The (un)Ethics of Conscientious Objection in Pharmacies

Nicole Weiler
University of Minnesota
April 19, 2015

The (un)Ethics of Conscientious Objection in Pharmacies

Introduction

In March 2005, a Wisconsin pharmacist's act of conscience garnered headlines across the United States. After a married woman with four children submitted a prescription for the morning-after pill Plan B, the pharmacist Neil Noesen not only refused to fill it, but also refused to transfer the prescription to another pharmacist or to return the prescription to the customer (Anderson, 2006 p. 379). Similarly, in December 2006, a young woman went to her local Rite-Aid pharmacy in Seattle, Washington to get non-prescription emergency contraception after her normal method of birth control failed. Although the pharmacy carried the emergency contraception, the pharmacist refused to give it to her because he "thought it was wrong." Only after repeated insistence from the patient did the refusing pharmacist find another pharmacy in the area that would provide her the legal drug (NWLC). Stories of pharmacists refusing to dispense emergency and hormonal contraception on religious or moral grounds have become more frequent in recent years. Numerous reports (See also: Greenberger & Volgelstein, 2005; Stein, 2005) identify similar refusals by medical professionals to provide such medication based on personal conscientious objection.

While physicians and other healthcare providers have been legally permitted to object to procedures such as abortion on conscience grounds for decades, such protections become blurry for pharmacists who operate a considerably public service. With the increased demand for Plan B, a form of emergency contraception the Food and Drug Administration (FDA) has approved for over-the-counter sale, pharmacist refusals have received increased attention. Many ill-informed pharmacists consider this form of contraception to be analogous to an abortion, and

according to national surveys, over thirty-five percent say that they would refuse to dispense drugs that cause an abortion, which is how they are characterize non-abortifacient medications like Plan B (Spreng, 2008).

In 1994, The American Pharmacist Association (APhA) adopted a comprehensive Code of Ethics, which assigns the well being of the patient a central role, focusing professional duties on upholding patients' right to care, autonomy, and dignity. Additionally, a pharmacist's duty to be just "in the distribution of health resources, balancing the needs of patients and society," and to "avoid discriminatory practices, behavior, or work conditions that impair professional judgment"(APhA, 2004). In 1998, just four years after adopting this Code of Ethics, the APhA introduced a Pharmacist Conscience Clause, stating that the "APhA recognizes the individual pharmacist's right to exercise conscientious refusal…" (APhA, 2004).

Clearly, the Conscience Clause is in direct contrast to the Code of Ethics. Because pharmacies operate as a public trust, the conscientious objector status awarded in more direct medical service is inappropriately extended to pharmacists. Additionally, hormonal and emergency contraception drugs are legal, non- abortifacient, time-sensitive medications and failure to provide access disproportionately affects women – especially for rural and lower-socio-economic status women who are already marginalized. Pharmacists are well educated of the professional duties to which they are agreeing upon entering their profession. Thus, conscientious objector status has no place in pharmacies.

Pharmacies as a Public Trust

Pharmacies are a public service, operating as a "public trust." A public trust, according to Edmund Pellegrino, highlights the "social obligations on the part of medical professionals that

are not possessed by persons who are simply members of an occupation" (2004, p. 1939). As Robert Card concurs, pharmacists are public professionals whose main function is to provide convenient access to medications (2007[2]). Pharmacists benefit from such a public professional status by way of subsidies provided by state and federal taxpayers for their education, their higher than average salaries, and the ostensible monopoly they hold over the dispensing of drugs to the public (Meyers & Woods, 2007). Because pharmacists maintain this virtual monopoly over such a vital public service, it follows that conscientious objection, based solely on religious beliefs without consideration of scientific and medical fact, should not be accommodated within this profession (Card, 2007; Wynn et al, 2007; Brock, 2008).

