. See Roseann B. Termini, *The Pharmacist Duty to Warn Revisited: The Changing Role of Pharmacy in Health Care and the Resultant Impact on the Obligation of a Pharmacist to Warn*, 24 OHIO N.U. L. REV. 551, 557-62 (1998).

285. *E.g.*, Heredia v. Johnson, 827 F. Supp. 1522, 1525 (D. Nev. 1993) (concluding that the pharmacist has a general duty to exercise due care in filling prescriptions properly, in labeling them properly, in including the proper warnings, and in being alert for plain errors); see also ABOOD & BRUSHWOOD, *supra* note 273, at 217 (describing how, in applying the "power model" of pharmacists' duty, courts have held that "pharmacists [have] a responsibility to a patient to prevent bad outcomes of drug therapy only (1) if the pharmacist has knowledge of a potential problem with drug therapy, (2) if a bad outcome is reasonably foreseeable to the pharmacist, and (3) if the pharmacist had the capacity to prevent the bad outcome").

includes protecting patients from reasonably foreseeable and obvious risks.²⁸⁶ However, this duty does not give the pharmacist any extra medical authority; rather, the duty stems from the minimum standard of care that a pharmacist owes to a patient.²⁸⁷

1. Duty to warn

Under the traditional view, a pharmacist's legal role is largely one of a gatekeeper, acting as a conduit between the patient, the physician, and the drug therapy.²⁸⁸ The majority of courts, holding the traditional view, have been reluctant to shift the responsibility of issuing warnings and information to pharmacists.²⁸⁹ They fear that shifting a greater degree of legal responsibility to pharmacists could undermine the physician-patient relationship.²⁹⁰ Applying the "learned intermediary rule," which posits that physicians are in the best position to explain the dangers of prescription drugs to the patient in light of the patient's individual medical circumstances,²⁹¹ most courts hold only physicians legally responsible for a "duty to warn."²⁹² They fear that imposing a duty to warn on pharmacists would require the pharmacist to question the appropriateness of a prescribed drug and second-guess the physician's judgment—essentially, to practice medicine without

286. See *Horner v. Spalitto*, 1 S.W.3d 519, 522–24 (Mo. Ct. App. 1999) (stating that "[p]harmacists have the training and skills to recognize when a prescription dose is outside a normal range" and may contact the physician to verify "that the physician intended such a dose for a particular patient" if there are any clear and avoidable errors or contraindications in a prescription).

287. See *Pittman v. Upjohn Co.*, 890 S.W.2d 425, 435 (Tenn. 1994) (indicating that if certain warnings are generally given when dispensing a particular prescription, a pharmacist who fails to meet this standard of care may be liable for injuries resulting from the lack of disclosure).

288. See David B. Brushwood, *The Pharmacist's Duty to Warn: Toward A Knowledge-Based Model of Professional Responsibility*, 40 DRAKE L. REV. 1, 3 (1991) ("Pharmacists are frequently identified as gatekeepers at the end of a complex drug distribution system.").

289. See *Schaerrer v. Stewart's Plaza Pharmacy, Inc.*, 79 P.3d 922, 928–29 (Utah 2003) ("The physician thus has the ability to combine medical knowledge and training with an individualized understanding of the patient's needs and is the best conduit for any warnings that are deemed necessary."); *McKee v. Am. Home Prods. Corp.*, 782 P.2d 1045, 1053 (Wash. 1989) (noting that pharmacists questioning every prescription which they fill will result in an antagonistic relationship between pharmacists and physicians).

290. See *Allberry v. Parkmor Drug, Inc.*, 834 N.E.2d 199, 202 (Ind. Ct. App. 2005) (concluding that the injection of a third-party pharmacist into the physician-patient relationship may undermine the effectiveness of ongoing medical treatment).

291. See *Walls v. Alpharma USPD, Inc.*, 887 So. 2d 881, 886 (Ala. 2004) (declining to extend the learned intermediary doctrine to pharmacists because it is the doctor, not the pharmacist, who has the responsibility and duty to undertake an evaluation of a prescribed drug); see also Termini, *supra* note 284, at 552–54.

292. See *Morgan v. Wal-Mart Stores, Inc.*, 30 S.W.3d 455, 467 (Tex. App. 2000) (holding that while pharmacists can check the technical accuracy of a prescription, they "do not possess the extensive knowledge of a physician with respect to a patient's complete medical history" and are thus not legally obligated to warn a patient of adverse drug reactions).

a license.²⁹³ Courts addressing this issue emphasize that pharmacists are not qualified to evaluate the soundness of a physician's choice of a drug regimen for a patient.²⁹⁴

This, however, does not mean pharmacists never have a duty to warn. Some courts have found a duty to warn when pharmacists have undertaken such a duty by advertising their safety mechanisms.²⁹⁵ These courts are willing to take a more expansive view of the pharmacist's role when the pharmacist affirmatively commits to a course of action or non-action beyond the bare duty to dispense prescriptions.²⁹⁶ Other courts recently have moved away from the question of whether a duty to warn exists, focusing instead on whether the pharmacist may be liable for a failure to perform to the proper standard of conduct.²⁹⁷

Additionally, one section of the federal Omnibus Budget Reconciliation Act of 1990 ("OBRA-90")²⁹⁸ established a minimum standard of care for pharmacists that requires pharmacists working with Medicaid patients²⁹⁹ to screen prescriptions before dispensing,³⁰⁰ provide limited patient counseling,³⁰¹ and document specific information. OBRA-90 was not designed to permit the

293. See *Nichols v. Cent. Merch., Inc.* 817 P.2d 1131, 1132–33 (Kan. Ct. App. 1991) ("[I]mposing a duty to warn on the pharmacist would intrude on the doctor-patient relationship and force the pharmacist to practice medicine without a license.").

294. See, e.g., *Cottam v. CVS Pharmacy*, 764 N.E.2d 814, 821 (Mass. 2002) ("The pharmacist does not have discretion to alter or refuse to fill a prescription because the risks and benefits of that prescription for that particular patient have already been weighed by the physician.").

295. See, e.g., *Baker v. Arbor Drugs, Inc.*, 544 N.W.2d 727 (1996) (holding that a pharmacy voluntarily assumed a duty of due care with respect to its advertised drug interaction warning system, and allowing a patient who suffered from a drug interaction to pursue a claim against the pharmacy for having failed to utilize its system with due care).

296. See, e.g., *Cottam*, 764 N.E.2d at 821 (holding that without a voluntarily assumed duty or "specific knowledge of an increased danger to a particular customer, the pharmacist has no duty to warn that customer of potential side effects").

297. In the majority of these cases, the courts found pharmacists liable for failure to properly perform their duty to ensure patient safety. See, e.g., *Kasin v. Osco Drug, Inc.*, 728 N.E.2d 77, 81 (Ill. App. Ct. 2000) (holding that when a pharmacist voluntarily undertakes a duty to warn about a possible side effect, the information must be provided in a non-negligent manner to avoid liability).

298. 42 U.S.C. § 1396r-8(g)(2)(A)(ii) (2000).

299. See *Kenneth R. Baker, The OBRA90 Mandate and Its Developing Impact on the Pharmacist's Standard of Care*, 44 *DRAKE L. REV.* 503, 510 (1995–1996) (explaining that OBRA-90 requires states to promulgate standards of practice for pharmacists to provide drug-use review and counseling, and noting that in most states its requirements apply to all pharmacists, not just those serving Medicaid patients).

300. See *id.* at 510–11 (stating that a pharmacist is required only to make a "reasonable effort" to obtain and record pertinent information about a patient, including known allergies and drug reactions).

301. See *id.* at 511 (summarizing the counseling provision, which requires only that pharmacists offer to discuss, with a willing patient, the basic properties of the drug and the physician's instructions for usage, and also to provide other significant information); see also *ABOOD & BRUSHWOOD*, *supra* note 273, at 162 (noting that any obligation to provide counseling ends once a patient consciously waives the right).

pharmacist to perform a risk-benefit analysis or determine what medication a patient should take, however.³⁰² The pharmacist's obligation to review the prescription does not permit any additional discretion or impose additional duties: Unless the prescribed course of drug therapy is completely unsafe, a pharmacist has satisfied the duty to review and may dispense the prescription once he or she has "indicated awareness of the possibilities and has taken these factors into the risk assessment decision."³⁰³

Regardless of the underlying theory, it is clear that courts are unwilling to treat pharmacists as primary health care providers on the same level as physicians.³⁰⁴ While pharmacists provide a valuable resource and patients may benefit from pharmacists' working more collaboratively with physicians,³⁰⁵ under the law, the physician remains in control of all treatment decisions.³⁰⁶ It would be inconsistent with established legal standards to permit a pharmacist to overrule a physician's clinical assessment of a patient's specific medical needs.³⁰⁷ Where the medication in question, like Plan B emergency contraception, has been determined safe for over-the-counter purchase by adult women, the pharmacist's duty should be limited to assuring that the customer receives the instructions and warnings included in the packaging.³⁰⁸

2. Duty to fill prescriptions

While the law generally imposes no duty to warn, pharmacists are obligated under a duty, either implicit or explicit, to fill prescriptions. This duty arises from the various regulations promulgated by state legislatures and pharmacy boards to govern the practice of pharmacy. In most states, those regulations

302. See Baker, *supra* note 299, at 517.

303. *Id.*

304. *But cf.* APHA SPECIAL REPORT, *supra* note 149, at 11 (2000) (discussing collaborative practice agreements, which, when authorized by state statute, create "a voluntary relationship between a pharmacist and an authorized prescriber that enables the pharmacist to manage a patient's drug therapy within the limits of an agreed-upon treatment protocol," including such requirements as educational courses, interviewing patients before dispensing the prescription, and periodically reviewing patient files with the sponsoring independent physician).

305. See *Position 3: ACP-ASIM Opposes Independent Pharmacist Prescriptive Privileges and Initiation of Drug Therapy*, in AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE, PHARMACIST SCOPE OF PRACTICE (2000) (cautioning that while patients may benefit from pharmacists working more collaboratively with physicians, it is still vital that physicians remain in control of all treatment decisions, as pharmacists do not have the same degree of education).

306. See *id.* (emphasizing that pharmacists lack the education, exposure or experience to diagnose and prescribe medications for patients).

307. Presumably, this is why commentators interpret the right of conscientious objection as applicable only to those "who otherwise would be required to perform services directly on patients for the purposes to which they object" and inapplicable to secondary providers, such as hospital staff, who may not refuse duties such as preparing operating rooms and booking appointments because of a conscientious objection to the medical service provided to the patient. COOK, REPRODUCTIVE HEALTH, *supra* note 224, at 140.

308. See Brushwood, *supra* note 288, at 3 (noting that pharmacists often serve as a gatekeeper in the drug distribution process).

enumerate the circumstances in which a pharmacist should refuse to dispense. These reasons typically include contraindications (the conditions under which it is unsafe to take the medication), possible harmful interactions with other drugs,³⁰⁹ suspected drug overuse or abuse,³¹⁰ and forgery.³¹¹ Most of these reasons are intended to prevent harm to the patient. By limiting the reasons pharmacists may refuse to fill prescriptions to valid medical and legal concerns, state pharmacy laws implicitly prohibit refusals for other reasons, including religious, personal, or moral beliefs.³¹² To date, only Georgia and Mississippi have adopted provisions that protect pharmacists from disciplinary action for refusing to fill a prescription based on religious or moral beliefs.³¹³

In response to the controversy over pharmacists refusing to fill prescriptions for contraception, several states have recently taken action to require pharmacists or pharmacies to fill these prescriptions or be subject to disciplinary action. In Illinois, a recently adopted regulation requires all pharmacies to fill prescriptions for contraception, including emergency contraception, without delay.³¹⁴ The Massachusetts Pharmacy Board issued a letter ruling, which concluded that pharmacists must fill valid prescriptions, including those for emergency contraception, subject to a review for contraindications or other health threats.³¹⁵ The Pharmacy Board of North Carolina issued a statement requiring pharmacists who object on religious or moral grounds to “get the patient and the prescription to a pharmacist who will dispense the prescription in a timely manner.”³¹⁶ Additionally, four states have adopted legislation that would require pharmacists to fill prescriptions for contraceptives;³¹⁷ the legislation in California

309. See, e.g., 21 N.C. ADMIN. CODE 46.1801(a) (2005) (“A pharmacist . . . may refuse to fill or refill a prescription order, if, in his professional judgment, it would be harmful to the recipient, is not in the recipient’s best interest or if there is a question as to its validity”); *Happel v. Wal-Mart Stores, Inc.*, 766 N.E.2d 1118, 1125 (Ill. 2002) (holding that a pharmacist had a duty to act to prevent harm to the patient where he knew patient would have an adverse reaction to a requested drug).

