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NOTE

THE UNCONSCIONABILITY OF CONSCIENCE CLAUSES: PHARMACISTS’ CONSCIENCES AND WOMEN’S ACCESS TO CONTRACEPTION

Jed Miller†

To say that contraceptives are immoral as such, and are to be forbidden to . . . persons who will nevertheless persist in having intercourse, means that such persons must risk for themselves an unwanted pregnancy, for the child, illegitimacy, and for society, a possible obligation of support. Such a view of morality is not only the very mirror image of sensible legislation . . . it conflicts with fundamental human rights.¹

"[C]onstitutional rights ‘cannot be allowed to yield simply because of disagreement with them.’"²

INTRODUCTION

Pharmacists are now at the forefront of the controversy surrounding abortion and contraception.³ In recent years, some pharmacists,

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motivated by religious or moral scruples, have refused to dispense birth control and emergency contraception (EC) to their female customers.\(^4\) As a result, women’s efforts to obtain contraception have been frustrated. The earliest report of a pharmacist who refused to dispense EC was in 1991.\(^5\) Since then, pharmacists across the country have acted on their beliefs and denied women access to contraception. In 1996, for instance, an Ohio pharmacist refused to dispense EC to a female patron.\(^6\) In January 2004, a Texas pharmacist objected to filling a rape victim’s prescription for EC.\(^7\) He explained, “I don’t think it’s fair that I be forced to participate in a chain of events that results in the taking of a life.”\(^8\) Later that year, another Texas pharmacist refused to dispense birth control pills for a mother of two.\(^9\) When asked to explain his refusal, he told the woman birth control pills “cause cancer.”\(^10\) After refusing to fill a prescription for birth control pills, a K-Mart pharmacist in Wisconsin declined to transfer the cus-

\(^4\) However, pharmacists are not the only health care providers who have refused to dispense contraception. See, e.g., *Must Hospitals Give the Morning-After Pill?*, TRIAL, June 1989, at 92, 93 (stating that many religious hospitals refuse to distribute EC); Meghan Gordon, *Nurse Sues Parish Hospital; She Refused to Give ‘Morning After Pill,’* TIMES-PICAYUNE, June 29, 2005, at A1 (describing a nurse who refused to dispense EC). Although some pharmacists have recently objected to dispensing contraceptives, many pharmacists have willingly distributed condoms and prescription contraceptives for quite some time. See Bernard M. Dickens, *Reproductive Health Services and the Law and Ethics of Conscientious Objection*, 20 MED. & L. 283, 290 (2001).


\(^8\) *Contraception*, supra note 7, at 33.

\(^9\) Gardner, supra note 7, at 11; Sweeney, supra note 6, at E1.

customer and her prescription to a different pharmacy. Similar refusals have also occurred in Missouri, California, Georgia, Louisiana, Massachusetts, North Carolina, and Washington. More recently, in autumn 2004, a New Hampshire pharmacist refused to dispense EC to a twenty-one-year-old single mother. After refusing to refer her to another pharmacist, he berated her.

As these stories illustrate, some pharmacists refuse to dispense contraception, while others refuse even to refer objectionable prescriptions to willing pharmacists. Studies of pharmacists' attitudes reflect these sentiments. In a 1972 survey of 780 Pennsylvania pharmacists, 25 percent believed unmarried minors should not be allowed to purchase contraceptives, while 10 percent believed married minors should not be allowed to purchase contraceptives, while 10 percent believed married minors should also be barred from such purchases. According to the study,

11 Gardner, supra note 7, at 11; Sweeney, supra note 6, at E1. According to the pharmacist's attorney, the pharmacist "sincerely believes he would be committing an act of sin to dispense [birth control], and to call someone else to dispense it." Gardner, supra note 7, at 11.

12 See Simon, supra note 3. Interestingly, the Missouri legislature considered a conscience clause that would have protected pharmacists who refused to transfer prescriptions. Cantor & Baum, supra note 5, at 2008.


14 Cantor & Baum, supra note 5, at 2008.

15 Id.

16 Pharmacists Refusing to Fill Contraceptive Prescriptions Due to Religious Beliefs (NBC Evening News television broadcast Aug. 31, 2004) [hereinafter Pharmacists]. While the instances cited in the introductory paragraph all involve EC or birth control pills, some pharmacists also find barrier methods of contraception objectionable. See Renée C. Wyser-Pratte, Comment, Protection of RU-486 as Contraception, Emergency Contraception and as an Abortifacient Under the Law of Contraception, 79 OR. L. REV. 1121, 1132 (2000).

17 Robert M. Veatch, Analysis and Commentary, in Pharmacist's Refusal to Dispense Diethylstilbestrol for Contraceptive Use, 46 PHARMACY ETHICS 1415, 1415 (1989). Other health care providers also find contraception and abortifacients objectionable. See Neville H. Golden et al., Emergency Contraception: Pediatricians' Knowledge, Attitudes, and Opinions, 107 PEDIATRICS 287, 289 (2001) (stating that 12 percent of pediatricians surveyed would not prescribe EC for moral or religious reasons). Furthermore, pharmacists in the United States have a much less favorable attitude toward EC than their counterparts in other countries. See N. Hariparsad, Attitudes and Practices of Pharmacists Towards Emergency Contraception in Durban, South Africa, 6 EUR. J. CONTRACEPTION & REPROD. HEALTH CARE 87, 89 (2001) (describing a survey of 112 South African pharmacists, in which “[s]ixty-nine percent . . . felt that emergency contraceptive pills should be available without a prescription and 67 [percent] felt that increasing public awareness regarding emergency contraception was very important”).

18 Ronald A. Chez, The Role of the Pharmacist in Family Planning: A Pennsylvania Survey, 12 J. AM. PHARMACEUTICAL ASS'N 464, 465 (1972). Some pharmacists have avoided the controversy altogether by refusing to stock EC. Molly
religion played a significant role in the decisions of those pharmacists who believed unmarried minors should not have access to contraception.\textsuperscript{19} In a 1994-95 survey, also conducted in Pennsylvania, 29 percent of pharmacists stated they would refuse to distribute an abortifacient on religious or moral grounds.\textsuperscript{20} According to a national survey, 36 percent of pharmacists stated they would refuse to dispense an abortifacient.\textsuperscript{21} However, this number is higher in some areas, such as the South, where 44 percent of pharmacists stated they would refuse.\textsuperscript{22} Because some pharmacists consider EC to be an abortifacient, these numbers may also reflect pharmacists' attitudes regarding some forms of contraception.\textsuperscript{23} A 2000 study of pharmacists in New Jersey and Oregon found that while 26 percent of New Jersey pharmacists and 19 percent of Oregon pharmacists had (mostly personal) reservations about dispensing EC, a relatively small percentage of those pharmacists—4 percent in New Jersey and 10 percent in Oregon—would actually act on those reservations and refuse to dispense EC.\textsuperscript{24}

Courts must recognize that a woman's constitutional right to obtain contraception should not be hindered by a pharmacist's conscience.\textsuperscript{25} Given some pharmacists' antipathy toward contraception, holding otherwise would make the right to contraception an "empty right."\textsuperscript{26} The thesis of this Note is that conscience clauses that provide legal protection to pharmacists who

\textsuperscript{19} McDonough, \textit{Rx for Controversy: Battle over Dispensing Emergency Contraceptives Creates Competing Legislation}, ABA J. REPORT (June 10, 2005), http://www.abanet.org/journal/ereport/jn10pill.html. According to a study conducted in May 2005, less than 29 percent of pharmacies in Missouri stock EC. \textit{Id.}

\textsuperscript{20} Vincent Giannetti, \textit{Pharmacists' Beliefs About Abortion and RU-486}, 36 J. AM. PHARMACEUTICAL ASS'N 698, 700-01 (1996). Attitudes toward barrier methods of contraception, on the other hand, are much more favorable. See Karyn Snyder, \textit{Ethical Hot Spots}, 141 DRUG TOPICS 41, 59 (1997) (describing a 1997 study which found that most pharmacists believed it was acceptable to provide a twelve-year-old boy with condoms).

\textsuperscript{21} Giannetti, \textit{supra} note 20, at 703 (citing another survey).

\textsuperscript{22} \textit{Id.} (citing another survey).

\textsuperscript{23} See infra notes 75-82 and accompanying text.


\textsuperscript{25} Contra Wardle, \textit{supra} note 3, at 219-21 (citing abuses health care workers face resulting from their beliefs and describing the need for strong rights of conscience legislation).

refuse to dispense contraception or refer patients to willing pharmacists violate the right to access contraception espoused by the United States Supreme Court in *Griswold v. Connecticut* and *Carey v. Population Services International*. Part I of this Note provides a brief background and description of conscience clauses. Part II, which is divided into three subparts, analyzes the constitutionality of pharmacist conscience clauses. First, it explores the ethical, medical, and legal distinctions between contraception and abortion. It argues that birth control and EC should be treated as contraception and protected under the Supreme Court's contraception jurisprudence. Second, it describes the cases that establish the right to contraception. Third, it analyzes whether pharmacist conscience clauses violate this right. Part III proposes how conscience clauses should be changed in order to protect pharmacists' consciences without jeopardizing women's access to contraception. Part IV urges that in the absence of legal protections, policy considerations dictate that pharmacists should dispense objectionable drugs to their customers or refer their customers to willing pharmacists, even if doing so violates their conscience.

I. BACKGROUND

A. What are Conscience Clauses?

Conscience clauses, also known as rights of conscience legislation or refusal clauses, protect health care providers who refuse to provide certain services, such as abortion, which those providers find objectionable on religious or ethical grounds. Pharmacist conscience clauses protect pharmacists from legal liability and disciplinary, discriminatory, or recriminatory actions that could result from conscien-

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27 For purposes of brevity, this Note will refer to such conscience clauses as "pharmacist conscience clauses."
28 381 U.S. 479 (1965).
29 431 U.S. 678 (1977) (holding that the suppression of contraceptive advertisements is not justified).
30 See Dykes, supra note 3, at 567 (discussing the balance of health care and patient autonomy through legislation).
31 See Pharmacists, supra note 16.
32 See Wardle, supra note 3, at 177, 178 (stating the purpose of conscience clauses is to protect health care providers who object to participating in certain services). One-third of jurisdictions do not require conscientious objection to be based on moral or religious grounds. Id. at 196. Some fear that conscience clauses could lead to a slippery slope whereby health care providers could refuse medication on any grounds (no matter how arbitrary). See Contraception, supra note 7, at 33.
Pharmacists face a number of unpleasant consequences that, in the absence of a conscience clause, could result from their failure to dispense medication. First, refusal could have ramifications on their employment, the most likely of which are termination or demotion. Second, since pharmacists owe a duty of reasonable care to their customers, they could face potential tort liability for failing to dispense medication or refer a patient to another pharmacist. Additionally, pharmacists who refuse to distribute contraception or abortifacients could be liable for wrongful birth, wrongful pregnancy, or wrongful conception claims. Finally, a woman who is forced to search for a willing pharmacist after learning that her pharmacist will not provide her with EC may be able to recover damages for the emotional pain and suffering resulting from her hurried and frantic attempt to find a willing pharmacist to dispense EC in the small time frame available.