Pharmacists enter into the profession voluntarily, accepting all professional ethics and obligations involved within this important sector of medicine (Card, 2007[1-2]; Wicclair, 2008). Consistent with Mark Wicclair's "incompatibility thesis," wherein he argues that conscientious objection is incompatible with these specific professional obligations by nature and basis of the profession itself (2008). According to this thesis, conscientious objection cannot be sustained on any plausible account. Conscientious objection in this field is not compatible because it stalls the time sensitive nature of hormonal and emergency contraceptives, disproportionately affecting already marginalized women, especially those of low socio-economic status and those in rural areas (Card, 2007; NWLC, 2012; Brock, 2008). Lastly, and perhaps most importantly, current conscientious objection clauses unreasonably and dangerously requires no explanation or accountability on behalf of the dissenting pharmacist, placing the burden of all repercussion on the patient (NCSL, 2012; Melo-Martin, 2007; Guttmacher, 2007; Meyers & Woods, 2007).

Contraception as a Lawful Drug

On August 24, 2006, the United States Food and Drug Administration (FDA) announced approval of emergency contraception as an over-the-counter medication for women aged 18 and older. This approval was later revised to women over 17 years of age, and in 2013 all age restrictions were dropped. Emergency contraception such as Plan B, acts to prevent pregnancy if taken within 72 hours after a sexual encounter. Consisting of 1.5 mg of the progestin Levonorgestrel (LNG), a synthetic hormone, the drug's mechanism suppresses the output of luteinizing hormone, the hormone that triggers ovulation, disrupting the process and preventing implantation.

Studies have conclusively shown that Plan B, the "morning-after pill," neither interrupts an established pregnancy nor increases the frequency of fetal abnormalities (Trussell & Raymond, 2008; Davidoff & Trussell, 2006). David Bainbridge adds an additional layer with the theory that *conception* is "a term to include all the different mechanisms that must act for a pregnancy to be established, of which fertilisation is only one" (Bainbridge, 2001, p. 278). Medical authorities define pregnancy as beginning with implantation (Hughes, 1972; USDHHS, 1983). Given this definition, even with a post-fertilization mechanism of action, emergency contraceptive pills would be considered contraceptive, not abortifacient, because they do not interrupt an established pregnancy (Wynn et al, 2007, p. 256). Hormonal contraceptives (colloquially birth control in its various forms) work in a vastly similar fashion of suppressing ovulation, and are an established form of family planning. Due to their prevailing efficacy and large benefit to women's health, these methods are considered a necessary health option. A powerful example of their substantial acceptance, hormonal birth control methods are mandated to be provided free of co-pay by the federal Affordable Care Act (2010, 2012).

Hormonal contraceptives are prescribed for uses outside of delaying or evading

pregnancy, and this medication is frequently used to manage such menstrual disorders as Pre-Menstrual Dysphoric Disorder (PMDD), Poly-Cystic Ovarian Syndrome (PCOS), Endometriosis, menorrhagia and dysmenorrhea. Additionally, pregnancy itself is a valid health concern. To a woman with Eisenmenger's syndrome for example, which is a congenital heart defect resulting in damage to blood vessels and arteries, culminating in depletion of oxygen to the organs and tissue as well as other complications, the strains fetal development puts on the woman's body would be fatal (Cantor & Baum, p. 2010). Pharmacists who opt to conscientiously object to selling hormonal birth control products do so with no knowledge of the physician's therapeutic intent. Because hormonal birth control is widely prescribed for issues such as those listed, refusing this prescription does not necessarily meet the requirements of a pharmacist objecting on the basis of preventing new life. Additionally, it disrespects the autonomy and dignity of the patient, as well as undermines the authority and ability of her prescribing medical professional. The resulting action causes undue harm to the patient, as well as violating 6 of the 9 parts of the American Pharmacist Association's Code of Ethics (2004).

Antithetically, the APhA has explicitly adopted a pharmacist conscience clause in conflict with its own professional ethical code. It states:

> [The] APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patients' access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal (JAPhA, 2004).