310. See, e.g., *Lasley v. Shrake’s Country Club Pharmacy Inc.*, 880 P.2d 1129, 1134 (Ariz. Ct. App. 1994) (holding that pharmacist may be held liable where he mailed a customer addictive drugs for a period of ten years and failed to warn of the drug’s addictive nature).

311. See, e.g., ME. REV. STAT. ANN. tit. 32, § 13795(2) (2005) (allowing pharmacists to refuse to fill any prescription or dispense any drug “if unsatisfied as to the legitimacy or appropriateness of any prescription presented”).

312. See NAT’L WOMEN’S LAW CTR., GUIDE, *supra* note 66, at 5.

313. See *supra* text accompanying notes 56–62.

314. See ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005); see also *supra* text accompanying notes 2–8.

315. See Bruce Mohl, *State Orders Wal-Mart to Sell Morning-After Pill*, BOSTON GLOBE, Feb. 15, 2006, at F1 (confirming that a Massachusetts regulation requiring all pharmacies to dispense “commonly prescribed medications in accordance with the usual needs of the community” means that pharmacies must stock emergency contraception).

316. North Carolina Board of Pharmacy Newsletter, *Conscience Concerns in Pharmacist Decisions* (Jan. 2005), available at <http://www.ncbop.org/Newsletters/NCO12005.pdf>.

317. See NAT’L WOMEN’S LAW CTR., PHARMACY REFUSALS 101, at 3 (Aug. 24, 2006), available at http://www.nwlc.org/pdf/PharmacyRefusals101_08.24.06.pdf (last

makes it a misdemeanor to refuse to fill such prescriptions.³¹⁸ At the federal level, three bills have been introduced that would ensure that pharmacists fill prescriptions for contraceptives, including the Pharmacy Consumer Protection Act of 2005,³¹⁹ and the Access to Legal Pharmaceuticals Act.³²⁰ The traditional view that the primary duty of a pharmacist is to accurately fill prescriptions remains firmly established.³²¹

B. Recent expansion of the pharmacist's role by pharmacy associations

A pharmacist's behavior is not governed by one set of rules; rather, it is guided by an interplay of statutory law, ethical obligations, moral codes, and professional responsibilities.³²² Although pharmacists historically were viewed as "dispensers" of medication, in recent years pharmacy associations have advocated for an expanded role for pharmacists that is more active and patient oriented.³²³ Ethical reforms and the enactment of OBRA-90 have also made the pharmacist a more active member of the health care team. While professional codes and definitions of the pharmacist's role differ among states, within the profession the pharmacist's role has grown beyond the traditional view of conduit between physician and patient.³²⁴ Thus, in order to look at the context in which pharmacists

visited Sept. 13, 2006) (listing California, Illinois, Nevada, and Maine, and noting that in the 2006 legislative session, eight additional states, Arizona, Maryland, Missouri, New York, New Jersey, Pennsylvania, West Virginia, and Wisconsin, have all introduced bills requiring pharmacists to fill prescriptions for contraception).

318. Current laws in California facilitating access to emergency contraception include: CAL. BUS. & PROF. CODE §§ 733, 4314, 4315 (2006); CAL. PENAL CODE § 13823.11 (2006) (establishing the provision of emergency contraception to sexual assault survivors as the minimum standard of care in hospitals).

319. See Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005).

320. See S. 809, 109th Cong. (2005); see also H.R. 1652, 109th Cong. (2005) (amending the Public Health Service Act, 42 U.S.C. § 238 et seq. (2005)). The third bill would also amend the Public Health Service Act, H.R. 1539, 109th Cong. (2005).

321. A pharmacist who refuses to fill prescriptions for contraceptives could be held liable under several other theories. For example, many states have regulations that make the transfer of prescriptions mandatory at the request of a patient, and a private cause of action may exist for injuries resulting from a refusal. See *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 245 (Ct. App. 1989) (finding a cause of action for malpractice where a hospital failed to provide a rape victim with emergency contraception if doing so is the standard of care in the medical community).

322. See David B. Brushwood & Bernadette S. Belgado, *Judicial Policy and Expanded Duties for Pharmacists*, 59 AM. J. HEALTH-SYS. PHARMACY 455, 455-56 (2002) (describing how pharmacists generally act in accordance with expanded professional responsibilities, even if courts have not yet transformed these professional standards into legally enforceable duties).

323. See ABOOD & BRUSHWOOD, *supra* note 273, at 209; Brushwood, *Professional Capabilities*, *supra* note 273, at 443-45; 2-13 DRUG PRODUCT LIABILITY § 13.02 (2005).

324. NAT'L ASS'N OF BDS. OF PHARMACY, MODEL STATE PHARMACY ACT, Art. I, § 104, available at <http://www.nabp.net/law/modelact/download/article1.pdf> (defining the practice of pharmacy as including "the interpretation, evaluation, and implementation of Medical Orders; . . . participation in Drug and Device selection, Drug Administration, Drug

refuse to fill prescriptions, it is necessary to look beyond the law to the culture of the pharmacy profession.

The American Pharmaceutical Association's (APhA) Code of Ethics, adopted in 1994, sets forth the standard of care and professional conduct expected of pharmacists.³²⁵ The Code of Ethics promotes a patient-centered role for the pharmacist, defining the pharmacist as a health professional "who assist[s] individuals in making the best use of medications."³²⁶ The first principle of APhA's Code of Ethics states, "A pharmacist respects the covenantal relationship between the patient and pharmacist."³²⁷ That covenantal relationship imposes upon pharmacists a moral obligation to help patients benefit from their medications.³²⁸ The Code emphasizes beneficence and respect for a patient's autonomy as the most important aspects of a pharmacist's role,³²⁹ places the "concern for the well-being of the patient at the center of the professional practice,"³³⁰ requires that the pharmacist tell patients the truth³³¹ and encourages patients' self-determination and participation in decisions about their health.³³²

The APhA's Principles of Practice for Pharmaceutical Care (Principles of Practice), also stress the "covenantal" relationship between the patient and the pharmacist and require the pharmacist to "hold the patient's welfare as paramount."³³³ The preamble of the Principles of Practice states that the pharmacist is to work "in concert with the patient and the patient's other health care providers" for the benefit of the patient.³³⁴ The Principles of Practice further clarify the pharmacist's professional role and highlight the differences between the

Regimen Reviews, and drug or drug-related research; provision of Patient Counseling and . . . acts or services necessary to provide Pharmaceutical Care in all areas of patient care including Primary Care").

325. See AM. PHARMACISTS ASS'N, CODE OF ETHICS FOR PHARMACISTS (1994), available at <http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2809>.

326. *Id.* at pmb1.

327. *Id.* at § I.

328. See *id.* ("Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society.").

329. See CODE OF ETHICS, *supra* note 325, § 3 ("A pharmacist respects the autonomy and dignity of each patient."); see also ABOOD & BRUSHWOOD, *supra* note 273, at 320 ("By holding the health and safety of the patients to be of first consideration, the APhA Code of Ethics implicitly gives the ethical principle of beneficence supreme importance.").

330. CODE OF ETHICS, *supra* note 325, § II. ("A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner . . . [and] considers the needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient.").

331. See *id.* § 4.

332. See *id.* § 3 ("In all cases, a pharmacist respects personal and cultural differences among patients.").

333. AM. PHARMACISTS ASS'N, PRINCIPLES OF PRACTICE FOR PHARMACEUTICAL CARE § A [hereinafter PRINCIPLES].

334. See *id.* at pmb1.

roles of a pharmacist and a physician.³³⁵ While the APhA advocates for a pharmacist's participation as a member of the patient's health care team involved in mutual decision-making, the Principles of Practice also clearly limit the extent of a pharmacist's involvement. When describing the drug therapy plan, the Principles state that a pharmacist should work in concert with other health care providers to assure safety, effectiveness, and economy, and minimize the potential for future health problems.³³⁶ Read together, the APhA Code of Ethics and Principles of Practice identify four central concepts guiding pharmacists in making ethically and legally defensible decisions: nonmaleficence, beneficence, justice, and respect for autonomy.³³⁷

In 1998, the APhA adopted a refusal clause for pharmacists. Unlike those enacted by state legislatures, which provide no safeguards for the patient, the APhA "Pharmacist Conscience Clause" takes steps to ensure respect for patient autonomy. It recognizes "the individual pharmacist's right to exercise conscious refusal," but also supports "the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of refusal."³³⁸ The APhA has commented that a pharmacist's moral objections do not absolve him or her of all responsibilities and duties owed to the patient.³³⁹ Instead, "removal from participation must be accompanied by responsibility to the patient and performance of certain professional duties which accompany refusal . . . ensuring that the patient will be referred to another pharmacist or be channeled into another available health system."³⁴⁰

Exercising the authority to excuse themselves from the dispensing process, and thus avoiding having personal, moral decisions of others placed upon them, requires the same consideration of the patient—the patient should not be required to abide by the

335. See *id.* at pmb1., § D (stating that the pharmacist's duty to ensure that the patient has access to pharmaceutical care and understands the prescribed therapy).

336. See *id.* § 3.1.

337. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (5th ed. 2001) (explaining that the concept of beneficence requires health care professionals to take positive actions in the best interests of their patient, and implying that a pharmacist can violate this principle through acts of omission, such as neglecting to provide counseling for patients); see also Sonfield, *supra* note 36, at 7 ("The value of justice drives the principle of nondiscrimination, and importantly, the respect for autonomy, which requires others to not interfere with a person's personal choices.").

338. See AM. PHARMACISTS ASS'N, 2004 ACTION OF THE APHA HOUSE OF DELEGATES 6 (Mar. 2004), available at <http://www.aphanet.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=2472> ("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.").

339. See *id.*

340. See Sonfield, *supra* note 36, at 8 (quoting AM. PHARMACISTS ASS'N, 1997-1998 POLICY COMMITTEE REPORT (1998)); cf. International Federation of Gynecology & Obstetrics (FIGO), Ethical Guidelines on Conscientious Objection (Aug. 2005), available at http://www.ipas.org/english/womens_rights_and_policies/international_health_policies/professional_associations_recommendations.asp.

pharmacist's personal, moral decision. Providing alternative mechanisms for patients in this situation ensures patient access to drug products, without requiring the pharmacists or the patient to abide by personal decisions other than their own. . . .³⁴¹

In recent testimony before the U.S. House of Representatives Small Business Committee, the APhA went on to state,

[R]ecognizing pharmacists' unique role in the health care system, there should also be systems in place to make sure that the patient's health care needs are served. It is possible to address the rights of patients and the ability of pharmacists to step away from an activity to which they object. Real world experience has proven this to be true. And it does *not* require a confrontation with the patient.³⁴²

A recent interpretation of the APhA resolution confirms that it is an attempt to balance the needs of the patient and the individual rights of the pharmacist, supporting "a pharmacist 'stepping away' from participating but not 'stepping in the way' of patient access to therapy."³⁴³ Yet the question remains whether this or any pharmacist refusal clause can be justified when balancing the other rights at issue.