B. Legal Background

Several states enacted conscience clauses in the 1970s in response to *Roe v. Wade*. Today, forty-four states have conscience clauses...

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33 See Dykes, supra note 3, at 574. However, uncertainty surrounding conscience clauses and their potentially limited application to pharmacists means that pharmacists may not always be protected by conscience clauses. See Donald W. Herbe, The Right to Refuse: A Call for Adequate Protection of a Pharmacist's Right to Refuse Facilitation of Abortion and Emergency Contraception, 17 J. L. & HEALTH 77, 100 (2002-03). Hostile interpretations of conscience clauses could also limit the protection afforded to pharmacists. Cf. Wardle, supra note 3, at 199-206 (describing "hostile interpretations" that limited the effect of conscience clauses in other contexts).

34 But see David B. Brushwood & Buford T. Lively, Refusal to Dispense a Prescription: What is the Law?, AM. PHARMACY, Oct. 1989, at 29 (describing how in certain situations pharmacists are under a legal duty to refuse to dispense drugs).

35 Herbe, supra note 33, at 89.

36 Id. at 90.

37 Id. at 91.

38 Id. at 92.

regarding abortion. Because conscience clauses were enacted in response to abortion in the 1970s, when most abortions were surgical, few states have conscience clauses that explicitly apply to pharmacists. Pharmacist conscience clauses, which enjoy relatively high support among pharmacists, are largely opposed by the general public. Nonetheless, several states are currently considering such legislation. Currently, four states have conscience clauses explicitly


41 Alan Meisel, Pharmacists, Physician-Assisted Suicide, and Pain Control, 2 J. HEALTH CARE L. & POL'Y 211, 234 (1999). Some commentators believe expanding conscience clause protection to pharmacists will ultimately be ineffective. See Dykes, supra note 3, at 591 ("As state legislatures respond to the FDA approval of R.U. 486, they should recognize and protect the rights of conscience of more health care providers, including pharmacists, and in relation to health care procedures besides abortion. . . . A quick statutory fix for pharmacists would be a minimal and inefficient response.").


44 See Carlos Campos, Legislature '05: Abortion Foes Target Use of Pill; Druggists May Refuse to Dispense, ATLANTA J. CONST., Feb. 4, 2005, at 1E (describing the Georgia legislature's efforts to make pharmacists immune from lawsuits for refusing to dispense emergency contraceptives); Gardner, supra note 7, at 11 (stating that ten states are considering conscience clause legislation for pharmacists); Greenberger & Laser, supra note 13, at 5B (Arizona); Sherry Jacobson & Gretel C. Kovach, Pharmacists' Right to Refuse Challenged Druggist Group Defends Denying Contraceptives on Moral Grounds, DALLAS MORNING NEWS, Apr. 1, 2004, at 1A (stating that at least five states are considering conscience clauses to protect pharmacists); Marina Pisano, Conservative Judicial Forces Threaten Cause of Abortion Advocates; Bush's Re-Election, Republican Senate Majority May Bring More Legal Battles to Shake the Foundation of Roe vs. Wade, SAN ANTONIO EXPRESS-NEWS, Jan. 23, 2005, at 1K (Texas); Simon, supra note 3 (stating that at least six states are con-
protecting pharmacists: Arkansas, South Dakota, Mississippi, and Georgia.

However, the broad conscience clauses present in many states may also implicitly protect pharmacists. For instance, although Ohio’s conscience clause does not expressly mention pharmacists, it has been interpreted to include them. Similarly, the broad language employed by Illinois’s conscience clause also applies to pharmacists. While most conscience clauses only protect health care providers who refuse to participate in an abortion, a few states also protect health care providers who refuse to provide contraception. It is not clear if EC is covered by abortion-oriented conscience clauses, since, as one author noted, “[M]ost statutes define ‘abortion’ as the ‘termination of a human pregnancy’ without defining ‘pregnancy.’”

South Dakota, Arkansas, Georgia, and Mississippi all have pharmacist-specific conscience clauses. The South Dakota conscience clause states,

No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to: (1) Cause an abortion; or (2) Destroy an unborn child. . . . No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for


Guttmacher, supra note 44.

See Wardle, supra note 3, at 182 (noting that “[o]ne-half of state conscience clauses broadly protect any ‘person’”). Cf. McDonough, supra note 18 (“Twenty states already have ‘conscience’ laws that give pharmacists the right to refuse to fill prescriptions based on their moral or religious beliefs.”).

For an argument that the phrase “health care providers” should be interpreted so as to include pharmacists, see William L. Allen & David B. Brushwood, Pharmaceutically Assisted Death and the Pharmacist’s Right of Conscience, 5 J. PHARMACY & L. 1, 14 (1996).

Brauer v. K-Mart Corp., No. C-1-99-618, slip op. at 12 (S.D. Ohio Jan. 23, 2001) (“[T]he plain language of the [Ohio] statute requires that the protections of the statute be afforded to all individuals who play a role in medical procedures which result in abortion, be they doctors, nurses, technicians, pharmacists, or others.”) (emphasis added).

Herbe, supra note 33, at 97.

Id. at 98-99.

Id.
any disciplinary, recriminatory, or discriminatory action against the pharmacist.\textsuperscript{51}

South Dakota defines an “unborn person” as “an individual organism of the species homo sapiens \textit{from fertilization} until live birth.”\textsuperscript{52} Arkansas’s statute specifically enables pharmacists to refuse to dispense contraceptives.\textsuperscript{53} Georgia’s conscience clause explicitly protects pharmacists who refuse to fill prescriptions for any “emergency contraceptive drug” so long as they state in writing their objection[s] to abortion[s] and their objection[s] is based on “moral or religious grounds.”\textsuperscript{54} The Mississippi conscience clause allows pharmacists to refuse to dispense any drug to which they have any moral, religious, or ethical objection.\textsuperscript{55} It also allows pharmacists to refuse to refer patients to a willing pharmacist.\textsuperscript{56} The Georgia, Arkansas, and South Dakota statutes, in contrast, do not state whether pharmacists may refuse to refer patients.

\textsuperscript{51} S.D. CODIFIED LAWS § 36-11-70 (Michie 2003) (emphasis added).
\textsuperscript{52} S.D. CODIFIED LAWS § 22-1-2 (Michie 2003) (emphasis added).
\textsuperscript{53} See ARK. CODE ANN. § 20-16-304 (2000).
\textsuperscript{54} See ARK. CODE ANN. § 20-16-304. Arkansas’s conscience clause also has a broad provision covering abortion. See ARK. CODE ANN. § 20-16-601 (2000).
\textsuperscript{55} See S.B. 123, 2005 Leg. Reg. Sess. (Ga. 2005) (enacted). The Georgia Administrative Code goes even further. It insulates pharmacists who refuse to fill any prescription on moral or religious grounds from disciplinary liability. Compare GA. ADMIN. CODE § 480-5-.03(2005) (“The Board is authorized to take disciplinary action for unprofessional conduct.”) with GA. ADMIN. CODE § 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.”).
II. CONSTITUTIONAL ANALYSIS

A. Contraception or Abortion?

The distinction between contraception and abortion lies at the heart of the conscience clause controversy. This distinction is important for two reasons. First, many pharmacists who refuse to dispense EC view it as equivalent to abortion and thus find it morally objectionable. Second, whether EC is classified as a contraceptive or an abortifacient dramatically affects which constitutional standard is applicable to pharmacist conscience clauses. This section briefly describes different forms of contraception and explains pharmacists’ beliefs regarding contraception. It argues that EC and birth control are legally and medically distinguishable from abortion and should therefore be protected under the Supreme Court’s contraception jurisprudence.

There are several different types of contraception, including “barrier-method” contraceptives, standard birth control pills, EC, and mifepristone (RU-486). Barrier methods, such as condoms and diaphragms, simply prevent sperm from reaching the egg. Birth control pills, by contrast, avert pregnancy by preventing ovulation. EC, which has been available for over twenty years, must be taken within seventy-two hours of intercourse and is roughly 75 percent effective in preventing pregnancy. It functions by preventing ovulation or if fertilization has already occurred, by preventing implantation of the fertilized egg. It is ineffective after implantation, which takes

58 ECs are also known as “morning-after pills,” oral contraceptives, hormonal contraceptives, and postcoital contraceptives. See Westside Pregnancy Resource Center, Emergency Contraception or Abortion?: About Abortion Pills, http://www.w-cpc.org/sexuality/ecp.html (last visited Oct. 30, 2005) [hereinafter Westside] (summarizing and comparing characteristics of the “morning-after pill” and the “abortion pill”).
59 Mifepristone is also known as RU-486, the abortion pill, Mifeprix, and medical abortion. See Wendy Bennett et al., Pharmacists’ Knowledge and the Difficulty of Obtaining Emergency Contraception, 68 CONTRACEPTION 261, 261 (2003); and Westside, supra note 58.
60 Prothro, supra note 57, at 718.
61 Id. at 718.
62 Herbe, supra note 33, at 80.
63 Westside, supra note 58.
64 Id.
65 Id.
place roughly a week after intercourse. In most states, patients must obtain a prescription from physicians before a pharmacist can dispense EC. However, in New Hampshire, Washington, California, Alaska, Hawaii, New Mexico, and Maine, pharmacists can distribute EC without a prescription from a physician.

First synthesized by a French scientist in 1980, mifepristone can act as birth control, EC, or as an abortifacient. In 1989, the FDA banned the importation of mifepristone, but in 2000, it was approved as an abortifacient. Under current FDA restrictions, only physicians and health clinics may distribute mifepristone, which means that pharmacists play no role in its distribution. Consequently, mifepristone is irrelevant for purposes of this Note.

Pharmacists’ objections to contraception largely revolve around when life and pregnancy begin. While some believe life begins at conception or fertilization, others believe life begins at implantation.