At present, professionals are not required to state their reasons for the objection of patient care, and as such their right to conscientiously object is unlimited in practice (Card, 2007, p. 9). As

pharmacy PhD and professor Charles Hepler astutely states, "the ethics of professional practice should not be primarily about professional *rights*, especially not rights asserted against patients, but rather about professional *duties,* especially those owed to patients or the public" (2005 p. 434).

The FDA's plan for emergency contraceptives over-the-counter status still uses pharmacists as gatekeepers, as the medication is as yet kept behind the counter. This creates an unnecessary barrier to access. Any pharmacist who conscientiously objects to the sale of emergency or hormonal birth control is presently professionally obligated to refer the patient to another pharmacist, or pharmacy, who can complete the transaction. As illustrated by the examples in Washington and Wisconsin, this obligation is not always carried out. Given the time sensitive nature of emergency and hormonal contraception, this places an undue burden on the patient. This sudden need to find a new location with permissible dispersal of a lawful drug disproportionately affects those of lower socio-economic status, as well as those living in rural areas (Card, 2007; Brock, 2008).

Consequences for Marginalized Women

Women of lower socio-economic status as well as women living in rural areas may not have a wide range of consenting pharmacies in their area, or may not possess the means to continue traveling to obtain this medication. In a theoretical posit from Brock, "referring for Plan B on a Saturday evening to a nearby pharmacy that will not be open until the following Monday would impose an unreasonable burden on the customer" given the maximum 72 hour time frame of efficacy for emergency contraceptives, or the daily schedule for hormonal birth control governed by the patient's individual menstrual cycle (2008, p. 195). Many scholars (Card, 2007;

NWLC, 2007; Loeben, 2007; Strong, 2007) have engaged in debate regarding the ethics of such a referral, following the line of thought that should a pharmacist refuse to provide emergency contraceptives on the basis of excusing their personal involvement in something they consider immoral, such professionals are not likely to provide the referral to a willing professional, which would still include them in the causal chain. Indeed, Davidson's study of the willingness of pharmacists to provide or refer emergency contraception has found that at least 6% of pharmacists who were unwilling to provide the medication were *also* unwilling to refer (Davidson, 2010 p. 162).

Zero-Probability Theory

A common reason given in studies for conscientious objection in regards to emergency and hormonal birth control, objecting pharmacists are attempting to avoid destruction of life (Card, 2007; Glasier, 1997; Brock, 2008; Wynn et al, 2007). As Robert Card explains in his "non-zero probability," given the original reasoning of the objecting pharmacist, persons should avoid all actions unless there is a zero probability that their action will result in an immoral action. Pharmacists reason that they cannot know whether the woman is pregnant, and because many conscientious objectors are operating under the false assumption that emergency and hormonal birth control terminate pregnancies, they cannot risk taking part in the causal chain. Here, pharmacists have created a Schrodinger's box paradox.

Pregnancy can be detected in women by the measurement of human chorionic gonadotropin (hCG), a hormone produced by the placenta in early pregnancy. It is not possible to confirm a positive pregnancy within the 72-hour window of efficacy required by emergency contraception, and so an objecting pharmacist cannot definitively shirk the probability of a

potential person. It has previously been established that emergency contraceptives do not affect a current pregnancy, and that pregnancy is defined by implantation. It follows that if implantation is avoided, there truly is no life to protect. Therefore, conscientious objection on the terms that one may be harming an innocent life does not stand.

Evaluation

Several surveys have shown that many pharmacists are ill informed about contraception. In May of 2007, a 49-year-old woman in Great Falls, MO using monthly hormonal birth control to treat a medical condition went to her local pharmacy to fill her latest prescription. She was given a slip of paper informing her that the pharmacy would no longer fill any prescriptions for birth control. The owner of the pharmacy justified this policy change on grounds that birth control was "dangerous" for women (NWLC, 2010). In a survey, a majority of pharmacists wrongfully agreed with the statement that "repeated use of emergency contraception is medically risky" (Alford, 2001).