C. Applying feminist practical reasoning: the day-to-day practice of pharmacy

Feminist practical reasoning requires an analysis of the context in which pharmacists refuse to dispense contraception in order to balance the rights of pharmacists against the rights of female patients. The obligations imposed on pharmacists by law establish one such context,³⁴⁴ and the professional standards adopted by pharmacist associations and boards establish another.³⁴⁵ It is also important to take into account the reality of the daily work circumstances of pharmacists to understand the lived experience of those who seek to exercise a right of refusal.

Nationwide, pharmacists practice in a variety of settings ranging from retail stores to hospitals to pharmaceutical companies.³⁴⁶ Most pharmacists, about

341. *Written Testimony of Deborah Margules Eldridge, M.D., Hearing Before the S. Comm. on Health Policy, 2004 Leg., 92d Sess. (Mich. 2004) (quoting AM. PHARMACISTS ASS'N, 1997-1998 POLICY COMMITTEE REPORT (1998)).*

342. *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Small Business Comm., 109th Cong. 3 (2005) (statement of Linda Garrelts MacLean, R.Ph., C.D.E., Am. Pharmacists Ass'n).*

343. *See Am. Pharmacists Ass'n, APhA Responds to Media Coverage (July 1, 2004), http://www.aphanet.org/AM/Template.cfm?Section=Resources_For_Reporter&Template=/CM/HTMLDisplay.cfm&ContentID=2689 [hereinafter *APhA Responds*].*

344. *See supra* Part IV.A.

345. *See supra* text accompanying notes 324-343; *see also* NAT'L ASS'N OF BDS. OF PHARMACY, PHARMACY PATIENT'S BILL OF RIGHTS (1992) (stating that patients have the right not be discriminated against on the basis of sex).

346. *See Am. Pharmaceutical Ass'n, Facts About Pharmacists and Pharmacies, <http://www.aphanet.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=3537> (last visited Oct. 5, 2005).*

sixty percent, practice in community or retail pharmacies³⁴⁷ (comprised of independent pharmacies, chain drug stores, supermarket pharmacies, and mass merchandiser pharmacies),³⁴⁸ while another twenty-nine percent work in hospitals and other institutional settings, including long-term and home health care facilities.³⁴⁹ Recent studies indicate that, despite a decade of effort to expand the pharmacist's role to one of pharmaceutical care,³⁵⁰ the large majority of community pharmacists, sixty-nine percent, are engaged primarily in dispensing prescriptions.³⁵¹ The growing trend among pharmacies of implementing electronic and automated services notwithstanding,³⁵² community pharmacists are still preoccupied with the accurate processing of prescriptions and have little time for significant patient interaction and counseling.³⁵³

An estimated ten to twenty percent of a pharmacist's working hours are occupied by administrative duties such as entering patient insurance information, resolving insurance conflicts, and other related non-patient-care activities.³⁵⁴ Community pharmacists also spend time each day contacting physicians regarding

347. See William A. Zellmer, *Unresolved Issues in Pharmacy*, 62 AM. J. HEALTH-SYS. PHARMACY 259, 261 (2005) (describing community pharmacy practices as "extremely insular," mainly pre-occupied with the technical aspects of pharmacy work, and focusing on production and productivity).

348. See PHARMACIST WORKFORCE, *supra* note 278 at 14-15.

349. *Id.* at 23 (reporting that in 2000, 24% of pharmacists worked in hospitals, 3.8% in long-term care facilities, and 2.4% in home care); Facts About Pharmacists and Pharmacies, *supra* note 346 (identifying 66,000 pharmacists working in chain pharmacies, 46,000 in independent pharmacies, and 21,000 working in consulting, government, academic, industry, and other such settings).

350. See *supra* text accompanying notes 322-324.

351. See Zellmer, *supra* note 347, at 262 (reporting the four major deployments of pharmacists: order fulfillment (136,400), primary care services (30,000), secondary or tertiary care services (18,000), and indirect or other services (12,300)). See also AM. PHARMACISTS ASS'N, CAREER PATHWAY EVALUATION PROGRAM FOR PHARMACY PROFESSIONALS SPECIALTY PROFILES § 4a, <http://www.aphanet.org/pathways/pharm-pdfs/p-chain-staff.pdf> (last visited Sept. 22, 2006) [hereinafter PATHWAYS SPECIALTY PROFILES] (indicating that community pharmacists spend fifty percent of their time dispensing prescriptions and additional time doing work related to dispensing prescriptions, such as transcribing telephone prescription orders and calling doctors with problems about dispensing prescriptions); PHARMACIST WORKFORCE, *supra* note 278, at 72 (stating that dealing with third-party issues now takes up one-fifth of pharmacists' workdays, and these tasks include contacting doctors' offices to clarify scripts, manually entering patient and insurance information into the computer, responding to insurance-related inquiries, verifying third-party eligibility through plan manuals, computer or phone calls, resolving billing conflicts, etc.)

352. Lisa B. Samalonis, *Automation Options Abound for Retail Pharmacies*, DRUGTOPICS, Aug. 22, 2005, <http://www.drugtopics.com/drugtopics/article/articleDetail.jsp?id=175692&searchString=%22automation%20options%22> (stating that electronic and automated services are used to assist with processing orders and reducing error).

353. See Zellmer, *supra* note 347, at 262.

354. See PHARMACIST WORKFORCE, *supra* note 278, at 72 (listing the different time-consuming activities related to third-party issues, including responding to insurance related inquiries, verifying eligibility, completing paperwork required by third-parties, and entering information into the computer system).

questions or concerns about prescriptions.³⁵⁵ An independent community pharmacist may work up to seventy hours a week, processing about 300 prescriptions a day.³⁵⁶ Likewise, pharmacists in a chain pharmacy must be able to handle long hours on their feet, heavy workloads, stress, and multitasking.³⁵⁷ Interestingly, the majority of pharmacists in these settings do not hold advanced degrees.³⁵⁸ Many of them express dissatisfaction with their workload.³⁵⁹

One pharmacist-commentator, in a February 2005 article, described the practice of pharmacy as follows:

The majority of pharmacists practice in community pharmacies, and most of them are extremely insular. They are preoccupied by the mechanics and rudiments of their work. They define their role in production terms: processing all the prescriptions that come in as quickly as possible without compromising accuracy.³⁶⁰

Despite the best intentions of pharmacy professionals to increase patient counseling by pharmacists, the daily reality of the pharmacist's workplace has not changed significantly:

Walk into almost any community pharmacy today and take a careful look at the personnel in the prescription department. A common model is for a sales clerk to be positioned for primary contact with the customer. Behind the sales clerk is typically a short wall of shelves filled with merchandise and bags of dispensed prescriptions. Behind the wall, sometimes on a raised platform, is the dispensing area, populated with a number of workers. There is rarely any distinction in garb between pharmacists and technicians, so consumers are unable to tell exactly what type of worker is in the dispensing area, although they may assume that everyone there is a pharmacist.³⁶¹

This description is familiar to the vast majority of consumers, most of whom come into contact with pharmacists in just such community pharmacies.³⁶²

355. See FULL PREPARATION: THE PFIZER GUIDE TO CAREERS IN PHARMACY 46 (Salvatore J. Giorgianni ed., 2002), available at <http://www.pfizercareerguides.com/pdfs/pharmacy.pdf> [hereinafter PFIZER GUIDE].

356. Pharmacists running independent pharmacies also spend significant time dealing with insurance companies, answering patient phone calls, ordering drugs, and handling other managerial tasks. *Id.* at 31–32.

357. See *id.* at 30.

358. See *id.* at 153 (stating that specialty or management-level positions in chain pharmacies generally require an advanced degree).

359. See, e.g., PATHWAYS SPECIALTY PROFILES, *supra* note 351, § 8A, <http://www.aphanet.org/pathways/pharm-pdfs/p-hosp-staff.pdf> (reporting that many of the chain pharmacists interviewed were dissatisfied with the large workload and amount of management and administrative duties).

360. Zellmer, *supra* note 347, at 261.

361. *Id.* at 263.

362. See PATHWAYS SPECIALTY PROFILES, *supra* note 351, § 8a (reporting that hospital pharmacists generally do not develop consistent relationships with their patients and have limited interaction with the general public whom they serve).

It is in this setting that pharmacists most often refuse to dispense birth control or emergency contraceptives.³⁶³ The empirical evidence in recent studies establishes that pharmacists in community pharmacies are too busy filling prescriptions to counsel most of their customers.³⁶⁴ This is exacerbated by an ongoing shortage of pharmacists nationwide.³⁶⁵

No one would dispute the fact that the majority of pharmacists are courteous professionals who strive to serve their patients' needs. Their work environment, however, requires them to struggle to make time for the limited patient counseling they are legally and ethically required to provide. The reality is that pharmacists working in community pharmacies are generally removed from regular patient contact. As a result many, if not most, of their customers are strangers. This is the setting in which members of organizations like Pharmacists for Life refuse to dispense birth control or emergency contraceptives, lecture women about morality, confiscate prescriptions, or mislead women about the availability of drugs necessary for their reproductive health.³⁶⁶ Not all objecting pharmacists take aggressive actions like those of Pharmacist for Life president Karen Brauer, who told *USA Today*, "I refuse to dispense a drug with a significant mechanism to stop human life."³⁶⁷ Regarding referrals, she stated to *The Washington Post*, "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.'"³⁶⁸ Anecdotal reports from other objecting pharmacists suggest that they feel deeply about their obligation to refuse to fill prescriptions for contraception because of their religious beliefs. For example, in an article entitled, "A Catholic Pharmacist's Struggle," one pharmacist stated,

363. See *supra* notes 342–343.

364. If an independent pharmacist were to spend five minutes counseling half of the approximately 300 patients for whom prescriptions are filled each day, see *supra* note 356, it would take 12 hours out of the work day, leaving little time for anything else.

365. See PHARMACIST WORKFORCE, *supra* note 278, at 73 (reporting on the adverse effects of the current shortage of pharmacists on pharmaceutical care in both hospital and community pharmacies, leading to increases in patient waiting times, prescription errors, patient complaints, and decreases in patient counseling and staff availability).

366. See, e.g., Editorial, *supra* note 10 (explaining that some pharmacists "berate, belittle or lecture" customers); Kari Lydersen, III, *Pharmacies Required to Fill Prescriptions for Birth Control*, WASH. POST, Apr. 2, 2005, at A2 (quoting Planned Parenthood's national president as saying that some pharmacists misinform customers that contraception is abortion); 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 A1 (noting that some refusing pharmacists hold prescriptions "hostage" and refuse to transfer prescriptions). While it is possible that an independent pharmacist, particularly in a small town or rural area, may know most of his or her customers, this does little to lessen the intrusiveness of a refusal to fill a prescription for emergency contraception, a time-sensitive emergency medical treatment. See PLANNED PARENTHOOD FED'N OF AM., *supra* note 2.

367. Charisse Jones, *Druggists Refuse to Give Out Pill*, USA TODAY, Nov. 8, 2004, at 3A.

368. Stein, *supra* note 366.

I am a Catholic pharmacist currently working for a large chain pharmacy. I am struggling with moral issues at work daily and seeking a more Catholic friendly position. There are mainly three types of drugs that are causing me to feel a tremendous amount of guilt after I have dispensed them. These three are misoprostol, birth control pills, and "morning after pills." . . .

. . .