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66 Herbe, supra note 33, at 80; Wyser-Pratte, supra note 16, at 1131.
67 Herbe, supra note 33, at 81.
69 Tina R. Raine et al., Direct Access to Emergency Contraception through Pharmacies and Effect on Unintended Pregnancy and STIs: A Randomized Controlled Trial, 293 JAMA 54, 54 (2005).
70 Prothro, supra note 57, at 725.
71 Wyser-Pratte, supra note 16, at 1121.
72 Giannetti, supra note 20, at 699.
75 See Caroline Bollinger, Access Denied: Growing Numbers of Doctors and Pharmacists Across the Country are Refusing to Prescribe or Dispense Birth Control Pills. Here’s Why, PREVENTION, Aug. 2004, at 151, 154, available at http://www.prevention.com/article/0,5778,s1-1-93-35-4130-1,00.html (“At the heart of the debate between anti-Pill forces and mainstream medicine lies a profound difference of opinion about when pregnancy and life begin.”); Herbe, supra note 33, at 85 (“The ambiguity of whether ECPs fit into the abortion debate is a result of a separate . . . question: when human life begins.”). But cf Ronald Dworkin, Life is Sacred. That’s the Easy Part, N.Y. TIMES MAG., May 16, 1993, at 36 (arguing that the abortion debate is not a debate over when life begins, but about how best to respect life).

Unlike the gametes (that is, the sperm and egg), the zygote is genetically unique and distinct from its parents. Biologically, it is a separate organism. It produces, as the gametes do not, specifically human enzymes and pro-
tion. For those who believe in the former, the fact that EC prevents the implantation and survival of eggs after fertilization is equivalent to murder. In fact, one pharmacist went so far as to compare the pharmaceutical termination of unborn life to the Nazi holocaust. Some individuals also believe that all forms of contraception, including birth control pills, are sinful. For some, contraception is immoral because it promotes infidelity, endangers women, and contributes to the degeneration of moral society, while others feel contraceptives devalue the institution of motherhood, threaten the institution of marriage, and devalue "the gift of fertility."

It possesses, as they do not, the active capacity or potency to develop itself into a human embryo, fetus, infant, child, adolescent, and adult. Id.; Contraception, supra note 7, at 34; All Things Considered: Resignation of Alabama Nurses over Objections to Administering the Morning-After Pill (National Public Radio broadcast Jul. 28, 2004) [hereinafter All]; Herbe, supra note 33, at 86 ("The Roman Catholic Church's official teaching and belief is that life begins, and conception occurs, at fertilization."). For purposes of this Note, conception and fertilization refer to the union of sperm and egg. See Karen L. Brauer, Selling the Pill, http://www.ptli.org/brauer_sellingthepill.html (last visited Oct. 28, 2005) ("In common usage, conception is equated with fertilization. . . .")

77 David A. Grimes, Mifepristone (RU 486) - An Abortifacient to Prevent Abortion?, 328 NEW ENG. J. MED. 354, 355 (1993) ("The biologic fact is that pregnancy begins at implantation and not at fertilization."); Jeff McDonald, More Health Professionals Balk at Giving Birth Control; Refusal to Prescribe, Dispense Increases; Moral Grounds Cited, SAN DIEGO UNION-TRIB., Aug. 8, 2004, at A-1 ("For many, a life starts the moment a sperm penetrates an egg; for others, it starts days later, once the fertilized egg is implanted in the lining of a woman's uterus. Still others believe life begins the moment a baby draws its first breath."). See Katha Pollitt, Special Rights for the Godly?, NATION, June 24, 2002, at 10 ("[EC] is not abortion, because until a fertilized egg implants in the womb, the woman is not pregnant.").

78 See Contraception, supra note 7, at 34; Simon, supra note 3 ([T]hose who believe life begins at conception view the high-dose hormones as baby killers, since they can block fertilized eggs from implanting in the uterus."). There may also be other reasons pharmacists refuse to fill a prescription. See Veatch, supra note 17, 1415 ("Pharmacists have refused to participate in medical research protocols and treatments involving drugs . . . that they consider to be ineffective or fraudulent.").


80 See Gardner, supra note 7, at 11; Pollitt, supra note 77, at 10 ("Some anti-choicers have long argued that not just EC but conventional birth control methods—the pill, Norplant, Depo-Provera and the IUD—are 'abortifacients' . . . ").


If abortion is defined as the termination of pregnancy, whether EC constitutes an abortifacient or a contraceptive depends on the definition of pregnancy. According to the American College of Obstetricians and Gynecologists, pregnancy begins with the implantation of a fertilized egg in the womb. This occurs after fertilization, which takes several hours and involves several steps. Several days after fertilization, the egg implants in the uterus, at which point pregnancy begins. Under this "medical" definition, abortion is the termination of a fertilized egg after implantation and contraception is any procedure that prevents conception or terminates the development of a fertilized egg prior to implantation. In contrast, some identify pregnancy as "the union of the sperm and the ovum." Under that definition, abortion is the termination of the egg at any point following fertilization, while contraception is any procedure that prevents fertilization. Based on either of these definitions, most birth control pills and all barrier-method devices are contraceptives, since they act before fertilization. Under the medical definition, which holds that pregnancy begins with implantation, EC is a contraceptive, whereas under the second definition, which states that pregnancy begins at fertilization, EC is an abortifacient insofar as it prevents the implantation of a fertilized egg.

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83 Prothro, supra note 57, at 718.
84 Id. at 717; Brauer, supra note 76. See Herbe, supra note 33, at 86 (stating that this is also the view adopted by the American Medical Association and several medical dictionaries).
85 Prothro, supra note 57, at 717.
86 Id. at 717-18.
87 Id. at 718.
89 Id. at 718.
90 Id. See Brauer, supra note 76 ("The word 'contraception' can be found by the lay person in Webster's New World Dictionary to mean the intentional prevention of fertilization of the human ovum.").
91 Prothro, supra note 57, at 718.
92 See Pollitt, supra note 77, at 10 (stating that the American Medical Association, the American Medical Women's Association, the American College of Obstetricians and Gynecologists and the Harvard Medical School have stated that EC does not constitute an abortifacient).
93 Herbe, supra note 33, at 85.
Since the Supreme Court provides different standards of protection to abortion and contraception, the constitutionality of conscience clauses directly depends on how courts define abortion, pregnancy, and contraception. Courts have overwhelmingly adopted the medical definition of pregnancy and the resulting definition of contraception as the prevention of either fertilization or implantation. As a result, EC should be afforded the same protection that other forms of contraception enjoy under the Supreme Court’s jurisprudence.

Although no case has explicitly held that postcoital contraceptives are protected under the law of contraception, several cases illustrate that postcoital contraception is properly characterized as contraception, not abortion. The language employed in two Supreme Court cases, Webster v. Reproductive Health Services and Planned Parenthood of Southeastern Pennsylvania v. Casey, supports this position. Justice O’Connor, concurring in Webster, which involved a challenge to a state abortion law, wrote, “[T]he use of postfertilization contraceptive devices is constitutionally protected by Griswold and its progeny.” O’Connor’s statement, if adopted by the Court, would clearly protect EC as contraception. Similarly, the Court’s opinion in Casey indicates that postcoital contraceptives should be protected as contraception: “Roe’s scope is confined by the fact of its concern with postconception potential life, a concern otherwise likely to be implicated by some forms of contraception, protected independently under Griswold and later cases.”

Some federal and state courts have also adopted this position. Charles v. Carey involved a challenge to a restrictive Illinois abortion law that defined "abortifacient" very broadly. The law in question defined an abortifacient as “any instrument, medicine, drug, or

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94 See Prothro, supra note 57, at 721 (“Unlike the right to contraception, a woman’s right to abortion can be regulated, and is anything but uncontroversial or unchallenged.”).
95 Id. at 733 & n.127.
98 492 U.S. at 523 (O’Connor, J., concurring). See also Wyser-Pratte, supra note 16, at 1140 (identifying this language); Prothro, supra note 57, at 723 n.52 (identifying this language) (“Traditional and post-coital contraceptives are protected by the Griswold line of cases.”).
99 Justice O’Connor is often the swing vote on the Court.
100 Prothro, supra note 57, at 723 n.52 (quoting Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 859 (1992)).
101 Kari Hanson, Approval of RU-486 as a Postcoital Contraceptive, 17 Puget Sound L. Rev. 163, 181-86 (1993) (discussing these cases).
102 627 F.2d 772 (7th Cir. 1980).
103 Id. at 789.
... substance or device which is known to cause fetal death,” and defined fetus as “a human being from fertilization until birth.” The Seventh Circuit ruled that the broad definition of abortifacient “incorporates the IUD, a common form of birth control, which functions by preventing implantation of the fertilized egg” and therefore interferes with “the fundamental right to birth control.” Margaret S. v. Edwards involved a vagueness challenge to a Louisiana abortion law, which defined abortion as “the deliberate termination of a human pregnancy after fertilization of a female ovum. . . .” There, the Eastern District of Louisiana wrote, “Abortion, as it is commonly understood, does not include . . . the ‘morning-after’ pill, or . . . birth control pills.” The Western District of Wisconsin reached a similar conclusion in Karlin v. Foust. The plaintiffs in Karlin v. Foust expressed concern that Wisconsin’s abortion statute, which failed to define pregnancy, would apply to EC. Absent any legislative language to the contrary, the court adopted the medical definition of pregnancy:

The only reasonable way to read [the statute] is as adopting the standard medical definition of pregnancy. . . . If the legislature had chosen to depart from the standard definition, it would have made that choice explicit. There is no reason to assume that the legislature chose a minority definition when the statutory text gives no indication of such a decision.

Finally, in Brownfield v. Daniel Freeman Marina Hospital, a California court held that EC did not constitute abortion and was therefore not covered by the state’s conscience clause. Because several courts have adopted the medical definition of pregnancy and chosen to treat EC and birth control as contraceptives, EC and birth control should be protected as contraceptives under the Constitution.