Because pharmacists have access to privileged and personal information, and because they currently do not need to state reasons for their conscientious objections, it is logical to assume personal opinion may be a guiding factor in these decisions. Outside of religious morality, ideologies about why or how sex should take place are constantly debated, however coded, throughout society. Opponents of emergency contraceptives' switch to over-the-counter status argued that it would lead to soaring rates of teenage pregnancy and sexually transmitted infections (Wynn and Trussell 2006).

Champions of the switch and other FDA staff countered with several studies showing that both adults and adolescents who had ready access to emergency contraceptive pills were no more

likely to engage in unprotected sex or to acquire sexually transmitted diseases (Gold et al. 2004; Harper et al. 2005; Raine et al. 2005). As noted, the original FDA decision included an age caveat, requiring anyone under 18 to obtain a prescription for an over-the-counter drug. Despite the evidence presented, the FDA took nearly 10 years to reverse their age restriction. Does this highlight a phenomenon common in legislation known as "politics trumps science?" (Wynn et al, 2007).

Pharmacists may conscientiously object based on assumptions from personal information to which they are privy. Theoretically, "a customer who fills prescriptions for zidovudine, didanosine, and indinavir is logically assumed to be infected with the human immunodeficiency virus (HIV). If pharmacists can reject prescriptions that conflict with their morals, someone who believes that HIV-positive people must have engaged in immoral behavior could refuse to fulfill those prescriptions" (Cantor & Baum, 2004, p. 2010). The same may be true if a pharmacist notes that a patient has accessed emergency contraceptives more than twice in the last year, and decide that – morally – he disagrees with the patients risky actions. Where is the line drawn if pharmacists are not required to provide a solid basis for their dissent from practical obliged professionalism?

Inmaculada de Melo-Martin, Professor of Medical Ethics at Cornell University, explains that "because pharmacists are the gatekeepers for legally available drugs, when the APhA and other pharmacist's organizations sanction conscientious refusal as a policy, they are in fact endorsing the withholding of specialized knowledge from the public. They are also endorsing a practice that puts the interests of the pharmacist above the well-being of the patients anytime a pharmacist appeals to his or her conscience" (Melo-Martin, 2007 p. 23).

Scholars have argued that this dilemma could be at the very least regulated by instituting a review board for evaluating claims of genuine conscientious objection (Card, 2007; Meyers & Wood, 2007; Brock, 2007). Meyers and Woods argue that because professionals are not strictly "free agents" because they provide social benefits and enjoy professional status, it follows that they "have a greater burden of proof for exemption to be justified." They argue that a successful governing board would be representative of the diverse community in which the professional serves, containing a variety of ethnicities, educational training, and spiritual beliefs. The process would be hierarchal, beginning at an informal level where the petitioner meets with a representative of the established review board to discuss the basis and reasons for claiming exemption status. Should the committee or petitioner not be satisfied with the outcome at the informal level, the full board would formally review the matter, and the petitioner would have the option of seeking professional counsel. In severe cases, Meyers and Woods recommend the case be escalated to a court of competent jurisdiction (p. 20). This would ensure that the petitioner has given fair consideration to their own motives, pharmacies would be aware of any staff persons awarded objecting status by the board, and conscientious refusal would be more difficult to aim at specific individuals due to regulation.

The need for a review board is evident, as this situation sits in direct contest of federal policies; the first amendment which protects the religious interests of the conscientious objector, and Roe vs. Wade which protects women's access to reproductive options.