[A]ll types of birth control pills cause changes to the lining of the woman's uterus making it very difficult for a fertilized egg to attach and develop. Therefore, the fertilized egg (a real baby) is expelled from the uterus and dies. This is the mechanism which I find most objectionable because this is actually an abortion. . . .

. . .

Even though I did not prescribe the medication or force the woman to take it, I still feel guilty for providing it . . . I feel as though I am causing these women to sin by providing them the means to do so.³⁶⁹

Another pharmacist, a twenty-two-year veteran practicing in Atlanta, told the *New York Times* she had never been presented with a prescription for emergency contraception, but "I would be opposed to dispensing that particular product. It's basically an early abortion . . . I would just hand it to the other pharmacist here. If I'm not filling it, it doesn't involve me."³⁷⁰ A third pharmacist, in a letter to the editor of the *Journal of the American Pharmacist Association*, wrote:

I agree with you that all must be done to minimize a patient's sufferings, however, not at the expense of providing inaccurate information, nor at the expense of being untrue to the ethics that I hold dear. . . The fact remains that the pharmacy profession cannot come to an agreement as to the value of the human embryo before implantation. This being the case, no amount of scientific information will solve this problem, as it remains a philosophical and moral one.³⁷¹

As these reports indicate, there is no common experience among pharmacists who refuse to fill women's prescriptions for contraception. At one end of the spectrum are those pharmacists who are motivated by sincere religious conviction and wish to avoid confrontations over the issue. At the other end are those who use their professional role as an opportunity to proselytize and lecture women on morality and religious doctrine. But whatever the pharmacist's

369. Erik A. McClave, *A Catholic Pharmacist's Struggle*, <http://tcrnews2.com/pharmacy.html> (2002).

370. Monica Davey & Pam Belluck, *Pharmacies Balk on After-Sex Pill and Widen Fight*, N.Y. TIMES, Apr. 19, 2005, at A1.

371. Cristina Alarcon, Letter to Charles D. Hepler, <http://www.pfli.org/archives.html> (last visited Aug. 23, 2006) (responding to Charles D. Hepler, *Balancing Pharmacists' Conscientious Objections With Their Duty to Serve*, 45 J. AM. PHARM. ASSOC. 434, 434-36 (2005)).

motivation or goals, each time a pharmacist refuses to dispense contraception for reasons of religion or conscience and does not insure that another pharmacist will do so, the effect will be the same. The pharmacist's action directly interferes with the physician-patient relationship between a woman and her doctor when the contraception is on prescription, and the woman's right to purchase legal non-prescription medication when it is not. The pharmacist uses professional authority to impose his or her religious beliefs on a stranger and to impede the woman's ability to obtain necessary, sometimes emergency, health care. The consequences of the pharmacist's actions for the woman could be an unintended pregnancy, with all the serious ramifications attendant to it. The pharmacist, on the other hand, bears no consequences for his or her actions when protected by a refusal clause.

Even the APhA refusal clause, and its attempt to balance the rights of the pharmacist and the rights of the patient, is untenable given the typical work environment of the community pharmacist.³⁷² The refusal clause endeavors to balance the rights of pharmacists and the rights of patients by requiring pharmacists to adopt a system of referral or transfer.³⁷³ The policy has been interpreted by the APhA to require a system that is "seamless" to the patient,³⁷⁴ a system where "the patient is unaware that the pharmacist is stepping away from the situation."³⁷⁵ However, given the serious, ongoing shortage of pharmacists in the United States,³⁷⁶ the underlying assumption that there are always two pharmacists working side by side is frequently not the case.³⁷⁷ Transfers to other pharmacies are likewise unworkable; the other pharmacy may be closed, or the woman may have no transportation, and in rural areas there may be no other pharmacy within a reasonable distance. In addition, the policy assumes that the objecting pharmacist is willing to transfer the prescription, yet groups like Pharmacists for Life call on their members to refuse to transfer as well as to fill.³⁷⁸ As discussed above, such acts violate the mandatory transfer requirements of many state pharmacy boards.³⁷⁹

372. See *supra* text accompanying notes 354–366.

373. See *supra* text accompanying note 338.

374. See *APhA Responds*, *supra* note 343.

375. *Id.*

376. See *PHARMACIST WORKFORCE*, *supra* note 278, at 17 (showing that retail pharmacies have an increasingly large number of positions waiting to be filled, with over twice as many vacancies in February 2000 as in February 1998).

377. The assumption is that the one who objects to contraceptives may simply ask the other to fill the prescription instead. *NAT'L WOMEN'S LAW CTR., GUIDE*, *supra* note 66, at 7.

378. See Stein, *supra* note 366, at A1 (quoting the president of Pharmacists for Life, who states that pharmacists should not assist in destroying human life and therefore should not dispense emergency contraception or refer women to other providers who will dispense the medication).

379. See *supra* text accompanying note 72; see also *COOK, REPRODUCTIVE HEALTH*, *supra* note 224, at 141 (noting that although some religious doctrines consider both performance of a procedure and complicity in its performance via a referral as wrong, the majority of legal systems interpret conscientious refusals as applying *only* to the performance of procedures, and not to justify a refusal to make an effective referral, which may constitute negligence or abandonment of patients).

D. Balancing the rights raised by pharmacist refusal clauses

Applying feminist methodology to an analysis of pharmacist refusal clauses expands the inquiry to include facts and perspectives often ignored in legal analysis. Asking the woman questions illustrates how necessary contraception is to the health of most women during a large part of their reproductive lives.³⁸⁰ It also makes clear that choosing whether and when to have a child is a responsible moral act.³⁸¹ Likewise, it reveals the centuries-old stereotypes about female sexuality and women's role in patriarchal society that underpin the religious doctrine invoked when a pharmacist refuses to dispense contraceptives.³⁸²

Feminist practical reasoning focuses on the context in which the dispute occurs, including the daily lived experiences of the pharmacists who come into conflict with women over prescriptions for birth control and emergency contraception. It identifies the multiple perspectives at issue and the consequences to each party when pharmacists refuse to dispense contraceptives. The analysis reveals that the consequences fall most heavily on the woman who is denied access to contraception. Supporters of refusal clauses argue that despite those consequences, protection of pharmacists' religious beliefs is a higher good,³⁸³ and invoke the right of conscientious objection to support their position.

A pharmacist, however, is not in the same situation as a doctor or nurse who refuses to participate in an abortion procedure based on his or her religious beliefs.³⁸⁴ The pharmacist is not directly administering a drug or performing a procedure,³⁸⁵ nor is there the potential danger to the patient that exists if a doctor or nurse is forced to perform a procedure he or she personally opposes.³⁸⁶ To the contrary, the daily reality of pharmacy practice reveals that most pharmacists are removed from significant patient contact and that many of their customers are strangers.³⁸⁷ Unlike conscientious objectors to the military draft, who are legally compelled to participate in military service, pharmacists willingly enter their field

380. The consequences of unintended pregnancy are serious and life-altering, impacting every aspect of a woman's health and well-being. *See supra* text accompanying notes 234–258.

381. *See supra* text accompanying note 254.

382. *See supra* Part II.B. (discussing the historical treatment of female sexuality by the Catholic Church, and its role in contemporary religious doctrine about contraception and abortion).

383. *See supra* text accompanying notes 366–371.

384. *See* Marcia D. Greenberger & Rachel Vogelstein, *Pharmacist Refusals: A Threat to Women's Health*, 308 *SCIENCE* 1557, 1557–58 (2005) (arguing that the role of pharmacists in a patient's care is less direct than that of a physician who administers treatments and performs procedures).

385. *See id.*

386. *See id.*; B.M. Dickens & R.J. Cook, *The Scope and Limits of Conscientious Objection*, 71 *INT'L J. OF GYNECOLOGY & OBSTETRICS* 71, 82 (2000) (noting that ethical obligations do not permit doctors and nurses to use conscientious objection to decline to perform a procedure necessary to save the life or prevent serious harm to the health of the mother). Even under the Catholic Directives, the principle of double effect provides that no wrong is involved in performing a legitimate procedure for a proper reason when an effect follows that is improper to achieve for its own sake. *Id.*

387. *See supra* text accompanying notes 353–365.

and adopt its obligations.³⁸⁸ They are aware of their legal and ethical obligations to dispense prescriptions and put the patient's well-being first. Like other professionals, they benefit from a license that grants them an exclusive franchise to practice a profession, and they obligate themselves to use their knowledge and expertise to help members of society and put their clients' interests and welfare above their own.³⁸⁹ They are also aware that contraceptives are among the most commonly used prescription medications in the United States,³⁹⁰ and that they will frequently be called upon to fill such prescriptions if they accept a job in a community-based pharmacy.³⁹¹

In addition, refusals by pharmacists for reasons other than scientific and medical considerations conflict directly with a pharmacist's legal and ethical obligations.³⁹² Nothing in the APhA's Code of Ethics or Principles of Practice empowers a pharmacist to interfere with the physician-patient relationship by challenging a physician's diagnosis or treatment plan and the patient's consent to that plan. Instead, the pharmacist's ethical obligations require that the well-being and autonomy of the patient be the focus of the pharmacist's practice. Even commentators supporting broader rights for pharmacists are skeptical of the compatibility of the right of conscientious objection and the "culture in pharmacy [which] stresses the need to get medications to patients, not withhold medications from patients."³⁹³

Bartlett's model of feminist practical reasoning poses several additional queries that expand the definition of the "legally relevant" in an analysis of refusal clauses for pharmacists.³⁹⁴ The first inquiry is to determine whether pharmacist refusal clauses disadvantage women. They undeniably do, since only women use the prescription contraception that pharmacists deny when invoking refusal clauses.³⁹⁵ The second is an examination of the justification given for singling out birth control and emergency contraception and permitting pharmacists to refuse to dispense these medications. Some pharmacists believe the religious doctrine that it is a sin to take steps to inhibit conception during sexual intercourse, while others believe that an ensouled human being exists from the moment of conception and

388. See Cantor & Baum, *supra* note 272, at 2011.

389. See Zellmer, *supra* note 347, at 261.

390. See The Top 300 Prescriptions for 2005 by Number of U.S. Prescriptions Dispensed, <http://www.rxlist.com/top200.htm> (last visited Sept. 9, 2006) (showing six different brands of birth control pills, one patch, one ring, and one injectible, with a combined total of 45,438,000 prescriptions dispensed in 2005, making hormonal birth control one of the most prescribed medications).

391. It has been suggested that one "system" to protect the pharmacist's right of conscience and the patient's access to legal prescriptions is for the pharmacist to choose carefully where to practice. See *Hearings*, *supra* note 342, at 3. Examples given include that a pharmacist who opposes assisted suicide should not practice in Oregon, and that a pharmacist who opposes contraceptives should not practice in a Title X clinic. This ignores the reality that contraceptives are in demand in all community pharmacies.

392. See NAT'L WOMEN'S LAW CTR., GUIDE, *supra* note 66, at 3.

393. William L. Allen & David B. Brushwood, *Pharmaceutically Assisted Death and the Pharmacist's Right of Conscience*, 5 J. PHARMACY & L. 1, 8 (1996).