104 Id.
105 Id
107 Id. at 190.
108 Id. at 191.
109 975 F. Supp. 1177 (W.D. Wis. 1997), aff’d on other grounds and rev’d on other grounds, 188 F.3d 446 (7th Cir. 1999).
110 Id. at 1228.
111 Id.
113 Id. at 245 (“The conclusion that [EC] constitutes ‘prevention,’ i.e., birth control, rather than ‘termination,’ i.e., abortion, is consistent with the above-cited law.”).
There is some additional support for adopting the medical definition of pregnancy. For instance, according to one physician, defining pregnancy from the point of conception can be conceptually awkward:

Fertilization is a necessary but insufficient step toward pregnancy. . . . For example, a couple . . . might go to a clinic offering in vitro fertilization. . . . If the procedure was successful, the sperm and egg would unite in a petri dish. Could the woman then announce to her . . . neighbors that she was pregnant? Her fertilized egg [could] reside . . . in a different ZIP code. Not until the preembryo was successfully implanted in her body would she become pregnant. The same holds true for the fertilized egg traversing the fallopian tube.\textsuperscript{114}

Furthermore, pregnancy is best measured by implantation, not fertilization, because fertilized eggs do not always successfully implant:

\textbf{[T]he notion that human life begins at fertilization does not necessarily take biologic reality into account. For example, a fertilized ovum may result in a hydatidiform mole or choriocarcinoma, not a human being. Moreover, human reproduction is inefficient. The majority of conceptions that occur either do not implant in the uterus or are lost through spontaneous abortion. Those of us alive today are the minority who survived this biologic winnowing. Rather than being an aberration of voluntary fertility control, the loss of zygotes is common in human reproduction.}\textsuperscript{115}

Finally, because a pregnancy test will only identify a pregnancy after implantation, there are also certain practical advantages to adopting the medical definition.\textsuperscript{116}

In sum, the medical definition of pregnancy, which holds that pregnancy does not begin until the fertilized egg implants in the uterus, has been adopted by several courts and is supported by prag-

\begin{thebibliography}{9}

\bibitem{} Brauer, \textit{supra} note 76 (quoting Dr. David A. Grimes of San Francisco General Hospital).
\bibitem{} Grimes, \textit{supra} note 77, at 355.
\bibitem{} Bollinger, \textit{supra} note 75, at 154. \textit{See} Karlin v. Foust, 975 F. Supp. 1177, 1228 (W.D. Wis. 1997) ("[A]doption of [the definition of pregnancy that life begins with conception] would create problems in determining whether a patient was pregnant because pregnancy cannot be detected until after implantation."); Cantor & Baum, \textit{supra} note 5, at 209 ("[E]mergency contraception cannot fit squarely within the concept of abortion because one cannot be sure that conception has occurred.").
\end{thebibliography}
mantic considerations. Consequently, birth control and EC should be evaluated under the Supreme Court’s contraception jurisprudence.

B. Cases & Discussion

Three Supreme Court cases are pertinent to the constitutionality of conscience clauses in the contraception context. This section will first explain why *Doe v. Bolton*, in which the Court upheld an abortion conscience clause, does not necessarily protect pharmacist conscience clauses involving contraception. It will then examine the cases that articulate a constitutional right to contraception and explain why pharmacist conscience clauses violate that right.


In *Doe v. Bolton*, the Supreme Court held a conscience clause constitutionally viable in the abortion context. In that case, a twenty-two-year-old pregnant woman, along with nurses, social workers, and physicians, challenged several provisions of a Georgia statute, one of which contained a conscience clause protecting any physician or hospital employee who refused to participate in an abortion. In upholding the conscience clause, the Court wrote, "[A] physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure. These provisions obviously are in the statute in order to afford appropriate protection to the individual . . . and to the denominational hospital."

Despite the Court’s ruling in *Bolton*, it is not controlling in this context for one reason: it involves abortions, not contraceptives. The Court has afforded the right to access contraception a considerably

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117 However, since the nonmedical or "religious" definition of pregnancy, which holds that pregnancy begins at conception, is closer to the root of many pharmacists' conscientious objection, perhaps it should be used as the standard for determining when pregnancy begins in the context of pharmacist conscience clauses. This argument is unpersuasive. Pharmacists who refuse to dispense EC may object to it on moral or religious grounds that have nothing to do with a particular definition of pregnancy. Furthermore, many pharmacists do not believe EC is an abortifacient. Therefore, it might be inappropriate for courts to adopt a nonmedical definition of pregnancy that does not accurately reflect pharmacists' consciences. Additionally, as described above, courts have chosen to adopt the medical definition of pregnancy. Nonetheless, even if this position were adopted, birth control would still be protected as contraception, since birth control constitutes contraception under both the medical and nonmedical views.

119 See id. at 197-98.
120 See id. at 184-86, 205.
121 Id. at 197-98.
higher level of protection than the right to an abortion. For instance, the right to access contraception is protected by strict scrutiny, which holds that states may only restrict access to contraception if a compelling state interest exists. The right to have an abortion, by contrast, is protected by the relatively weaker "undue burden" standard. According to the Supreme Court in Planned Parenthood of Southeastern Pennsylvania v. Casey, an "undue burden" exists where "a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." Commentators have noted that the "undue burden" standard applicable to abortions is considerably weaker than the "strict scrutiny" standard governing contraceptives. Therefore, even if conscience clauses are constitutional as they relate to abortion, this does not entail that they are constitutional in the contraception context. Thus, Bolton does not entail that pharmacist conscience clauses will survive constitutional scrutiny.

2. Griswold & Carey

The Griswold line of cases, which includes Griswold v. Connecticut and Carey v. Population Services International, established a "relatively uncontroversial and unchallenged" right to use contraception. In Griswold v. Connecticut, the Executive Director of the Planned Parenthood League of Connecticut and a licensed physician offered information and advice to married persons regarding the use of contraceptives. They were subsequently arrested and convicted as accessories for violating a Connecticut law, which provided that "[a]ny person who uses any drug, medicinal article or instrument for
the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned."\textsuperscript{129} Appellants challenged their convictions, claiming the statute in question violated the Fourteenth Amendment.\textsuperscript{130}

Although the Supreme Court noted that "[w]e do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch economic problems, business affairs, or social conditions," it felt the Connecticut law required special attention, for it "operate[d] directly on an intimate relation of husband and wife and their physician's role in one aspect of that relation."\textsuperscript{131} The Court reasoned that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance."\textsuperscript{132} According to the Court, the guarantees of the First, Third, Fourth, Fifth, and Ninth Amendments create "zones of privacy," or "penumbral rights of 'privacy and repose.'"\textsuperscript{133} The Court decided that marriage lies within one such zone of privacy:

We deal with a right of privacy older than the Bill of Rights—older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. It is an association that promotes a way of life. . . . Yet it is an association for as noble a purpose as any involved in our prior decisions.\textsuperscript{134}

The Court found that the Connecticut law, by banning the use of contraceptives, was "repulsive to the notions of privacy surrounding the marriage relationship."\textsuperscript{135} It wrote, "[The Connecticut law], in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon [the marital] relationship."\textsuperscript{136} Thus, the Court held that states cannot constitutionally prohibit the use of contraceptives by married persons and cannot prevent individuals

\textsuperscript{129} Id.
\textsuperscript{130} Id.
\textsuperscript{131} Id. at 482.
\textsuperscript{132} Id. at 484. For a definition of "penumbra," see LESLIE FRIEDMAN GOLDSTEIN, CONTEMPORARY CASES IN WOMEN'S RIGHTS 10 (1994) ("A penumbra is a kind of a hazy shadow around the edges of a thing.").
\textsuperscript{133} Griswold, 381 U.S. at 484-85.
\textsuperscript{134} Id. at 486.
\textsuperscript{135} Id.
\textsuperscript{136} Id. at 485 (emphasis in original).
from providing married couples with contraceptives or information regarding contraceptives.\textsuperscript{137}

Carey\textsuperscript{138} involved a New York law making it . . . a crime (1) for any person to sell or distribute any contraceptive of any kind to a minor under the age of [sixteen] years; (2) for anyone other than a licensed pharmacist to distribute contraceptives to persons [sixteen] or over; and (3) for anyone, including licensed pharmacists, to advertise or display contraceptives.\textsuperscript{139}

Threatened with the possibility of prosecution, Population Planning Associates, a business that sold nonprescription contraceptives through the mail, challenged the constitutionality of the New York law.\textsuperscript{140}

The Court's opinion began by noting that the Due Process Clause of the Fourteenth Amendment recognizes a "right of personal privacy, or a guarantee of certain areas or zones of privacy."\textsuperscript{141} The Court then reiterated that contraception falls within this protected area: "While the outer limits of this aspect of privacy have not been marked by the Court, it is clear that among the decisions that an individual may make without unjustified government interference are personal decisions 'relating to . . . contraception . . .'"\textsuperscript{142} However, the Court acknowledged that not all laws regulating contraception are impermissible:

That the constitutionally protected right of privacy extends to an individual's liberty to make choices regarding contraception does not, however, automatically invalidate every state regulation in this area. The business of manufacturing and selling contraceptives may be regulated in ways that do not infringe protected individual choices. And even a burdensome regulation may be validated by a sufficiently compelling state interest.\textsuperscript{143}

\textsuperscript{137} Laurence H. Tribe, American Constitutional Law 1338 (2d ed. 1988) (using Griswold to discuss what states can and cannot do regarding contraceptives).


\textsuperscript{139} Id. at 681.

\textsuperscript{140} Id. at 682-84, 683 n.3.

\textsuperscript{141} Id. at 684 (quoting Roe v. Wade, 410 U.S. 113, 152 (1973)).

\textsuperscript{142} Id. at 684-85 (quoting Loving v. Virginia, 388 U.S. 1, 12, and Eisenstadt v. Baird, 405 U.S. 438, 453-54).

\textsuperscript{143} Id. at 685-86 (emphasis added).
Thus, laws restricting an individual’s right to access contraception may be constitutional, provided they are narrowly drawn to serve a compelling state interest.  

The first part of the Court’s analysis focused on the “wider restriction on access to contraceptives created by . . . [the statute’s] prohibition of the distribution of nonmedical contraceptives to adults except through licensed pharmacists.” According to the Court, Griswold, when understood in the context of subsequent decisions, holds that “the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State.” Therefore, while “there is an independent fundamental ‘right of access to contraceptives’ . . . 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.”

The Court realized that limiting the ability to distribute contraceptives to pharmacists imposed a significant burden on this right, and though this significant burden was not as great as that under a total ban on distribution . . . the restriction of distribution channels to a small fraction of the total number of possible retail outlets renders contraceptive devices considerably less accessible to the public, reduces the opportunity for privacy of selection and purchase, and lessens the possibility of price competition.

