

*Winter 2010*

## Good Medicine: Why Pharmacists Should Be Prescribed a Right of Conscience

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### Recommended Citation

Michael E. Duffy, *Good Medicine: Why Pharmacists Should Be Prescribed a Right of Conscience*, 44 Val. U. L. Rev. 509 (2010).

Available at: <https://scholar.valpo.edu/vulr/vol44/iss2/5>

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## GOOD MEDICINE: WHY PHARMACISTS SHOULD BE PRESCRIBED A RIGHT OF CONSCIENCE

*On some positions, Cowardice asks the question, "Is it safe?" Expediency asks the question, "Is it politic?" And Vanity comes along and asks the question, "Is it popular?" But conscience asks the question "Is it right?" And there comes a time when one must take a position that is neither safe, nor politic, nor popular, but he must do it because Conscience tells him it is right.*

–Martin Luther King, Jr.<sup>1</sup>

### I. INTRODUCTION

Medical professions are among those where ethics and morality are of paramount concern.<sup>2</sup> The ease with which pharmacists, doctors, scientists, and other healthcare professionals can cross over the line of reason into ethical quagmires requires vigilance on their part, a willingness to illuminate ethical problems as they occur, and respect from society for those whose consciences compel them to resist conduct they find objectionable.<sup>3</sup> The pharmacist, like the physician, is a healer, a human being with a personality and moral convictions.<sup>4</sup> However, in recent years, the interest of the pharmacist to comply with his or her conscience has collided with the interest of the patient seeking a medication whose purpose or effect may be morally objectionable to the pharmacist.<sup>5</sup>

Recent actions by courts and state legislatures have created a Hobson's choice for pharmacists: disobey your conscience or lose your job.<sup>6</sup> Neither the conscientious pharmacist—more than just a glorified pill dispenser—nor any other healthcare provider should be compelled

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<sup>1</sup> Merriam-Webster Online, Word for the Wise: January 15, 2007 Broadcast: Topic: Doctor Martin Luther King, Junior, <http://www.merriam-webster.com/cgi-bin/wftwarch.pl?011507> (last visited Jan. 25, 2010).

<sup>2</sup> *Cf. infra* note 38 and accompanying text (discussing the improvement in U.S. medical ethics starting in the nineteenth century).

<sup>3</sup> *See infra* note 208 (discussing the manipulation of the medical community in Nazi Germany).

<sup>4</sup> *See infra* Part IV.A (discussing the importance of conscience protection for pharmacists).

<sup>5</sup> *See infra* notes 137–49 and accompanying text (discussing conscience law critics' beliefs that patient needs may not be met by objecting pharmacists).

<sup>6</sup> *See* Bradley L. Davis, Note, *Compelled Expression of the Religiously Forbidden: Pharmacists, "Duty to Fill" Statutes, and the Hybrid Rights Exception*, 29 U. HAW. L. REV. 97, 118 (2006) (discussing the concept of a Hobson's Choice). *See infra* Parts II.B.2.a–b, II.C (discussing state and federal laws pertaining to conscience and also the professional standards of the pharmaceutical industry, respectively).

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or coerced into acting contrary to deeply held beliefs.<sup>7</sup> Thus, right-of-conscience laws, which have a long tradition in both the military and the medical profession, are appropriate for pharmacists, who should not be compelled to interface with medications they find morally objectionable.<sup>8</sup>

In Part II, this Note explores the primary source of controversy for pharmacists—interfacing with drugs labeled as contraceptives—and the reasons why many pharmacists object to these medications.<sup>9</sup> This Part then examines the role of conscientious objection throughout the history of the United States military and in the medical profession in the United States of the twentieth and twenty-first centuries to demonstrate that respect for conscience has long been a part of American law.<sup>10</sup> In addition, Part II briefly surveys the current status of conscience laws at both the state and federal levels, including the regulation recently issued by the Department of Health and Human Services aimed at greater enforcement of existing federal laws, and also addresses the American Pharmacists Association’s stance on conscientious objection by pharmacists.<sup>11</sup>

Part III analyzes the debate over the value of pharmacist conscience laws and their constitutionality by briefly exploring: whether inconvenience is an adequate justification to require pharmacists to dispense medications to which they object; the differences between substantial and incidental burdens on constitutional rights; the extent of protection for the free exercise of religion after *Employment Division, Department of Human Resources of Oregon v. Smith*;<sup>12</sup> the difference between alleviating a government-imposed burden on religion and extending free exercise rights; and whether a duty to dispense medications even exists.<sup>13</sup>

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<sup>7</sup> See *infra* Part IV.A (examining the importance of conscience protection for pharmacists).