394. See Bartlett, *supra* note 35, at 852.

395. See *supra* text accompanying notes 255–258.

that emergency contraception is an abortifacient which results in murder.³⁹⁶ These pharmacists contend that the theory of conscientious objection protects their choice to refuse to dispense contraception when it violates their religious principles, despite the impact on their female customers.³⁹⁷

The third inquiry is whether there are different understandings of the facts used to justify pharmacists' refusals; indeed, there are. Medical science recognizes that birth control is necessary to women's reproductive health to avoid multiple unintended pregnancies throughout women's childbearing years; this cannot be reconciled with the position of pharmacists who refuse to fill prescriptions for oral contraceptives because they believe birth control is a sin. In addition, medical science directly refutes the argument that emergency contraception is an abortifacient; instead, studies have repeatedly shown that emergency contraception has no impact on an established pregnancy.³⁹⁸ Yet objecting pharmacists, employing what has been referred to as "theo-physiology"³⁹⁹ insist that pregnancy occurs at fertilization (i.e. life begins at conception), and that when emergency contraception prevents implantation of a fertilized ovum, it causes an abortion. This clash between medical science and the beliefs of certain religious denominations creates an impasse which cannot be resolved by additional facts.⁴⁰⁰

Finally, it should be determined whether refusal clauses that permit pharmacists to decline to dispense contraceptives cause harm to women. As noted above, pharmacist refusal clauses clearly harm women in several ways. First, they permit pharmacists to deny women access to necessary reproductive health care, exposing a woman to the life-altering and potentially life-threatening consequences of unintended pregnancy, and possibly interfering with the woman's relationship with her physician. Second, refusal clauses allow pharmacists to impose their religious beliefs on individuals who do not share them, interfering with a woman's ability to exercise her own religious or moral beliefs to determine whether or when to have a child, and her ability to access legal medication to effectuate that decision. And third, refusal clauses harm all women by granting pharmacists permission to take actions that reinforce stereotypes about female promiscuity and women's proper role in society. Rather than pitting a pharmacist's "religious freedom" against a woman's "lifestyle choice," pharmacist refusal clauses grant pharmacists the right to avoid their legal and ethical duties, potentially causing grave harm to women, while protecting pharmacists from the consequences of their actions.

396. See *supra* text accompanying notes 212–216, 368–371.

397. Cf. COOK, REPRODUCTIVE HEALTH, *supra* note 224, at 89 (noting that while health care practitioners shouldn't be legally compelled to perform procedures to which they object to on ethical grounds, they cannot lawfully impose their ethical values to limit a patient's ethical choices).

398. See *supra* text accompanying notes 149–167.

399. Cook, *supra* note 166.

400. The International Federation of Gynecologists & Obstetrics has resolved this impasse by requiring physicians to "abide by scientifically and professionally determined definitions of reproductive health services and to exercise care and integrity not to misrepresent or mischaracterize them on the basis of personal beliefs." See FIGO, *supra* note 340.

Applying feminist methodology to the religious freedom versus lifestyle choice debate reveals that this characterization is the type of "static choice between opposing, mismatched perspectives" that Katherine Bartlett sought to avoid when developing the concept of feminist practical reasoning.⁴⁰¹ Feminist methodology demonstrates that the choice raised by pharmacist refusal clauses is not one between religious freedom for pharmacists on the one hand, and lifestyle choices for women on the other. The debate is really about balancing the right of a pharmacist to exercise personal belief (whether based on religion, conscience or moral values), and the right of a woman to exercise personal belief (whether based on religion, conscience or moral values) *and* to access medically necessary reproductive health care—a constitutionally protected right. Thus, the only justification for permitting pharmacist refusal clauses would be a clearly identifiable right under the Constitution that would mandate adoption of refusal clauses despite the constitutional protections afforded to reproductive decision-making. As presently interpreted, however, the Constitution provides no such right.

V. IMPACT OF THE CONSTITUTION ON REFUSAL CLAUSES

Constitutional jurisprudence provides little guidance regarding the validity of broad refusal clauses that cover abortion as well as contraception and other reproductive health services.⁴⁰² However, on the narrower issue of refusal clauses permitting pharmacists to decline to dispense contraception, the state's right to protect potential life is not implicated.⁴⁰³ Instead, the conflict requires the courts to balance the pharmacist's First Amendment claims of religious freedom against the woman's due process right of reproductive choice, specifically, the right to use contraception.⁴⁰⁴ While recent changes to the membership of the Supreme Court make it impossible to predict with any certainty how the Court will address the intersection of the rights at stake, current Supreme Court precedent does provide a framework for analysis.

401. See Bartlett, *supra* note 35, at 831 (defining feminist practical reasoning as "reasoning from an ideal in which legal resolutions are pragmatic responses to concrete dilemmas rather than static choices between opposing, mismatched perspectives").

402. See ACLU RELIGIOUS REFUSALS, *supra* note 27, at 7. For thirty years, there has been little litigation regarding broad refusal clauses that exempt individuals and entities from the obligation to perform abortions or provide contraceptive and other reproductive health care. The erosion of Free Exercise application under *Employment Division v. Smith*, 494 U.S. 872 (1990), the funding cases permitting the government to refuse to fund Medicaid abortions such as *Harris v. McRae*, 448 U.S. 297 (1980), and *Maher v. Roe*, 432 U.S. 464 (1977), and the curtailment of reproductive rights in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), left a muddled constitutional landscape that advocates on both sides of the issues were hesitant to challenge.

403. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 690 (1977).

404. Also implicated is the woman's right of religious freedom and conscience. See *supra* notes 223–231 and accompanying text.

A. Free Exercise Clause

Proponents of pharmacist refusal clauses will find little refuge in the Free Exercise Clause.⁴⁰⁵ While it is undisputed that the Free Exercise clause provides absolute protection for “the right to believe and profess whatever religious doctrine one desires,”⁴⁰⁶ the freedom to act, “even when the action is in accord with one’s religious convictions, is not totally free from legislative restrictions.”⁴⁰⁷ When an individual’s actions “are found to be in violation of important social duties or subversive of good order, even when the actions are demanded by [that person’s] religion,” the state is not prohibited from regulating those actions.⁴⁰⁸

The current standard for assessing free exercise claims, articulated in *Employment Division v. Smith*⁴⁰⁹ and confirmed in *Church of the Lukumi Babalu Aye v. City of Hialeah*,⁴¹⁰ imposes no obligation on states to create exemptions to protect religiously motivated conduct that is incidentally burdened by “valid and neutral law[s] of general applicability.”⁴¹¹ A religious health care provider, including a pharmacist, has no federal constitutional right to refuse to perform a duty or otherwise abide by a general law requiring the provision of health services.⁴¹² Unless a law is specifically directed at a religious practice, the law is constitutional under the Free Exercise Clause even if the law has an incidental effect of prohibiting an individual’s or group’s exercise of religion.⁴¹³

In *Smith*, the court determined that a statute criminalizing the use of peyote did not violate the First Amendment merely because the law burdened a

405. The First Amendment provides: “Congress shall make no law respecting the establishment of religion or prohibiting the free exercise thereof” U.S. CONST. amend. I.

406. *Smith*, 494 U.S. at 877 (holding that freedom of religious beliefs and opinions are absolute, and that compulsion by law of the acceptance of any creed or practice of any form of worship is strictly forbidden).

407. *Braunfeld v. Brown*, 366 U.S. 599, 603 (1961) (citing *Cantwell v. Connecticut*, 310 U.S. 296, 303–04, 306 (1940)).

408. *See id.* at 603–04 (citing *Reynolds v. United States*, 98 U.S. 145, 164 (1879)). While *Braunfeld* and *Reynolds* were both distinguished in later cases applying the test set forth in *Sherbert v. Verner*, 374 U.S. 398 (1963), the majority cited to them with approval when abandoning the *Sherbert* test in *Smith*, 494 U.S. at 880, 885.

409. 494 U.S. at 890 (holding that the State’s valid and lawful prohibition of peyote use did not violate the Free Exercise Clause where it incidentally inhibited the use of the drug for sacramental purposes).

410. 508 U.S. 520, 526–32 (1993) (reaffirming and applying the *Smith* standard to strike down a Florida law prohibiting ritual animal slaughter).

411. *Smith*, 494 U.S. at 879 (Stevens, J., concurring) (quoting *United States v. Lee*, 455 U.S. 252, 263 n.3 (1982)) (internal quotation marks omitted); *see also Clark, supra* note 29, at 629.

412. *See* ACLU RELIGIOUS REFUSALS, *supra* note 27, at 7.

413. *See Smith*, 494 U.S. at 879; *see also Lukumi*, 508 U.S. at 542 (finding that the contested Florida ordinances were not neutral because they “had as their object the suppression of religion”).

religious group's ceremonial use of the drug.⁴¹⁴ Declining to apply the test developed in *Sherbert v. Verner*,⁴¹⁵ the Court fashioned a new test: laws that are valid, neutral, and generally applicable, such as the restriction on peyote use, do not violate the First Amendment even if they have the effect of burdening religious conduct.⁴¹⁶ The *Smith* Court gave great deference to the states' power to regulate the health, safety and welfare of society.⁴¹⁷ Justice Scalia, writing for the majority, stated that the First Amendment was designed to prevent the persecution of and deliberate discrimination against particular religions, not to put the Court in the role of providing extra or special protections for religious claimants.⁴¹⁸ He expressed concern about the consequences of over-extending refusals on religious grounds, stating:

[B]ecause 'we are a cosmopolitan nation made up of people of almost every conceivable religious preference,' and precisely because we value and protect religious divergence, we cannot afford the luxury of deeming *presumptively invalid*, as applied to the religious objector, every regulation of conduct that does not protect an interest of the highest order.⁴¹⁹

The Court did, however, leave open the option for a legislature to create an exemption to accommodate religious objectors in certain instances.⁴²⁰

414. See *Smith*, 494 U.S. at 890 (declaring that Oregon's denial of unemployment benefits to two employees fired for the ceremonial use of peyote did not violate the Free Exercise Clause).

415. 374 U.S. 398, 404 (1963). Prior to *Smith*, the Court did not distinguish between intentional and unintentional burdens on religious conduct; the previous test, set forth in *Sherbert*, protected against significant impediments upon or discrimination against even indirect burdens on the observance of religion. *Id.* at 404 (citing *Braunfeld v. Brown*, 366 U.S. 599, 607 (1961)).

416. See *Smith*, 494 U.S. at 879; see also *Lukumi*, 508 U.S. at 531 ("A law failing to satisfy [the neutrality and general applicability] requirements must be justified by a compelling governmental interest and must be narrowly tailored to advance that interest.").

417. See *Smith*, 494 U.S. at 888–89.

418. See *id.* at 877–78.

419. *Id.* at 888 (quoting *Braunfeld*, 366 U.S. at 606) (citation omitted). Justice Scalia also noted: "[I]t is hard to see any reason in principle or practicality why the government should have to tailor its health and safety laws to conform to the diversity of religious belief." *Id.* at 885 n.2.

420. *Id.* at 890 (discussing how several state legislatures have made exceptions to their drug laws for peyote use in religious ceremonies, and implying that the constitution neither requires nor forbids the creation of such an exception). Such exemptions would not be constitutional, however, if they collided with another constitutionally protected right, such as the right to use contraception. See *infra* text accompanying notes 467–485.