In other words, the Court made it clear that this provision, even though it did not effect a total ban on access to contraception, burdened a constitutionally protected right. The Court came to these conclusions in spite of a provision in the statute, like a “reverse conscience clause,” which allowed any pharmacist who did not own a pharmacy or a registered store to dispense contraceptives “as [he] . . . deems proper in connection with his practice.” According to the Court, that provision “obviously does not significantly expand the number of regularly available, easily accessible retail outlets for non-

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144 Id. at 686.
145 Id.
146 Id. at 687.
147 Id. at 688-89.
148 Id. at 689-90.
149 Id. at 689 n.7.
Having concluded that the law implicated a constitutional right, the Court proceeded to assess whether it furthered a compelling state interest. It decided the law did not further the State’s interests in protecting health or potential life, which, it noted, are not “implicated in state regulation of contraceptives.”151 Furthermore, the Court rejected the following state interests as compelling: (1) “a proper concern that young people not sell contraceptives;” (2) “allow[ing] purchasers to inquire as to the relative qualities of varying products and prevents anyone from tampering with them;” and (3) facilitat[ing] enforcement of the other provisions of the statute.”152 According to the Court, preventing young people from selling contraceptives is not a compelling state interest.153 Regardless, this interest was not promoted by the New York law.154 The Court rejected the second state interest because pharmacists are not qualified to evaluate the relative qualities of non-medical contraceptives or prevent tampering with those products.155 The Court held that the third purported state interest, administrative ease, did not rise to the level of a compelling state interest.156

Next, the Court considered the provision of the statute that prohibited the distribution of contraceptives to those under the age of sixteen. According to the Court, “Since the State may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori foreclosed.”157 It rejected the possibility that the State has a compelling interest in deterring minors’ sexual activity.158 Quoting Eisenstadt, it wrote, “It would be plainly unreasonable to assume that [the State] has prescribed pregnancy and the birth of an unwanted child... as punishment for fornication.”159

Finally, the Court addressed the appellants’ argument that because the New York law did not completely ban access to contraceptives to those under sixteen, it could not be found unconstitutional.160 The law

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150 Id.
151 Id. at 690.
152 Id. at 690.
153 Id. at 690-91.
154 Id. at 691 n.10.
155 Id. at 691.
156 Id.
157 Id. at 694.
158 Id.
159 Id. at 695 (quoting Eisenstadt v. Baird, 405 U.S. 438, 448 (1972)).
160 Id. at 697.
did not completely ban access to contraceptives because it contained a
physician exception, like the "reverse conscience clause" provision
discussed above, that allowed "[a]ny physician . . . from supplying his
patients with such drugs as [he] . . . deems proper in connection with
his practice."161 First, the Court noted that "less than total restrictions
on access to contraceptives that significantly burden the right to de-
cide whether to bear children must also pass constitutional scru-
tiny."162 Furthermore, the Court noted that the law "delegates the
State's authority to disapprove of minors' sexual behavior to physi-
cians, who may exercise it arbitrarily, either to deny contraceptives to
young people, or to undermine the State's policy of discouraging il-
licit early sexual behavior."163

Any state regulation restricting access to contraception must sat-
sify strict scrutiny, i.e., it must further a compelling state interest and
be narrowly tailored to achieve that interest. Therefore, pharmacist
conscience clauses are unconstitutional if (1) they infringe on the right
to access contraception; (2) they do not further a compelling state
interest; and (3) if they do further a compelling state interest, they are
not narrowly tailored to achieve that interest.

a) Infringes on a Constitutional Right

No court has ever invalidated a conscience clause containing a
contraception exemption on constitutional grounds.164 Nonetheless, as
the stories described at the beginning of this Note illustrate, pharma-
cists are restricting women's access to contraceptives by acting on
their consciences. Conscience clauses could further restrict women's
access to contraceptives by encouraging otherwise obedient pharma-
cists to act on their consciences and refuse to dispense or to refer pre-
scriptions for contraception. According to one commentator,

The greatest opposition to laws protecting the rights of con-
science of health care institutions has come from advocates of
absolute reproductive choice. These writers fear (probably
correctly) that if health care providers, including organiza-
tions, were entirely free to choose whether or not to provide
or participate in providing elective abortion services, there

161 Id.
162 Id.
163 Id. at 699.
164 See generally Wardle, supra note 3, at 199-217 (describing cases involv-
ing conscience clauses).
would be fewer facilities in which such services would be available.\textsuperscript{165}

Similarly, providing legal immunity for conscientious objection could provide the impetus for some pharmacists to refuse to dispense contraception, which in turn could restrict the availability of contraception for many women.\textsuperscript{166} For some, a pharmacist's refusal could restrict any meaningful access to EC, which is only effective during a limited amount of time.\textsuperscript{167} This problem could be particularly acute in rural areas, where women could effectively have no access to contraceptives if faced with an objecting pharmacist.\textsuperscript{168} In fact, studies confirm that EC is easier to obtain in urban areas.\textsuperscript{169} Inaccessibility may

\textsuperscript{165} Id. at 186.

\textsuperscript{166} Unfortunately, I have been unable to locate any studies that support the proposition that conscience clauses would encourage otherwise obedient pharmacists to refuse to dispense EC or refer prescriptions. Two studies have found, however, that abortion-related conscience clauses do not affect the behavior of health care providers in other contexts. See Steven S. Smugar et al., \textit{Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims}, 90 AM. J. PUB. HEALTH 1372, 1373 (2000) (finding that hospital policies restricting information relating to EC were not more prevalent in states with permissive abortion-related conscience clauses) (also noting the study's limited sample size); and Reza Keshavarz et al., \textit{Emergency Contraception Provision: A Survey of Emergency Department Practitioners}, 9 ACAD. EMERGENCY MED. 69, 72 (2002) ("[Emergency department physicians from states with 'abortion-related consciousness clauses' were as likely to be willing to provide EC as those residing in other states... ").

\textsuperscript{167} Querido, \textit{supra} note 39, at 3.

\textsuperscript{168} See Bennett et al., \textit{supra} note 59, at 266 ("Because women who live in rural areas are likely to have only one or two pharmacies near their homes, the lack of access in rural pharmacies may pose significant obstacles."); Cantor & Baum, \textit{supra} note 5, at 2010.

[T]he refusal of a pharmacist to fill a prescription may place a disproportionately heavy burden on those with few options, such as a poor teenager living in a rural area that has a lone pharmacy. Whereas the savvy suburbanite can drive to another pharmacy, a refusal to fill a prescription for a less advantaged patient may completely bar her access to medication. \textit{Id.;} Bruce D. Weinstein, \textit{Do Pharmacists Have a Right to Refuse to Fill Prescriptions for Abortifacient Drugs?}, 20 L.MED. & HEALTH CARE 220, 221 (1992) ("[P]regnant women in rural settings might not have anyone else to turn to, should their pharmacists refuse to honor prescriptions for abortifacient drugs."); Jacobson & Kovach, \textit{supra} note 44, at 1A; McDonald, \textit{supra} note 77; and Simon, \textit{supra} note 3. Cf. Dresser, \textit{supra} note 26, at 281 ("Women seeking [abortions] may be substantially burdened by the costs, the travel, and the time away from their jobs and families that can accompany performance of the service."). Additionally, Wal-Mart pharmacies do not carry EC. Consequently, its dominance in rural areas could rob women of the ability to receive EC. See Gardner, \textit{supra} note 7, at 11.

\textsuperscript{169} See Bennett et al., \textit{supra} note 59, at 266.
also be heightened for adolescents and the poor, who are unable “to shop around.” According to the executive director of NARAL Pro-Choice Wisconsin, “If we let pharmacists pick and choose which prescriptions they’re going to honor, you basically invalidate that healthcare for large numbers of people. . . .” Put differently, without “reasonable access,” the constitutional right to control reproductive choice via contraception may become “an empty right.” Although pharmacist conscience clauses may effect a less-than-absolute ban on access to contraception in many situations, the Carey Court noted that laws that entrust the distribution of contraception to the discretion of a limited number of pharmacists may unconstitutionally burden the right to access contraception. Therefore, pharmacist conscience clauses infringe on a constitutional right by burdening women’s access to contraception.

b) No Compelling State Interest

Because pharmacist conscience clauses infringe on a constitutional right relating to contraception, whether or not that infringement is permissible depends on whether it serves a compelling state interest. There is no compelling state interest in protecting pharmacists’ consciences, life prior to implantation, or the ethical integrity of the pharmaceutical profession. In other words, although pharmacist conscience clauses may advance several state interests, these interests, however strong, do not rise to the level of compelling state interests that justify infringing on the right to access contraception. Since pharmacist conscience clauses do not advance any compelling state

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170 Lee Ann E. Conard et al., Pharmacists’ Attitudes Toward and Practices with Adolescents, 157 Archives Pediatrics & Adolescent Med. 361, 364-65 (2003) (“[o]f pharmacists who do stock and dispense emergency contraception to adolescent women, many feel uncomfortable providing this service”) (“[pharmacist] refusal is likely to serve as a barrier to access for adolescents, especially when emergency contraception is not universally available”).

171 Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 243 (Cal. Ct. App. 1989) (“She describes herself as a ‘consumer of the most tragic sort . . . in need of special emergency services . . . not in a position to shop around, or to educate herself as to the medical ramifications of rape, and the treatment options available to her . . . unsophisticated and entitled to receive optimal care. . . .’”). See Cantor & Baum, supra note 5, at 2010.

172 Gardner, supra note 7, at 11. See Sweeney, supra note 6, at E1 (stating that opponents of Ohio’s pharmacist conscience clause “fear it would limit access to emergency contraceptives and birth control”).

173 Dresser, supra note 26, at 280.

interests, they must be struck down insofar as they restrict access to contraception.

The most obvious interest promoted by conscience clauses is the interest in "giving healthcare workers the freedom to follow their conscience and protecting them from forced participation." However, there is no compelling state interest in the moral or religious consciences of pharmacists. The Alaska Supreme Court has held there is no compelling state interest in the conscience rights of a hospital. In Valley Hospital Ass'n v. Mat-Su Coalition for Choice, the Alaska Supreme Court evaluated the validity of two conscience clauses under the Alaska Constitution. The Alaska Supreme Court noted that under the Alaska Constitution, "reproductive rights are fundamental" and "may be legally constrained only when the constraints are justified by a compelling state interest..." The court concluded that the rights of conscience of individuals and institutions, protected by statute, are not compelling state interests and cannot supersede the right to an abortion, which is constitutionally guaranteed. It struck down the conscience clause as unconstitutional under the Alaska Constitution. This case involved the conscience rights of medical institutions, which are arguably weaker than the conscience rights of individual health care providers, such as pharmacists. Nonetheless, while pharmacists, like health care institutions, may have a statutory inter-

175 Freedom to Refuse, http://www.pfli.org/alarcon_freedom_to_refusev2.html (last visited Oct. 28, 2005). See Testimony, supra note 42 (statement of Paula Koch, licensed pharmacist) ("[The proposed conscience clause] gives health care professionals the freedom to make difficult choices without fear of demotion or termination."); and Wardle, supra note 3, at 181 ("the basic principles underlying the extension of any such protection—respect for constraints of individual conscience, care for the conscience rights of minorities, and commitment to the value (and the belief in the feasibility) of accommodation"). However, relatively little attention is given to the interests of nonobjecting employers who mistakenly hire objecting pharmacists and are thus victims of their beliefs because of a conscience clause. See Pollitt, supra note 77, at 10 (criticizing the ACLU's view that "secular institutions should be sitting ducks for any fanatic who can get hired even provisionally").