In a 2007 poll, "71% of voters said that pharmacists should not be allowed to refuse to fill prescriptions on moral or religious grounds, including majorities of every voter demographic such as Republicans (56%), Catholics (73%), and evangelical Christians (53%). Even more

respondents (73% overall) supported requiring pharmacies to dispense contraception to patients without discrimination or delay" (NWLC, 2010). In a survey by Davidson et al on pharmacists' willingness to dispense controversial medications including emergency contraception and hormonal birth control, religious affiliation significantly predicted pharmacists' willingness to dispense emergency contraception (p. 161). It follows that because pharmacists elect voluntarily to their profession, objecting pharmacists should pursue employment opportunities that comport with their morals — in religious communities or private hospitals for example.

Conclusion

When pharmacists voluntarily pledge to serve the public, "it is unreasonable to expect those in need of health care to acquiesce to their personal convictions" (Cantor & Baum, 2007 p. 2012). Conscientious objection promotes the practice of basing treatment decisions on personal or religious views despite and in spite of empirical medicine and research. If conscientious objection cannot be exempted from the pharmacy sector, patient care and access to medicine will continue to be significantly impeded.

To mitigate these negative outcomes, conscientious objection should be banned from the pharmaceutical sector. Alternately, at the very least conscientious objection must be regulated by an established review board, committed to upholding the Code of Ethics established by the American Pharmaceutical Association, the FDA, and on a uniform level both national and state. The current system grants privileges to the professional and compromises the patient, which for this purpose are almost exclusively women. Unless a change is made to the current system of conscientious objection, false stigmas will permeate the medical community, and female patients will continue to have limited access to lawful drugs and bear the burden of

negative outcomes. Because women are full human beings who have the legal right to conduct their social, sexual, and family lives on their own terms, the unlimited ability for pharmacists to object to these lawful rights must be reduced, based in accountability and regulation.

At the heart of this paradox is practicality. Generally supportive efforts to accommodate the religious and moral beliefs of health care professionals may be reasonable, however there are limits to even our most fundamental rights, particularly when two rights come into conflict. In this analysis, when conflict ensues and no accommodation can be made that allows a health care professional to heed his beliefs without obstructing a patient's access to care, it is the patient's needs that must prevail.

Works Cited

Alford S, Davis L, Brown L. Pharmacists' attitudes and aware- ness of emergency contraception for adolescents. Transitions 2001; 12(4):1-17.

Anderson, R., Bishop, L., Darragh, M., Gray, H., & Poland, S. (2006). Pharmacists and Conscientious Objection. *Kennedy Institute of Ethics Journal, 16*(4), 379-396.

Bainbridge, D. (2001). *Making babies: The science of pregnancy*. Cambridge, Mass.: Harvard University Press.

Brock, D. (2008). Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why? *Theoretical Medicine and Bioethics, 29*(3), 187-200.

Cantor, J., & Baum, K. (2004). The Limits Of Conscientious Objection — May Pharmacists Refuse To Fill Prescriptions For Emergency Contraception? *New England Journal of Medicine,* 2008-2012.

Card, R. (2007[1]). Response to Commentators on "Conscientious Objection and Emergency Contraception": Sex, Drugs and the Rocky Role of Levonorgestrel. *The American Journal of Bioethics, 7*(6), 8-14.

Card, R. (2007[2]). Response to Commentators on "Conscientious Objection and Emergency Contraception": Sex, Drugs and the Rocky Role of Levonorgestrel. *The American Journal of Bioethics, 7*(10), W4-W6.

Davidoff, Frank and James Trussell. 2006. "Plan B and the politics of doubt." *Journal of American Medical Association.* 296(14): 1775-1778

Davidson, L., Pettis, C., Joiner, A., Cook, D., & Klugman, C. (2010). Religion and conscientious objection: A survey of pharmacists' willingness to dispense medications. *Social Science & Medicine, 71*, 161-165.

Glasier, A. 1997. Emergency postcoital contraception. *New England Journal of Medicine* 337: 1058–1064.

Gold, Melanie A., Jennifer E. Wolford, Kyn A. Smoth, and Andrew M. Parker. 2004. "The effects of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors." *Journal of Pediatric and Adolescent Gynecology* 17(2): 87-96

Greenberger, M. D., and R. Vogelstein. 2005. Pharmacist refusals: A threat to women's health. *Science* 308: 1557–1558.