Pharmacist refusals also do not fall under the exceptions to the rule created in *Smith*. The first exception, based on a line of unemployment cases, *Smith*, 494 U.S. at 884 (preserving the *Sherbert* line of cases, but limiting the *Sherbert* test to unemployment compensation cases), is inapplicable to refusal clauses. Under the second, the "hybrid rights" exception, a free exercise claim that implicated other constitutional protections, such as free speech, might qualify for strict scrutiny review even if the challenged law is neutral and generally applicable. *Id.* at 881. While a pharmacist may attempt to assert a "hybrid rights" claim by arguing that the duty to fill prescriptions for contraception violates the Free

The distinction between the absolute protection of religious belief under the Free Exercise Clause and only qualified protection for religiously motivated conduct is essential in the analysis of pharmacist refusal clauses. A pharmacist has an absolute right to believe that using birth control or emergency contraception is a sin, to express and even proselytize those beliefs in his or her individual capacity, and to act upon those beliefs personally by refraining from the use of birth control or emergency contraception.⁴²¹ The state may not interfere with any of these manifestations of religion. However, when the pharmacist refuses to fulfill the professional obligation to dispense prescriptions for these medications, thus interfering with the provision of health care services (and imposing his or her beliefs on other individuals),⁴²² the state may enforce the pharmacist's duty to fulfill his or her professional obligation.⁴²³ Such an obligation is certainly an "important social dut[y],"⁴²⁴ one which the pharmacist voluntarily assumed when entering the profession.⁴²⁵ And, as the Supreme Court noted in *Braunfeld v. Brown*,⁴²⁶ there are alternatives available to the pharmacist which may result in some financial hardship, but would not involve duties requiring the pharmacist to compromise his or her religious beliefs.⁴²⁷ In a similar situation, the European

Exercise Clause and another constitutional right, *see, e.g.*, *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 88–89 (2004) (determining that *Catholic Charities* failed to assert a colorable claim because the statute requiring the organization to provide contraceptives to its employees did not affect the ability of the organization to express its disapproval of contraceptives), current jurisprudence offers no guidance on whether a court will recognize such a claim. Both scholars and the lower federal courts have questioned whether this claim actually exists, suggesting that the hybrid rights portion of *Smith* was designed merely to explain away inconsistencies with past decisions. *See Lukumi*, 508 U.S. at 567 (Souter, J., concurring) (criticizing the hybrid rights framework in *Smith* as illogical and unworkable); *see, e.g.*, Clark, *supra* note 29, at 632 (explaining divergent interpretations, applications, and criticisms of *Smith's* hybrid rights exception).

421. *See Smith*, 494 U.S. at 879.

422. *See supra* notes 289–294.

423. The Court has held that the state may compel actions forbidden by the individual's religion, *see, e.g.*, *United States v. Lee*, 455 U.S. 252, 258–61 (1982) (ruling that exemption to payment of Social Security taxes for Amish not required despite religious prohibition against participating in government entitlement programs) or forbid acts required by it, *Reynolds v. U.S.*, 98 U.S. 145, 166 (1878). As the Supreme Court has stated, "Our cases do not at their farthest reach support the proposition that a stance of conscientious opposition relieves an objector from any colliding duty fixed by a democratic government." *Gillette v. U.S.*, 401 U.S. 437, 461 (1971) (sustaining military Selective Service System against claim it violated free exercise rights by conscripting persons who opposed a particular war on religious grounds).

424. *Braunfeld*, 366 U.S. at 603 (citing *Reynolds*, 98 U.S. at 164). Similarly, lower courts have ruled that providers of services such as police officers and firefighters must be neutral in providing their services. *See, e.g.*, *Endres v. Ind. State Police*, 349 F.3d 922, 926 (7th Cir. 2003) (citing *Shelton v. Univ. of Med. & Dentistry*, 223 F.3d 220, 228 (3d Cir. 2000)).

425. *See supra* text accompanying notes 325–332.

426. 366 U.S. at 605–06.

427. *Id.*

Court of Human Rights in *Pinchon and Sajous v. France*,⁴²⁸ held that pharmacists cannot refuse to sell contraceptives on the basis of their religious beliefs, stating that the pharmacists “cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products.”⁴²⁹

The Supreme Court’s analysis in *Smith* also permits a state to require that pharmacists dispense contraceptives under the Free Exercise Clause. A statute mandating pharmacists to dispense contraceptives would not offend the Free Exercise Clause merely because it had the “incidental effect” of barring some pharmacists from refusing on religious grounds.⁴³⁰ Such a neutral law of general applicability would apply equally to all pharmacists, regardless of religious affiliation or practice, and would further the valid secular goal of ensuring that women have access to contraception to protect their reproductive health. Thus, under current case law, the Free Exercise Clause does not require religious refusal clauses for pharmacists, nor does it prohibit mandates requiring pharmacists to dispense contraceptives.⁴³¹

B. Establishment Clause

While the Free Exercise Clause does not require states to adopt refusal clauses for pharmacists, the Establishment Clause does not prohibit governments from enacting such statutes to accommodate religious beliefs. Generally, the Establishment Clause prohibits governments from privileging one religion over another, or from privileging religion over nonreligion.⁴³² In a recent case addressing religious accommodations, *Cutter v. Wilkinson*, the Supreme Court reiterated the fundamental principle that the Establishment Clause “commands a separation of church and state.”⁴³³ And in *McCreary County v. ACLU*,⁴³⁴ the Court

428. *Pichon & Sajous v. France*, App. No. 49853/99, <http://www.echr.coe.int/> (2001) (denying application of two pharmacists fined for refusing to fill prescriptions for oral contraception based on religious beliefs).

429. *Id.* (emphasizing that the conduct the French pharmacists wished to be exempted from was legal and “occurred on medical prescription nowhere other than in a pharmacy”). The Court went on to state that “[t]he word ‘practice’ used in Article 9 § 1 [of the European Convention for the Protection of Human Rights and Fundamental Freedoms] does not denote each and every act or form of behaviour motivated or inspired by a religion or a belief.” *Id.*

430. *See Employment Div. v. Smith*, 494 U.S. 872, 878 (1990) (stating that a neutral law of general applicability does not violate the Free Exercise Clause merely because it incidentally burdens the exercise of religion).

431. It is interesting to note the central concept running through *Smith* that “[t]he government’s ability to enforce generally applicable prohibitions of socially harmful conduct . . . cannot depend on measuring the effects of a governmental action on a religious objector’s spiritual development.” *Id.* at 885 (quoting *Lyng v. Nw. Indian Cemetery Protective Ass’n*, 485 U.S. 439, 451 (1988)). Such a practice, cautions the *Smith* court, would in effect permit any conscientious objector, by virtue of their own religious beliefs, “to become a law unto himself.” *Id.* (quoting *Reynolds v. United States*, 98 U.S. 145, 167 (1878)) (internal quotation marks omitted).

432. *McCreary County v. ACLU of Ky.*, 125 S. Ct. 2722, 2733 (2005).

433. 544 U.S. 709, 719 (2005).

reaffirmed and applied the traditional Establishment Clause test first enunciated in *Lemon v. Kurtzman*,⁴³⁵ requiring that a statute: 1) serve a secular legislative purpose, 2) have a principle or primary effect that neither advances nor inhibits religion, and 3) not excessively entangle government in religion, in order to overcome an Establishment Clause challenge.⁴³⁶

In *Cutter*, the United States Supreme Court noted that the Establishment Clause and the Free Exercise Clause “express complementary values, [but] often exert conflicting pressures.”⁴³⁷ Nevertheless, “there is room for play in the joints’ between the Clauses, some space for legislative action neither compelled by the Free Exercise Clause nor prohibited by the Establishment Clause.”⁴³⁸ *Cutter* upheld a federal statute⁴³⁹ prohibiting governments from imposing burdens on the religious exercise of prison inmates.⁴⁴⁰ It found that the statute was a permissible accommodation of religion not barred by the Establishment Clause “because it alleviates exceptional government-created burdens on private religious exercise.”⁴⁴¹ The Court admonished, however, that in properly applying the statute, “courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries”⁴⁴²

Cutter cited with approval⁴⁴³ the Court’s *Estate of Thornton v. Caldor* decision, in which it found unconstitutional a Connecticut statute granting Sabbath observers an “absolute and unqualified right not to work on whatever day they

434. 125 S. Ct. at 2735 (holding that a display of the Ten Commandments at a county courthouse violated the Establishment Clause).

435. 403 U.S. 602, 612–13 (1971).

436. In *McCreary*, the Supreme Court specifically declined to abandon the *Lemon* “secular purpose test” as urged by the appellant. 125 S. Ct. at 2735. In *Catholic Charities of Sacramento, Inc. v. Superior Court*, the California Supreme Court also relied upon *Lemon* to reject Establishment Clause challenges to the California Women’s Contraceptive Equities Act (WCEA). 85 P.3d 67, 79–81 (Cal. 2004); see also *supra* text accompanying note 267. The California Supreme Court applied the *Lemon* test to determine that the WCEA did not violate the Establishment Clause by requiring Catholic Charities to cover prescription contraceptives under its health benefit plan. *Catholic Charities*, 85 P.3d at 79–81.

437. *Cutter*, 544 U.S. at 719 (citing *Walz v. Tax Comm’n of N.Y.*, 379 U.S. 664, 668–69 (1970) (“The Court has struggled to find a neutral course between the two Religion Clauses, both of which are cast in absolute terms, and either of which, if expanded to a logical extreme, would tend to clash with the other.”)).

438. *Id.* (quoting *Walz*, 397 U.S. at 669) (internal citations omitted); see also *Locke v. Davey*, 540 U.S. 712, 725 (2004) (finding Washington state could deny scholarship to theology major).

439. Religious Land Use and Institutionalized Persons Act of 2000, 42 U.S.C. § 2000cc-1(a) [hereinafter RLUIPA].

440. *Cutter*, 544 U.S. at 720. RLUIPA also covered persons in state mental institutions. *Id.*

441. *Cutter*, 544 U.S. at 720 (citing *Corp. of Presiding Bishops of the Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327 (1987) (discussing plaintiff’s suit against the Mormon Church after he was fired from his job in a Church-owned public gymnasium because he failed to qualify as a member of the church in good standing).

442. *Id.*

443. *Id.* at 722.

designated as their Sabbath."⁴⁴⁴ The Court found the statute unconstitutional because it put the interests of religious adherents above all others involved.⁴⁴⁵ Similarly, in *Texas Monthly, Inc. v. Bullock*,⁴⁴⁶ the Court held that a religious exemption, in that case from the payment of a tax by religious periodicals, was unconstitutional because it imposed "substantial burdens on nonbeneficiaries."⁴⁴⁷

Thus, while the Establishment Clause permits certain types of religious exemptions or accommodations, the exercise of the exemption or accommodation must not burden others. The Court's analysis in *Estate of Thornton v. Caldor* is particularly applicable to refusal clauses for pharmacists. The Connecticut statute in *Thornton* provided that a person who states that a particular day of the week is observed as his Sabbath may not be required by his employer to work on that day.⁴⁴⁸ The Court emphasized that the exemption unyieldingly benefited a religious adherent "no matter what burden or inconvenience this imposes on the employer or fellow workers."⁴⁴⁹ It found that the statute imposed an absolute duty to conform business practices to particular religious practices, and took "no account of the convenience or interests of the employer or those of other employees *who do not observe a Sabbath*."⁴⁵⁰ Nor did it provide exceptions for special circumstances that would alleviate the burden placed on the employer or the other employees.⁴⁵¹ Therefore, the statute contravened a "fundamental principle of the Religion Clauses [that] . . . [t]he First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities."⁴⁵²

Like the statute in *Thornton*, the refusal clauses for pharmacists currently adopted in Arkansas, Mississippi, South Dakota, and Georgia create an "absolute and unqualified right"⁴⁵³ on the part of a pharmacist to refuse to fulfill a duty, while imposing substantial burdens on nonbeneficiaries of the statute.⁴⁵⁴ None of the existing refusal clauses provide exceptions for special circumstances, thus putting the interests of the religious adherent above all others.⁴⁵⁵ Unlike the statute in *Thornton*, where the "duty" involved was merely that of an employee to show up for work, pharmacist refusal clauses permit a professional to refuse to perform a legal and ethical duty, voluntarily assumed in return for the state's grant of a professional monopoly to dispense prescriptions, thereby placing a significant

444. 472 U.S. 703, 709 (1985).

445. *See id.* at 710.

446. 489 U.S. 1 (1989).

447. *Id.* at 18, n.8.

448. CONN. GEN. STAT. § 53-303e(b) (1985). It also provided that an employee's refusal to work on his Sabbath could not constitute grounds for his dismissal and included fines for violation of the provision. *Id.*

449. *Caldor*, 472 U.S. at 708-09.

450. *Id.* at 709 (emphasis added).