176 But see Irene Prior Lofius, Note, I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die, 65 NOTRE DAME L. REV. 699, 719 n.150 (1990) ("[A] compelling state interest is served by protecting the consciences of medical personnel... ").


179 Id. at 969.

180 Id. at 972.

181 Id.
in their consciences, this right, according to the Valley Hospital court, must yield to any constitutional rights, such as the right to access contraception.

The second possible interest served by pharmacist conscience clauses is an interest in protecting life before implantation. However, courts have not found a compelling state interest in life at such an early point in development. In Planned Parenthood of Southeastern Pennsylvania v. Casey, the Supreme Court held that a compelling state interest exists in an embryo only once the embryo reaches viability. The Casey Court stated, “[A] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.” Since it is unlikely medical technology will ever be able to push viability to conception or even before implantation, an unimplanted egg does not warrant a compelling state interest.

The First Amendment does not protect pharmacists’ consciences. Cf. Wardle, supra note 3, at 216 (“Under [Employment Division v.] Smith [494 U.S. 872 (1990)], neither patients nor health care providers can expect courts to extend any first amendment protection against laws, judicial doctrines, or government policies . . . that incidentally violate their strong religious or moral beliefs.”). Moreover, it is questionable whether the consciences of health care providers were constitutionally protected before Smith. Katherine A. White, Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights, 51 STAN. L. REV. 1703, 1728 (1999).

948 P.2d at 972. (“The legislature, however, may not balance statutory rights against constitutional ones, like the right to an abortion.”).


Susan Tall, Legal and Ethical Implications of Human Procreative Cloning, 3 J. L. & SOC. CHALLENGES 25, 43 (1999).

505 U.S. at 879 (emphasis added).


See also Philip J. Prygoski, The Implica-
The state might also have an interest in promoting and protecting the "ethical integrity of the pharmaceutical profession." In several "right to die" cases, the Supreme Court and several lower courts have recognized that states have an interest in the ethical integrity of the medical profession. However, this does not necessarily entail that states have a similar interest in protecting the integrity of the pharmaceutical profession. In order for states to have this interest with respect to pharmacists, pharmacy must be a profession. Although pharmacy is not one of the traditional medieval professions, such as medicine, clergy, or the law, it partakes of five attributes essential to any profession: (1) a systematic body of theory; (2) professional authority; (3) sanction of the community; (4) a code of ethics; and (5) a professional culture. Since pharmacy may be a profession, there might be a state interest in protecting its ethical integrity.

Nonetheless, any right of conscientious refusal physicians have does not entail that pharmacists have similar rights, since pharmacists have less decision-making ability than physicians. For instance, physicians can prescribe medications, while pharmacists cannot. This increased level of decision-making ability entails increased accountability and morally distinguishes physicians from pharmacists.

Furthermore, any purported state interest in the ethical integrity of the pharmaceutical profession is unlikely to rise to the level of a compelling state interest. In *Washington v. Glucksberg*, the Court held that the state interest in the ethical integrity of the medical profession is sufficient to satisfy a rational basis review. However, this does

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190 See William E. Fassett & Andrew C. Wicks, *Is Pharmacy a Profession?*, in *ETHICAL ISSUES IN PHARMACY* 1, 6-10 (Bruce D. Weinstein ed., 1996).
191 Weinstein, *supra* note 168, at 221.
192 Kenneth Mullan & Bruce D. Weinstein, *Do Pharmacists Have a Right to Refuse to Fill Prescriptions for Abortifacient Drugs?*, in *ETHICAL ISSUES IN PHARMACY* 175, 184 (Bruce D. Weinstein, ed. 1996).
193 Id.
195 See *id.* at 731.
not entail that states have a compelling interest in the ethical integrity of the medical profession needed to satisfy strict scrutiny, which is the standard applicable to contraception cases. Therefore, even if states have a legitimate interest in the ethical integrity of the pharmaceutical profession, it may not be strong enough to satisfy strict scrutiny.

Even if there is a compelling state interest in the ethical integrity of the pharmaceutical profession, it would probably weigh against expanding a pharmacist’s right to refuse to dispense contraception. There are at least four models of professionalism, three of which require objecting pharmacists to refer or dispense contraception or EC. Under the libertarian model, which does not recognize a basic right to health care, a pharmacist has no moral duty to dispense or refer prescriptions unless she is contractually bound to do so. This model values autonomy and nonmaleficence, which holds that an individual should avoid harming others. Ironically, a pharmacist’s refusal to dispense contraception may harm female patients while compromising their autonomy.

The technician model, in contrast, holds that a pharmacist is no more than a puppet and must dispense any prescription written by a physician. Under this model, a pharmacist has virtually no autonomy. In other words, the technician model requires that pharmacists dispense any prescription for contraception or EC as long as the patient has a valid prescription, regardless of whether the pharmacist objects.

The third model is the guild model. According to this model, a pharmacist must follow the dictates of the profession. In other words, if the pharmaceutical profession allows for conscientious objection, then a pharmacist may refuse to dispense contraception or EC. The professional obligations imposed on pharmacists illustrate that while pharmacists do enjoy a limited right of conscientious

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196 Similarly, the state interest in the ethical integrity of the medical profession has not always weighed against the “right to die.” See Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426-27 (Mass. 1977) (“Recognition of the right to refuse necessary medical treatment in appropriate circumstances is consistent with exiting medical mores; such a doctrine does not threaten . . . the integrity of the medical profession. . . .”); Satz v. Perlmutter, 362 So. 2d 160, 163 (Fla. Dist. Ct. App. 1978).
197 See Mullan & Weinstein, supra note 192, at 182-83 (describing four models of professionalism).
198 Id. at 182, 187.
199 Id. at 185.
200 Id. at 182.
201 Id.
202 Id.
objection, it is not absolute. Professional obligations dictate that pharmacists should dispense contraceptives even if it violates their consciences. As professionals, pharmacists are expected to put their clients’ interests above their own.  

The American Pharmaceutical Association’s (APhA) Code of Ethics states that “a pharmacist promotes the good of every patient in caring, compassionate, and confidential manner,” ‘a pharmacist respects the autonomy and dignity of each patient,’ and ‘a pharmacist serves individual, community, and societal needs.”

The Code also states,

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. . . . In all cases, a pharmacist respects personal and cultural differences among patients. . . . A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

The APhA has also adopted a conscience clause, which states, “APhA recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patient’s [sic] access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.”

According to the APhA,

Pharmacists choosing to excuse themselves from such a situation continue to have a responsibility to the patient—ensuring that the patient will be referred to another pharmacist or be channeled into another available health system . . . the patient should not be required to abide by the pharmacist’s personal, moral decision.

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203 Cantor & Baum, supra note 5, at 2009.
204 Id.
Thus, according to the guidelines of the pharmaceutical profession, while pharmacists do have a limited right of conscientious objection, this right must never compromise the patient’s ability to receive medication. In other words, under the guild model, conscience clauses that do not ensure that women receive access to contraception do not promote or protect the ethical integrity of the pharmaceutical profession.

The societal model, the fourth model of professionalism, also weighs in favor of dispensing contraception. According to the societal model, pharmacists may only refuse to dispense a drug when refusal is endorsed by society. Because studies show that society frowns upon pharmacists’ refusal to dispense drugs, this model does not favor conscientious objection. According to one study, 88 percent of the general public objects to allowing pharmacists to refuse to dispense prescriptions. A CBS/New York Times poll found that 78 percent of Americans believe pharmacists who object to birth control should not be able to refuse to dispense it. Because society does not support a pharmacist’s right to refuse, pharmacist conscience clauses do not promote the ethical integrity of the pharmaceutical profession. In sum, three out of four models of professionalism do not support pharmacist conscience clauses. Therefore, pharmacist conscience clauses do not promote or protect the ethical integrity of the pharmaceutical profession.

There is no compelling state interest furthered by pharmacist conscience clauses. Courts do not recognize a compelling state interest in pharmacists’ consciences or in life prior to implantation. It is unclear whether the ethical integrity of the pharmaceutical profession

2473 (2005) (stating that this “is the approach taken by virtually all the major medical, nursing, and pharmacy societies.”).

Mullan & Weinstein, supra note 192, at 183, 186.

For example, the duty to rescue is not strong enough to require laypersons to enter a burning building to save someone’s life. However, firefighters do have such an obligation, and we would say that a firefighter who refused to perform such an action was acting unethically because he or she has made a promise to society to assume a greater degree of risk than laypersons must assume.

Id.

209 See Protecting, supra note 39, at 19 (statement of Catherine Weiss, Director, American Civil Liberties Union, Reproductive Freedom Project).

210 See Religion, supra note 43.

211 But cf. William W. Bassett, Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine, 17 J. CONTEMP. L. & POL'Y 455, 544 (2001) (arguing that because religious hospitals will pull out of the health care industry in the absence of conscience clauses, “protection of the rights of conscience of religiously-motivated health care providers is a compelling state interest. There is no equally compelling state interest in destroying this right”).
merits a compelling state interest. Even if states have a compelling interest in protecting and promoting the ethical integrity of the pharmaceutical profession, this interest is not served by pharmacist conscience clauses. Because pharmacist conscience clauses infringe on a constitutionally protected right and do not advance a compelling state interest, they are unconstitutional.

c) Not Narrowly Tailored

Even if a compelling state interest existed in pharmacists' consciences, in life before implantation, or in the ethical integrity of the pharmaceutical profession, pharmacist conscience clauses are not narrowly tailored to advance any of those interests and therefore do not satisfy strict scrutiny. Pharmacist conscience clauses are not narrowly tailored to promote a state interest in protecting pharmacists' consciences for two reasons. First, pharmacist conscience clauses do not protect the consciences of pharmacists who do not object to dispensing contraception. These pharmacists are equally deserving of protection. Secondly, situations could arise where pharmacists' consciences are threatened not because of their refusal to fill prescriptions, but because of their desire to do so. Second, pharmacist conscience clauses that only allow pharmacists to refuse to dispense contraceptives or abortifacients, such as those in Arkansas, Georgia, and South Dakota, do not fully protect pharmacists' consciences. Pharmacists may object to filling a prescription on a number of grounds, many of which may be inapplicable to birth control or EC. For instance, a pharmacist may refuse to fill a prescription because she feels it is immoral on some other grounds or because the drug or dosage is unsafe. Therefore, pharmacist conscience clauses are not narrowly tailored to protect pharmacists' consciences.