Guttmacher Institute: Refusing to Provide Health Services. (2015, February 1). Retrieved February 19, 2015, from http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf

Harper, Cynthia C. Monica Cheong, Corinne H. Rocca, Philip D. Darney, and Tina R. Raine.

2005. "The effect of increased access to emergency contraception among young adolescents." *Obstetrics & Gynecology* 106(3): 483-491

Hepler, C. (2005). Balancing Pharmacists' Conscientious Objections with Their Duty to Serve. *Journal of the American Pharmacists Association, 45*(4), 434-436.

Hughes, Edward C. (ed.). 1972. *Obstetric-Gynecologic Terminology.* Philadelphia: F. A. Davis Company.

Journal of American Pharmacist Association. Pharmacist Conscience Clause. 38(4):417 July/August 1998) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2010)

Library of Congress. Civil War Conscription Laws. (n.d.). Retrieved March 3, 2015, from http://blogs.loc.gov/law/2012/11/civil-war-conscription-laws/
Melo-Martin, I. (2007). Should Professional Associations Sanction Conscientious Refusals? *The American Journal of Bioethics, 7*(6), 23-24.

Loeben, G., & Chui, M. (2007). Conscientious Objection: Does the Zero-Probability Argument Work? *The American Journal of Bioethics, 7*(6), 28-30.

Melo-Martin, I. (2007). Should Professional Associations Sanction Conscientious Refusals? *The American Journal of Bioethics, 7*(6), 23-24.

Meyers, C., & Woods, R. (2007). Conscientious Objection? Yes, But Make Sure It Is Genuine. *The American Journal of Bioethics, 7*(6), 19-20.

NCSL, Pharmacist Conscience Clauses: Laws and Information. (2012, May 1). Retrieved February 21, 2015, from http://www.ncsl.org/research/health/pharmacist-conscience-clauses-laws-and-information.aspx

Pellegrino, E. D. 1987 [2004]. Altruism, self-interest, and medical ethics. *Journal of the American Medical Association* 258: 1939– 1940.

Raine, Tina R., Cynthia C. Harper, Corinne H. Rocca, Richard Fischer, Nancy Padian, Jeffrey D. Klausner, and Philip D. Darney. 2005. "Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs: A randomized controlled trial." *Journal of the American Medical Association* 293(1): 54-62

Spreng, Jennifer E. "Pharmacists and the "Duty" to Dispense Emergency Contraceptives," 23 ISSUES L. & MED. 215, 218 (2008) (discussing national surveys of pharmacists). Id.

Stein, R. 2005. Pharmacists' rights at the front of new debate. *Washington Post* March 28: A01.

Strong, C. (2007). Conscientious Objection The Morning After. *The American Journal of Bioethics, 7*(6), 32-34.

Trussell, James and Elizabeth G. Raymond. 2006. "How do we prevent unintended pregnancy? Let us count the ways." Lancet 368(9,549) 1747-1748

United States Department of Health and Human Services (USDHHS). 1983. *OpRR Reports: Protection of Human Subjects.* Code of Federal Regulations 45CFR 46, 8 March.

Welsh v. United States, 398 U.S. 333 (1970)

Wicclair, M. (2008). Is conscientious objection incompatible with a physician's professional obligations? *Theoretical Medicine and Bioethics, 29*, 171-185.

Wynn, L. and James Trussell. 2006. "The social life of emergency contraception in the United States: Disciplining pharmaceutical use, disciplining sexuality, and constructing zygotic bodies." *Medical Anthropology Quarterly* 20(3): 297-320.

Wynn, L., Erdman, J., Foster, A., & Trussell, J. (2007). Harm Reduction Or Women's Rights? Debating Access To Emergency Contraceptive Pills In Canada And The United States. *Studies in Family Planning, 38*(4), 253-267.