451. *Id.*

452. *Id.* at 710 (citing *Otten v. Baltimore & Ohio R. Co.*, 205 F.2d 58, 61 (2d Cir. 1953)).

453. *Id.*

454. *See supra* text accompanying notes 241-258 (discussing the burdens placed on women by pharmacist refusal clauses).

455. *See supra* notes 449-451 and accompanying text.

burden on the very individuals the pharmacist has a professional obligation to serve.⁴⁵⁶

In addition, a statute like the South Dakota refusal clause, which permits pharmacists to refuse to dispense medication that “destroys an unborn child,” and defines “unborn child” as existing from fertilized egg to live birth,⁴⁵⁷ adopts and endorses a “religious tenet of some but by no means all Christian faiths [and] serves no identifiable secular purpose. That fact alone compels a conclusion that the statute violates the Establishment Clause.”⁴⁵⁸ Such a statute privileges one religion over another in violation of the Establishment Clause by adopting a specific religious tenet as the basis of the right to refuse. The Supreme Court has stated repeatedly that the Establishment Clause prohibits government from putting “an imprimatur on one religion, or on religion as such, or to favor the adherents of any sect or religious organization.”⁴⁵⁹

In the same way, broad refusal clauses such as the Mississippi statute,⁴⁶⁰ which allows anyone to refuse to participate in any medical procedure on the basis of religion, morals, or conscience, violate the Establishment Clause. Such refusal clauses empower *any* individual to impose his or her own religious (moral or conscience) beliefs on others who do not share them,⁴⁶¹ thereby giving the state’s imprimatur on the beliefs of the objecting individual.⁴⁶² While the Mississippi Protection of Conscience Act was cleverly drafted to avoid the appearance of

456. See *supra* text accompanying notes 325–343. It is useful to distinguish among the different circumstances in which religious exemption statutes are enacted. The term “accommodations” is typically used when the statute removes government-imposed restrictions on religious practices; there is no existing duty to others that is violated by the accommodation. See, e.g., *Cutter v. Wilkinson*, 544 U.S. 709, 724 (2005) (permitting inmates to exercise religion without interference from prison authorities); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989) (a religious exemption *may* be valid under the Establishment clause even if not required by the Free Exercise clause) (citing *Goldman v. Weinberger*, 475 U.S. 503 (1986) (exemption for soldier to wear yarmulke not required by Free Exercise clause)). Likewise, the term “exemptions” is used in cases such as *Texas Monthly*, 489 U.S. at 5 (prohibiting exemption from taxes for religious periodicals) and *Thornton*, 472 U.S. 703, 770–11 (1985) (exempting Sabbatarians from working on Sabbath of their choice), and does not permit the avoidance of a duty of service to others. A “refusal clause” or “conscience clause,” on the other hand, is designed specifically to permit a professional to refuse to fulfill a legal or ethical duty, thereby placing a significant burden on those intended to be served.

457. S.D. CODIFIED LAWS, §§ 36-11-70, 22-1-2(50) (2005).

458. *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 566–67 (1989) (Stevens, J., dissenting) (finding that the preamble of the Missouri statute declaring that life begins at conception and conception occurs at fertilization has no secular purpose and violates the Establishment Clause).

459. *Texas Monthly*, 489 U.S. at 8–9 (quoting *Gillette v. United States*, 401 U.S. 437, 450 (1971) (internal quotation marks omitted)).

460. See MISS. CODE ANN., §§ 41-107-3, 41-107-5 (2004).

461. See COOK, REPRODUCTIVE HEALTH, *supra* note 224, at 140 (asserting that it would be unethical for ancillary providers of health care, such as hospital staff, to refuse to perform duties ranging from changing sheets to booking appointments because of a conscientious objection to the medical service provided).

462. See *Texas Monthly*, 489 U.S. at 8.

endorsing religion, the Supreme Court has made it clear that an “avowed” secular purpose will not avoid conflict with the Establishment Clause,⁴⁶³ where the underlying religious purpose is clear from the legislative history and implementation of the statute.⁴⁶⁴

Therefore, under current First Amendment jurisprudence the Free Exercise Clause does not require a state to permit pharmacists to refuse to dispense contraception, and the Establishment Clause would not prohibit such a religious accommodation, provided that the refusal clause did not impose significant burdens on the rights of others. As discussed above, current refusal clauses for pharmacists do impose substantial burdens on women’s ability to access necessary reproductive health care.⁴⁶⁵ The question remains whether the burdens created by pharmacist refusal clauses are an unconstitutional infringement upon the right to reproductive decision-making protected by the Due Process Clause of the Fourteenth Amendment.

C. Due Process Clause

The right to use contraception is a privacy interest protected by the liberty provision of the Due Process Clause of the Fourteenth Amendment. Beginning with the Supreme Court’s decisions in *Griswold v. Connecticut*,⁴⁶⁶ and *Eisenstadt v. Baird*,⁴⁶⁷ there has been a consistent and unbroken recognition in Constitutional jurisprudence that individuals have a right to determine “whether to bear or beget a child.”⁴⁶⁸ As Justice O’Connor stated in 1992 in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, “the scope of recognized protection accorded to the liberty relating to intimate relationships, the family, and decisions about whether or not to beget or bear a child” has not been disturbed nor diminished.⁴⁶⁹

In *Carey v. Population Services International*, the only case following *Griswold* and *Eisenstadt* in which the Court has addressed contraception outside of dicta in abortion cases, the Court struck down a New York law that barred distribution of all contraceptives to minors under the age of sixteen and prohibited anyone other than a pharmacist from distributing nonprescription contraceptives to teenagers.⁴⁷⁰ The appellant argued that in *Griswold* and *Eisenstadt* the Court

463. *E.g.*, *Stone v. Graham*, 449 U.S. 39, 41 (1980) (holding “avowed” secular purpose for posting Ten Commandments in schoolrooms not sufficient to avoid conflict with the First Amendment); *School Dist. of Abington Twp. v. Schempp*, 374 U.S. 203, 225–26 (1963) (holding unconstitutional daily reading of Bible verses despite assertion of secular purpose).

464. *McCreary County v. ACLU of Ky.*, 125 S.Ct. 2722, 2734 (2005).

465. *See supra* text accompanying notes 325–343.

466. 381 U.S. 479 (1965) (holding that a state could not bar married couples from having access to contraception under the Due Process Clause).

467. 405 U.S. 438 (1972).

468. *Id.* at 453 (extending that fundamental right to unmarried individuals under the Equal Protection Clause). Unlike with the abortion cases, there has been no whittling away of the right to contraception.

469. 505 U.S. 833, 857 (1992).

470. 431 U.S. 678, 681 (1977).

merely established a right to *use* contraceptives, not a right to *access* contraceptives. Rejecting that argument, the Court stated,

[T]his argument . . . overlooks the underlying premise of those decisions Read in light of its progeny, the teaching of *Griswold* is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State.

Restrictions on the distribution of contraceptives clearly burden the freedom to make such decisions. . . .

. . .

This is so not because there is an independent fundamental “right of access to contraceptives,” but because such access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the holdings in *Griswold*, *Eisenstadt v. Baird*, and *Roe v. Wade*.⁴⁷¹

The Court applied strict scrutiny to the New York statute, stating that the same test must be applied to state regulations that “burden an individual’s right to decide to prevent conception . . . by substantially limiting access to the means of effectuating that decision, as is applied to state statutes that prohibit the decision entirely.”⁴⁷² The Court expressed significant concern over the State’s delegation of its “authority to disapprove of . . . sexual behavior to physicians [and by implication pharmacists],” who in turn could distribute or deny contraception in an arbitrary and inconsistent manner.⁴⁷³ Importantly, the Court noted that the interest in protecting potential life is not implicated in state regulation of contraception, further undercutting the state’s ability to limit access.⁴⁷⁴

There are no Supreme Court cases addressing refusal clauses under a Fourteenth Amendment Due Process analysis. Instead, there is a long line of cases holding that the Due Process Clause does not require states to facilitate or fund abortion. The Court has permitted states to require parental notification by a minor before obtaining an abortion, even without requiring a judicial bypass provision,⁴⁷⁵ extended waiting periods to encourage women to carry a pregnancy to term,⁴⁷⁶ and required counseling regarding the risks of abortion and the gestational age and development of the fetus.⁴⁷⁷ In the funding area, the Supreme Court has made it

471. *Id.* at 687–89.

472. *Id.* at 688.

473. *Id.* at 699; *cf.* *Planned Parenthood v. Danforth* 428 U.S. 52, 71 (1976) (striking down statute requiring husband’s consent for abortion because the state cannot delegate to a third party a right the state itself does not possess). Likewise, a state may not delegate to a pharmacist the right to limit a woman’s access to contraception, a right the state itself does not possess under *Carey*. 431 U.S. at 699.

474. *Carey*, 431 U.S. at 690.

475. *E.g.*, *Ayotte v. Planned Parenthood of N. New England*, 126 S.Ct. 961 (2006) (declining to overturn New Hampshire parental notification law just because it lacked a judicial bypass or health exception).

476. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885 (1992).

477. *Id.* at 881. In *Webster v. Reproductive Health Services*, the Court ruled that public hospitals and health care providers are not constitutionally required to offer abortion

clear that no government is required to provide funds for abortion. The Court in *Harris v. McRae* held that the Hyde Amendment's prohibition of the use of federal Medicaid dollars to fund medically necessary abortions for indigent women did not violate the Due Process Clause.⁴⁷⁸ The Court has also held that states are not required to fund abortions for indigent women on Medicaid.⁴⁷⁹ None of these cases, however, address the constitutionally protected right to use contraception; instead, the state's interest in protecting potential life and right to favor childbirth over abortion were at the center of these holdings.⁴⁸⁰ Since refusal clauses allowing pharmacists to refuse to dispense contraception do not implicate the state's interest in potential life,⁴⁸¹ these cases are inapplicable.⁴⁸²

On the other hand, the Court's reasoning in *Planned Parenthood v. Danforth*⁴⁸³ would apply to pharmacist refusal clauses. In *Danforth*, the Court struck down a spousal consent provision in an abortion statute, reasoning that the state cannot delegate to a third party a right the state itself does not possess.⁴⁸⁴ Likewise, by enacting a pharmacist refusal clause, the state is delegating the right to limit a woman's access to contraception to a third party, a right the state itself does not possess under the Supreme Court's decision in *Carey*. Thus, under *Griswold*, *Eisenstadt*, and *Carey*, the Due Process Clause protects a woman's

services, and upheld a Missouri law prohibiting the use of public hospitals or employees to provide, participate in, or counsel about abortion services. 492 U.S. 490, 510 (1989). See also *Rust v. Sullivan*, 500 U.S. 173, 177–78, 203 (1991) (upholding a federal regulation prohibiting federally funded facilities from counseling, referral or other activities intended to inform their clients about abortion).

478. 448 U.S. 297, 325 (1980); see also *Maher v. Roe*, 432 U.S. 464, 474, 479–80 (1977) (finding exclusion of funding for non-therapeutic abortions does not violate the constitutional right of a woman to decide to terminate her pregnancy).

479. *Maher*, 432 U.S. at 478–79 (concluding that a state's encouraging of childbirth over abortion by not providing public funding for abortion related services did not impose any disadvantage on indigent women seeking an abortion); see also *Poelker v. Doe*, 432 U.S. 519, 521 (1977) (upholding *Maher*).