Additionally, pharmacist conscience clauses are not narrowly tailored to advance a state interest in life before implantation. Pharmacist conscience clauses that allow pharmacists to refuse to dispense all

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212 See Allen & Brushwood, supra note 46, at 16.
213 See infra notes 79-81.
214 For a discussion of pharmacists' legal duty to dispense a high dose or potentially risky drug, see Brushwood & Lively, supra note 34.
objectionable prescriptions or contraceptives are obviously not narrowly tailored to prevent pharmacists from dispensing EC, which implicates life before implantation. Therefore, in order to be narrowly tailored to advance a state interest in protecting life before implantation, pharmacist conscience clauses must only prohibit pharmacists from dispensing drugs, such as EC, which implicate life before implantation. Furthermore, in addition to being overly broad, pharmacist conscience clauses are in many ways too narrow. First, pharmacist conscience clauses arbitrarily entrust the protection of this state interest to individual pharmacists, many of whom will not object to dispensing EC and will therefore not protect the putative state interest in life before implantation. Second, for some pharmacists, referring an objectionable prescription may break the chain of causation that deters pharmacists from dispensing EC in the first place. In other words, pharmacist conscience clauses that allow pharmacists to refer objectionable prescriptions may not protect life before implantation, since many women will still be able to obtain EC through a referral. States could better protect this interest by enacting wholesale prohibitions on the sale and production of EC.

Finally, pharmacist conscience clauses are not narrowly tailored to protect the ethical integrity of the pharmaceutical profession. In fact, as the discussion in Section II(B) illustrates, pharmacist conscience clauses are probably antithetic to the ethical integrity of the pharmaceutical profession. Therefore, pharmacist conscience clauses are not narrowly tailored to advance a state interest in protecting and promoting the ethical integrity of the pharmaceutical profession.

d) Pharmacist Conscience Clauses are Unconstitutional

Because pharmacist conscience clauses do not advance any compelling state interest and are not narrowly tailored to advance a compelling state interest, they unconstitutionally burden the right to reproductive choice by restricting women’s access to contraceptives. This legislation restricts access to contraception by encouraging pharmacists who would otherwise dispense contraception to act on their beliefs and refuse to fill prescriptions for contraception. However, the unconstitutionality of pharmacist conscience clauses does not mean that pharmacists in private practice are acting unconstitutionally when they refuse to dispense contraceptives. As one author noted, “For patients to make a due process argument that they have a fundamental right to health care services, the entity acting to deny them services

\[215\] Id.
must be the state itself or a quasi-governmental entity." Nonetheless, legislation which provides legal protection to those individuals is unconstitutional.

III. PROPOSAL

In their current form, pharmacist conscience clauses are unconstitutional. This section proposes how pharmacist conscience clauses can be improved to ensure their constitutionality and afford women greater access to contraception. Any remedy should strike a balance between pharmacists’ rights of conscience and women’s access to contraceptives. 217 This section examines several proposed changes to conscience clauses and concludes that requiring mandatory distribution or referral is the only tenable solution, since it is the only solution that preserves meaningful access to contraception.

One proposed solution is to require rigorous notice requirements, whereby pharmacies must post signs and schedules indicating when objecting pharmacists are on duty or when contraception will or will not be available. 218 A variation of this notice requirement would require objecting pharmacists to inform physicians of their refusal before the physician issues a prescription. 219 While these solutions would probably ensure access to contraception in most cases, they might not improve access to contraception in rural or impoverished areas. Undoubtedly, providing notice would be informative to potential customers. However, notice alone will not increase likelihood of obtaining contraception for women who do not have the time or means to travel to another pharmacy. In these situations, women who are constrained by time, money, or distance may be unable to reach a

216 White, supra note 182, at 1734.
217 See Herbe, supra note 33, at 101 ("In any event, an effective conscience statute should take into consideration many complex issues including broad protection against recriminatory action, efficient administration of pharmacies, and accommodation of patients."). If objecting pharmacists are forced en masse to distribute contraceptives against their will, they may decide to leave the pharmaceutical market altogether, which could be disastrous for the health care industry and patients. Cf. Bassett, supra note 211, at 544 (making this argument with respect to private religious hospitals). Failing to protect pharmacists' consciences could also deter future pharmacists from entering the profession. Ohio, supra note 79 (testimony of Karen Brauer, M.S., R.Ph.).
218 Herbe, supra note 33, at 101.
219 Querido, supra note 39, at 3. A similar proposal would require physicians to identify willing pharmacists before issuing prescriptions. See Bennett et al., supra note 59, at 266. That proposal, like the proposed notice requirements, would probably be very effective, but would be unhelpful if women needing EC were unable to reach a willing pharmacist.
willing pharmacist.\footnote{220} Therefore, notice may not meaningfully increase access to contraception for some women.

Forcing transfer of patients is another potential solution.\footnote{221} The APhA’s conscience clause, for instance, allows pharmacists to refuse to dispense medication to which they have personal objections, but requires objecting pharmacists to refer patients to a willing pharmacist.\footnote{222} Referrals have also been endorsed by the APhA.\footnote{223} However, this may be an unsatisfactory solution for some objecting pharmacists: “For many pharmacists, a referral would be no more than a passive participation in the activity they initially refused to actively assist.”\footnote{224} Currently, four jurisdictions allow pharmacists to refuse to dispense “information” regarding contraception, which could include a refusal to refer a patient to a willing pharmacist.\footnote{225} Statutes could effect a
forced transfer by establishing a formal, institutional body to oversee pharmacists, assess conflicts between patients and pharmacists, and make appropriate recommendations, such as transfers, when necessary.\textsuperscript{226} Conceivably, requiring a pharmacist to refer a prescription to which she objects might infringe on the patient’s privacy interest in protecting her medical information. However, given the relatively weak constitutional protection afforded to that interest, it is unlikely this would create any problems for mandatory referrals.\textsuperscript{227} While mandatory referral is an attractive solution, it will be ineffective where referral to a willing pharmacist is impractical. Referral will be impractical where women seeking contraception are unable to reach a willing pharmacist. Obviously, this will be a problem for women in rural and impoverished areas. Additionally, given the narrow time frame in which EC is effective, some women may not be able to find a willing pharmacist in time.

Another potential solution is to exempt medical emergencies from conscience clauses, a position which some states have adopted.\textsuperscript{228} Currently, none of the conscience clauses explicitly protecting pharmacists contain a medical emergency exemption.\textsuperscript{229} This solution would only protect access to contraception if all forms of prescription contraception were treated as related to medical emergencies. In other words, rape, contraceptive failure, and consensual sexual intercourse would have to be considered medical emergencies for this solution to ensure access to contraception. This is unlikely, since medical emer-

Consider, for example, the hypothetical case of a low-income woman in Washington State who has just been raped. The police take her to a local emergency room in a large, urban catholic hospital. State law in Washington requires hospitals to offer all rape victims emergency contraception so that they can prevent a pregnancy resulting from the assault. The hospital, however, believes that emergency contraception is an abortifacient, so relying on H.R. 4691 the hospital refuses to provide or even inform the patient about emergency contraception. She leaves not knowing that this drug exists.

\textit{Id.}  

\textsuperscript{226} See Daar, \textit{supra} note 221, at 1280-88 (adopting this approach with respect to physicians, modeled after the American Bar Association’s Model Rules of Professional Conduct, whereby hospitals would create treatment evaluation boards (TEBs) to oversee physician-patient disputes).


\textsuperscript{228} Wardle, \textit{supra} note 3, at 194 (“Of the few statutory exceptions in conscience clauses, the most common are for medical emergencies.”). However, few states provide such exceptions. \textit{Id.}

gencies are often restricted to life-threatening conditions. Moreover, it is doubtful that legislatures would create broad medical emergency exceptions to pharmacist conscience clauses, since those exceptions would defeat pharmacists’ ability to refuse to dispense contraception in most cases. Therefore, the medical emergency solution is not viable.

A final solution is to label multipurpose drugs as either abortifacients or contraceptives so that a pharmacist may act accordingly. This could compromise patient privacy. For instance, providing a pharmacist with information regarding the purpose of a drug would likely threaten patient confidentiality when drugs like RU-486, which are likely to inspire boycotts or protests, are involved. Furthermore, as one commentator noted, since prescriptions do not always entail knowledge of a patient’s history, a pharmacist’s “judgments regarding the acceptability of a prescription may be medically inappropriate.” Presumably, because the medical definition of pregnancy treats both birth control and EC as contraceptives, these drugs would always be labeled as contraceptives, regardless of whether they were used before or after fertilization. In other words, this solution would be unhelpful to objecting pharmacists.

See IOWA CODE ANN. § 146.1 (West 2004) (“Abortion does not include medical care which has as its primary purpose the treatment of a serious physical condition requiring emergency medical treatment necessary to save the life of a mother.”) (emphasis added); and MD. CODE. ANN., HEALTH—GEN. I § 20-214(d)(1) (2004).

[A] health care provider . . . is not immune from civil damages, if available at law, or from disciplinary or other recriminatory action, if the failure to refer a patient to a source for any medical procedure that results in sterilization or termination of pregnancy would reasonably be determined as: . . . The cause of death or serious physical injury. . . .

Id. (emphasis added); OKLA STAT. tit. 63, § 1-741(B) (2004).

No person may be required to perform, induce or participate in medical procedures which result in an abortion which are in preparation for an abortion or which involve aftercare of an abortion patient, except when the aftercare involves emergency medical procedures which are necessary to protect the life of the patient.

Id. (emphasis added).

For instance, if rape, contraceptive failure, and consensual sexual intercourse were considered medical emergencies, pharmacist conscience clauses containing a medical emergency exemption would never allow pharmacists to refuse to dispense birth control or EC, since these forms of contraception would inevitably implicate one of these “medical emergencies.”


Cf. id. at 15 (discussing this issue in the context of assisted suicide).

Id.

Cantor & Baum, supra note 5, at 2010.
The most viable solution is to redraft current conscience clauses so as to require pharmacists who object to dispensing contraceptives to refer patients to a willing pharmacist. Conscience clauses should also provide that if referral is impossible or impractical, the objecting pharmacist must dispense contraception. In rural areas, referrals should be reasonably nearby. Mandatory distribution should be required where women, either because of time, location, or financial status, are unable to obtain effective contraception. Although this proposal will thwart pharmacists’ consciences in some situations, this solution guarantees that women will be able to access contraceptives, regardless of whether their pharmacist sympathizes with their plight. Additionally, this proposal may protect pharmacists’ consciences in those situations where pharmacists do not find referral objectionable. This is the same approach adopted by Rod R. Blagojevich, the Governor of Illinois, in an April 1, 2005 emergency rule.

IV. POLICY CONSIDERATIONS

As this Note previously stated, the unconstitutionality of conscience clauses does not mandate that pharmacists in private practice provide contraceptives. Obviously, pharmacists who refuse to dispense contraceptives in the absence of a conscience clause face legal liability and possible demotion or termination as a result of their decision. For some pharmacists, legal and employment ramifications alone may not be enough to sway their conduct. However, policy considerations dictate that pharmacists should dispense contraception even when doing so violates their conscience.

Though it seems unlikely that women will resort to illicit, unsafe methods of contraception in the absence of legally available alterna-

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236 See id. at 2011.
237 Id.
238 Illinois Emergency Rule Requires Pharmacies to Fill Prescriptions for Contraceptives, [2005] Pharmaceutical Law & Industry Report (BNA), at 355 (Apr. 8, 2005). California, Missouri, New Jersey, West Virginia, and Congress are also considering similar legislation that would ensure a patient’s access to prescriptions. McDonough, supra note 18. Under a recent policy, the AMA will support state legislation requiring pharmacists to fill prescriptions or refer patients to willing pharmacists. Bruce Jaspen, Rx-filling Mandate Backed by AMA; Contraceptive Denial Prompts Resolution, CHI. TRIB., June 21, 2005, at C-1.
239 Contra Cantor & Baum, supra note 5, at 2008-09; Brian Kaatz, Position 2: Pharmacist Has the Right to Refuse, in Pharmacist's Refusal to Dispense Diethylstilbestrol for Contraceptive Use, 46 AM. J. HOSP. PHARMACY 1414, 1414-15 (1989) (arguing that pharmacists should not be required to dispense contraceptives); Weinstein, supra note 168, at 222.
the unavailability of contraception will almost undoubtedly increase the number of medical and surgical abortions, which is presumably an undesirable prospect for pharmacists who place a high value on fetal life. Studies show that large numbers of American women rely on contraceptives to prevent unwanted pregnancy. Overall, 60 percent of American women between fifteen and forty-four use some form of contraception. Between 80 percent and 90 percent of American women use birth control at some point in their lives. In 2003, an estimated sixteen million women used birth-control pills, spending over $2.8 billion. EC sales range between $12 and $15 million per year. Roughly twelve million American women use EC each year, making it the most used type of birth control after sterilization. Eighty-three percent of obstetrician-gynecologists and 37 percent of family practice physicians prescribed EC at least once in 2000. Furthermore, increasing numbers of women are using EC. One percent of American women used EC in 1997, whereas 2 percent of American women used EC in 2000, which constitutes an absolute increase of 1 percent within a three-year period.

Given the staggering numbers of women who rely on contraception, if pharmacists' refusal to dispense contraceptives significantly affects women's access to contraception, the number of abortions will almost undoubtedly rise. Over the years, a general decrease in the

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240 Cf. Dresser, supra note 26, at 281 ("[W]omen who cannot assume [the burdens of obtaining abortions] will increasingly seek abortions from unqualified persons, thus exposing themselves to serious health risks."); Mickey Smith, The Abortion Pill, in PHARMACY ETHICS 298, 298 (Mickey Smith et al. eds., 1991) (describing the laity's (unsuccessful) search for effective abortion pills, which have included cotton root bark extract and "synthetic vasopressin nasal spray (administered vaginally)").

241 For pharmacists who value fetal life equally at all stages of development after conception, this argument will be unconvincing.


243 See id. at 196.

244 Gardner, supra note 7, at 11.

245 Jacobson & Kovach, supra note 44, at 1A. For a description of the worldwide use of birth control, see ROSS ET AL., supra note 242, at 196 (stating that sixty million women worldwide used the pill in 1990).

246 Simon, supra note 3.

247 Bollinger, supra note 75, at 152. Cf. ROSS ET AL., supra note 242, at 194 ("Among never-married black women, sterilization increased most significantly between 1982 and 1988 and is now second only to oral contraceptives.").

248 Bennett et al., supra note 59, at 266.

249 Id.

250 Id.

251 See Bollinger, supra note 75, at 156.
number of abortions is in part due to "changes in contraceptive practices." Other countries have successfully employed birth control to decrease the rate of pregnancy and abortion. Of the 50 percent of pregnancies in the U.S. that are unplanned, 50 percent of those end in abortion. Consequently, nearly 1.5 million pregnancies end in abortion each year. Restricting access to birth control will certainly increase the number of unintended pregnancies and abortions. However, because almost half of unintended pregnancies result from contraceptive failures, restricting access to EC will also contribute to the number of abortions performed every year. In 2000, EC prevented roughly 51,000 pregnancies and is responsible for a 43 percent drop in the abortion rate in the last decade. According to one estimate, EC could prevent 17,000 pregnancies each year in Alabama alone. Pharmacists, who play an important role in distributing and stocking EC, can curb the abortion rate by dispensing it. In sum, if pharmacists are interested in preventing abortions, they should ensure that their patients have access to the contraceptives they request.

   In Sweden a law was enacted in 1974 that was designed to increase the use of birth control in order to reduce the rate of abortion. This law put into place an aggressive program of birth control education and provided for reductions in the cost of contraceptives. The result has been a sharp decrease in the rate of both teenage pregnancy and abortion in Sweden.
   Id.
255 See Giannetti, supra note 20, at 699. See also Gold et al., supra note 254, at 533. Cf. Golden et al., supra note 17, at 287 (stating that "although the rate of adolescent pregnancy in the United States is declining, it is still more than twice that of other industrialized countries").
256 See Wyser-Pratte, supra note 16, at 1122.
257 Bennett et al., supra note 59, at 261.
258 All, supra note 76.
259 Id.
260 Bennett et al., supra note 59, at 261 (stating that pharmacists can also increase access to EC by advising medical colleagues, answering women's questions, and dispelling misconceptions about EC, such as the belief that EC is identical to mifepristone).
CONCLUSION

Pharmacists, intent not to be considered pharmaceutical “vending machines,” now enter into a “complex social situation” each time they dispense a drug that could be considered immoral. Though pharmacists’ refusal is not yet an epidemic, this “dangerous

261 See Testimony, supra note 42 (“I was told that a ‘pharmacist’ conscience clause was bizarre because a pharmacist is simply a conduit of the physician’s wishes.”); Allen & Brushwood, supra note 46, at 1 (“Once thought of as mere retail dealers in a product, pharmacists have expanded their activities as service providers to patients, and have adopted a mission for themselves referred to as ‘pharmaceutical care.’”) (“[I]n filling a prescription, especially given the recent advances in pharmacy practice, a pharmacist is no longer a mere bystander in drug therapy.”). Cf. Daar, supra note 221, at 1245.

[S]tripped of their ability to advocate based on their own belief system, doctors may begin to perceive themselves as ‘medical vending machines’ whose only role is to dispense medical treatments. This image of a physician as a mere purveyor of medical ‘goods’ belies the notion that an essential element of the doctor-patient relationship is open communication about treatment options.

Id.

While some conscience clause advocates are fond of comparing the situation of pharmacists to that of conscientious objectors to the draft, this is a poor analogy because pharmacists voluntarily enter their profession, unlike those who are involuntarily drafted. See Cantor & Baum, supra note 5, at 2009; Dickens, supra note 4, at 292-93. Rather, the women who are forced to endure pregnancy against their wishes are more like conscripts than objecting pharmacists, since those women’s bodies are effectively conscripted by pharmacists who refuse to dispense contraception. See id. at 293 (quoting Justice Blackmun, who stated, “By restricting the right to terminate pregnancies, the State conscripts women’s bodies into its service. . . . The State does not compensate women for their services.” Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 928 (1992) (Blackmun, J., dissenting)). Cf. Charo, supra note 207, at 2473 (“Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust.”).

262 Smith, supra note 240, at 300. See Giannetti, supra note 20, at 700 (predicting that “[i]f abortifacients become increasingly accepted or preferred as a method of inducing abortions, many pharmacists in the United States will find themselves facing, in their practice, the same ethical issues that society is grappling with”). For a discussion of pharmacists’ increased role in health care, see Allen & Brushwood, supra note 46, at 2-6; and Herbe, supra note 33, at 77-78, 83 (“The proliferation of abortive and contraceptive drug therapies has thrust many pharmacists into roles as facilitators of practices they oppose on fundamental levels.”) (“Whether they like it or not, pharmacists are being thrust into the role of common, everyday providers of controversial reproductive medications.”).

263 See Gardner, supra note 7, at 11 (quoting Lisa Boyce, vice president of public affairs for Planned Parenthood of Wisconsin) (according to Michael Stewart, spokesman for the American Pharmacists Association, “In the great majority of cases, the pharmacist’s right to conscience is exercised appropriately and seamlessly, so the patient is not even aware that the pharmacist has exercised that right.”); Jacobson &
trend\textsuperscript{264} threatens to erode women’s access to contraception. Consequently, conscience clauses that encourage pharmacists to refuse to dispense contraception also threaten women’s constitutional right to access contraception. Because these conscience clauses do not serve a compelling state interest and are not narrowly tailored to advance any state interest, they violate the constitutional right of privacy described in \textit{Griswold} and \textit{Carey}. While the fact that pharmacist conscience clauses are unconstitutional does not require pharmacists to dispense contraception, pharmacists’ refusal will likely increase the number of abortions. Presumably, this is an unattractive prospect for those pharmacists who find birth control and EC objectionable. Although part of this debate could soon be moot, as the federal government and several states are considering legislation that would enable EC to be sold over the counter,\textsuperscript{265} standard birth control pills still remain a controversial drug for many pharmacists.

Kovach, \textit{supra} note 44, at 1A (citing the Executive Director of the Texas State Board of Pharmacy, who stated that she was unaware of any pharmacist ever refusing to fill a prescription on moral or religious grounds).

\textsuperscript{264} Kovach, \textit{supra} note 10, at 1A (quoting officials at Planned Parenthood Federation of America).

\textsuperscript{265} Simon, \textit{supra} note 3. The FDA’s rejection of OTC sale of EC was based largely on the belief that it would result in increased unsafe sexual activity and the spread of STDs. Raine, et al. \textit{supra} note 69, at 62. Such beliefs are not restricted to the United States. See Hariparsad, \textit{supra} note 17, at 89.

[M]ore than half of the pharmacists [in Durban, South Africa] indicated that the increased availability of emergency contraceptive pills would increase promiscuity, 60\% felt that increased availability of emergency contraceptive pills would decrease the use of the barrier methods of contraception, and 58\% indicated that increased emergency contraception availability would be likely to increase the incidence of sexually transmitted diseases (STDs).

\textit{Id.} However, a recent study claims that such concerns are unfounded. See Raine, et al. \textit{supra} note 69, at 62. Unlike in the United States, EC is currently available OTC in some countries, such as the United Kingdom. Iris F. Litt, \textit{Placing Emergency Contraception in the Hands of Women}, 293 JAMA 98, 98 (2005).