480. In light of these cases, however, there have been few challenges to the broad refusal clauses adopted nationwide, many of which also address sterilization, a form of contraception. The Church Amendment has remained unchallenged since 1973 and expressly provides that receipt of federal funds does not "authorize" any court or government to require an individual to provide sterilization or abortion if it violates religious belief or moral convictions. See *supra* text accompanying notes 37–39. Likewise, refusal clauses enacted by most states governing abortion and sterilization also have remained unchallenged for over two decades. More recently, in 1997 Congress amended the Medicaid and Medicare statutes to exempt managed care plans from the requirement to provide or cover family planning services (including contraception and sterilization) if the organization "objects to the provision of such services on moral or religious grounds." Balanced Budget Act of 1997, Pub. L., No. 105-33, tit. IV, § 18529(j)(3)(B), 111 Stat. 251, 295 (2005).

481. See *supra* note 403.

482. While in *Harris*, the Supreme Court stated in dicta that *Griswold's* protection of the right to use contraception does not create a governmental obligation to pay for it, 448 U.S. at 318, this has no impact upon pharmacist refusal clauses, where payment for the contraceptives is not at issue.

483. 428 U.S. 52 (1976).

484. *Id.* at 71–72.

fundamental right to access contraception, and pharmacist refusal clauses may not impermissibly limit that right.⁴⁸⁵

Neither the First Amendment nor the Fourteenth Amendment would permit pharmacist refusal clauses that burden a woman's right to necessary reproductive health care or infringe upon her right to be free from the imposition of religious beliefs she does not share. Applying feminist methodology to pharmacist refusal clauses supports the conclusion that, when a woman seeks contraception, her right to reproductive choice should prevail over the religious freedom claim of the pharmacist refusing to dispense the contraceptive to her.

VI. PUBLIC POLICY PROPOSAL FOR PHARMACIST REFUSAL CLAUSES

States must look to constitutional jurisprudence, their own laws governing pharmacists, and the public policy considerations implicated when women are denied access to necessary health care to determine the efficacy of pharmacist refusal clauses. None of the refusal clause statutes currently in force in Arkansas, Mississippi, or South Dakota, nor the regulations adopted in Georgia, provide protections or safeguards for patients; therefore, they ignore the harm caused to women when access to contraception is impeded. While the policy of "referrals and seamless access" adopted in the APhA refusal clause⁴⁸⁶ has facial appeal, in practice it has proved impracticable because community pharmacists often work alone.⁴⁸⁷ Requiring transfers to other pharmacies is also ineffectual for several reasons, particularly because many objecting pharmacists also refuse to transfer contraceptive prescriptions as well to fill them.⁴⁸⁸ In addition, the APhA refusal

485. Given that pharmacist refusal clauses harm women only (because only women use prescription contraception), the Equal Protection Clause provides another framework for analysis clauses, albeit one the Supreme Court has not adopted when addressing reproductive choice. The Court in *Thornburgh v. American College of Obstetricians and Gynecologists* did acknowledge that states' regulation of abortion raises issues of equality for women. 476 U.S. 747, 772 (1986). But only in Justice Blackmun's dissent in *Webster v. Reproductive Health Services* has abortion been analyzed as an issue of sex equality for women. 492 U.S. 490, 557 (1989) (Blackmun, J., dissenting). In *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1277 (W.D. Wash. 2001), the court held that the exclusion of contraception from employee's insurance coverage was sex discrimination in violation of Title VII. See also *Comm'n Decision on Coverage of Contraception*, 2000 WL 33407187, at *2-3 (Equal Employment Opportunity Comm'n Dec. 14, 2000) (holding that the denial of benefits for contraception is discrimination on the basis of a woman's ability to become pregnant and is thus prohibited by the Pregnancy Discrimination Act). Numerous scholars have proposed an equal protection analysis as a better or complementary approach to the due process analysis adopted by the Court in the abortion cases. See, e.g., Elizabeth Schneider, *The Synergy of Equality and Privacy in Women's Rights*, 2002 U. CHI. LEGAL F. 137 (2002); Siegel, *supra* note 184; Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375 (1985); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1007-28 (1984).

486. See *supra* text accompanying notes 374-376.

487. See *supra* text accompanying notes 372-379.

488. E.g., Editorial, *Prescription Politics Hard to Swallow*, BALT. SUN, Apr. 22, 2005, at 13A (noting that Pharmacists for Life International President Karen Brauer stated

clause directly contradicts many of the broad ethical obligations set forth in the APhA Code of Ethics.⁴⁸⁹ Thus, the APhA's conscience clause, with its policy of seamless access, has meaning in the real world only if every *pharmacy* has a legal obligation to fill all prescriptions.

In light of the current campaign by organizations such as Pharmacists for Life to encourage pharmacists to block women's access to contraception, states should take action to require every pharmacy to dispense contraceptives to women who are legally entitled to purchase them. The Illinois governor's emergency order of 2005 requiring pharmacies in Illinois to fill all prescriptions for contraceptives without delay sparked lawsuits and a firestorm of media attention.⁴⁹⁰ Yet the final version of the emergency order, which was adopted as an amendment to the Illinois Pharmacy Practice Act, provides an excellent example of an appropriate treatment of pharmacist refusals. The regulation adopted by the Illinois legislature states, "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."⁴⁹¹ It requires the pharmacy to obtain the contraceptive if it is not in stock, or if the patient prefers, to transfer the prescription to another pharmacy of the patient's choosing or return the prescription to the patient.⁴⁹² The Illinois regulation, like a recent decision of the Massachusetts pharmacy board,⁴⁹³ also requires pharmacies to stock emergency contraception, thereby assuring that women are not denied access to this time-sensitive medication due to a pharmacy's refusal to carry it.⁴⁹⁴ Further, the regulation ensures that pharmacists may still screen customers with prescriptions for potential problems due to contraindications, drug interactions, and other possible problems.⁴⁹⁵

The Illinois regulation provides the appropriate balancing of the rights of women to access contraception and the rights of pharmacists to exercise conscientious objection. Women are guaranteed that their prescriptions for contraception will be filled without delay. By requiring each pharmacy, rather than each pharmacist, to dispense the contraceptives, the regulation leaves room for the pharmacy to adopt procedures to accommodate an individual pharmacist who wishes to step aside when another pharmacist is available to fill the prescription.

that she not only urges pharmacists to refuse to dispense contraception, but to refuse to refer to another pharmacist as well); Stein, *supra* note 366 (describing incident in Wisconsin where the pharmacist both refused to fill a University of Wisconsin student's birth control prescription and to transfer it to another drugstore).

489. See *supra* text accompanying notes 325–337.

490. See *supra* text accompanying notes 2–8.

491. ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005).

492. *Id.*

493. See Mohl, *supra* note 315, at F1 (clarifying that all pharmacies must stock emergency contraception pills in order to comply with state pharmacy regulations requiring stores to stock medications needed by the community).

494. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1); see Mohl, *supra* note 315 (describing how Wal-Mart pharmacies in Massachusetts are required to stock and dispense emergency contraception).

495. See § 1330.91 at subsection (j)(3).

And while requiring the pharmacy to fill the prescription “without delay,” the regulation ensures that pharmacists can and should exercise professional judgment to determine if there are any health hazards or legal problems with the prescription presented to them. If no other pharmacist is available, however, the pharmacist on duty must fill the prescription or be subject to discipline. Such a policy is the only way to ensure that women have access to validly prescribed medication without interference by pharmacists who hold different views on the use of contraception.⁴⁹⁶ The reasoning underlying this policy clearly applies to the over-the-counter sale of emergency contraception as well. Women should be free to purchase this medication upon proof that they are age eighteen or older without interference by a pharmacist. The only role the pharmacist should play in the transaction is the gatekeeper role required by the FDA.⁴⁹⁷

In April of 2005, three bills containing similar provisions were introduced in Congress, including the Pharmacy Consumer Protection Act,⁴⁹⁸ introduced by Senator Barbara Boxer, and the Access to Legal Pharmaceuticals Act,⁴⁹⁹ introduced by Senator Frank Lautenberg. All three bills would require pharmacies to fill legal prescriptions (not limited to contraceptives) without delay, but none include language recognizing a pharmacist’s duty to screen for contraindications and other health problems.⁵⁰⁰ As such, these bills are deficient because they do not adequately protect the pharmacist who fulfills his or her obligation to screen for contraindications. Only a policy that requires a pharmacy to ensure that valid prescriptions for contraception are filled, while assuring that a pharmacist is free to properly screen for contraindications, protects the rights of both parties involved. In light of the FDA’s recent approval of Plan B emergency contraception for over-the-counter sale, the bills also should be amended to require all pharmacies to dispense emergency contraception without a prescription to women who are age eighteen or older.

CONCLUSION

The pharmacist refusal clauses presently in force cannot be justified under a legal, ethical, or public policy analysis. Applying feminist methodology expands

496. Similarly, a letter ruling by the Massachusetts Pharmacy Board also requires prescriptions to be filled without delay, subject to a review for contraindications. See Mohl, *supra* note 315, at F1.

497. See FDA Press Release, *supra* note 13 (noting that pharmacists who stock Plan B must keep it behind the counter and dispense it when shown proof of age, but that responsibilities to educate the public about Plan B’s safe usage remain with Duramed, the division of Barr Pharmaceuticals that is bound by the FDA’s CARE (Convenient Access, Responsible Education) program).

498. S. 778, 109th Cong. (2005) (requiring pharmacies receiving Medicare or Medicaid to fill prescriptions “without unnecessary delay”).

499. S. 809, 109th Cong. (2005) (proposing to subject pharmacies to civil penalties and liability for a failure to fill a prescription for contraception “without delay” and noting that “an individual’s right to religious belief and worship cannot impede an individual’s access to legal prescriptions, including contraception”).

500. Rep. Carolyn McCarthy introduced the third, H.R. 1539, 109th Cong. (2005) (amending the Public Health Service Act). This bill includes the same provisions as the Access to Legal Pharmaceuticals Act, but does not include the preliminary findings.

the definition of the legally relevant inquiries to include the multiple harms women suffer when they are denied access to necessary reproductive health care and forced to endure an unintended pregnancy. It also unearths the historical roots of the misogynistic stereotypes about female sexuality and women's role as child-bearer underlying the modern attitudes which frame the issue as a struggle between "religious freedom" and a "lifestyle choice." When seen through the lens of feminist methodology, it is clear that the pharmacists' claims to religious freedom cannot take precedence over a woman's right to necessary health care and reproductive autonomy. Constitutional jurisprudence supports the conclusion that pharmacist refusal clauses unconstitutionally permit pharmacists to impose their religious beliefs on women who do not share them and to interfere with a woman's constitutionally protected right to reproductive decision-making.

In addition, each of the refusal clauses currently in place conflicts with the legal and ethical obligations of the pharmacy profession. In order to address the issue without violating the constitutional rights of women, states should enact legislation or adopt regulations that require all pharmacies to fill legal prescriptions for ordinary birth control and emergency contraception. Additionally, pharmacies should be required to stock emergency contraception and sell it to adult women who request it upon proof of age. Thus, every pharmacy will be under a legal obligation to ensure that women have access to medication they are legally entitled to purchase, whether the pharmacy is a part of a large corporate chain, an independent corner drugstore, one of multiple pharmacies in a single city, or the sole provider in a rural community. An individual pharmacist may refuse to dispense contraceptives by "stepping aside" from the transaction only if another pharmacist in that pharmacy is available to provide them immediately. If no alternative dispenser is available and a pharmacist refuses to dispense the contraceptive, both the individual pharmacist and the pharmacy should be subject to losing their licenses.

The regulations adopted by the state of Illinois provide a good model for a regulatory scheme that appropriately addresses the needs of pharmacists and their customers. The Illinois regulations recognize women's right to access birth control and emergency contraception without delay, while at the same time guaranteeing that a pharmacist is not impeded from exercising the professional judgment necessary to fulfill his or her legal and ethical obligations. States should be encouraged to adopt similar regulations or legislation to ensure that women are no longer subject to interference by pharmacists as they attempt to access medications necessary for their reproductive health.