<sup>8</sup> Cf. *infra* Part II.B.1-2 (discussing the role of conscientious objection throughout the history of the U.S. military and in the U.S. medical profession of the twentieth and twenty-first centuries).

<sup>9</sup> See *infra* Part II.A (explaining the reasons pharmacists may object to contraceptives). This Note’s referral to certain drugs being contraceptives, or any references to contraceptives in general, should not be interpreted as the author’s belief that they do in fact function to prevent conception.

<sup>10</sup> See *infra* Part II.B.1-2 (looking at conscientious objection in the U.S. military and the medical profession).

<sup>11</sup> See *infra* Parts II.B.2.a-b, II.C (reviewing state and federal conscience laws and professional standards for pharmacists).

<sup>12</sup> 494 U.S. 872, 879 (1990) (holding that religious believers may be subject to neutral and generally applicable laws).

<sup>13</sup> See *infra* Part III.A-F (all analyzing constitutional issues pertaining to pharmacist conscience laws).

Finally, Part IV examines the importance of preserving medical ethics and the ability of healthcare providers to exercise their consciences, offers recommendations to pharmacists on how to avoid conflicts with their patients over conscientious objection, and proposes a model right-of-conscience statute.<sup>14</sup>

## II. BACKGROUND

This Part explores the primary source of controversy for objecting pharmacists and the role of conscientious objection in both the United States military and in the U.S. medical profession of the twentieth and twenty-first centuries, at both state and federal levels.<sup>15</sup> Finally, this Part briefly addresses the professional standards of the pharmaceutical profession.<sup>16</sup>

### A. *The Pill Controversy*

A request for drugs or devices labeled as contraceptives, Plan-B (also known as the “morning-after” pill), or RU-486 commonly creates an ethical dilemma for pharmacists.<sup>17</sup> Approximately fourteen million women in the United States use any one of forty different brands of oral contraceptives each year.<sup>18</sup> The American College of Obstetricians and

<sup>14</sup> See *infra* Part IV (discussing the value of pharmacist conscience laws, ways pharmacists can avoid liability, and proposing a model conscience law). While the goal of this Note is to address the conscience issues of pharmacists, at times it speaks generally about healthcare providers outside the pharmaceutical industry because the ethical dilemmas shared by all those in the medical field are quite similar.

<sup>15</sup> See *infra* Parts II.A–B (enumerating the reasons why pharmacists may object to contraceptives and the history of conscientious objection in the U.S. military and the U.S. medical profession of the twentieth and twenty-first centuries).

<sup>16</sup> See *infra* Part II.C (discussing professional standards for pharmacists).

<sup>17</sup> Cf. Amy Bergquist, Note, *Pharmacist Refusals: Dispensing (With) Religious Accommodation Under Title VII*, 90 MINN. L. REV. 1073, 1074 (2006). Plan-B is a medicine designed for use after unprotected sex or the failure of a contraceptive and can function by preventing conception or by preventing the implantation of a fertilized egg onto the uterine wall. See *infra* notes 26–27 and accompanying text (discussing same).

<sup>18</sup> RANDY ALCORN, DOES THE BIRTH CONTROL PILL CAUSE ABORTIONS? 10 (2007) <http://www.epm.org/media-files/pdf/bcpill.pdf>. Oral contraceptives (“Ocs”) are also referred to as birth control pills (“BCPs”), oral contraceptive pills (“OCPs”), or Combination Pills because they can contain a mix of the hormones estrogen and progesterone. *Id.* Objection among pharmacists to contraceptives likely encompasses all forms of contraceptives (patches, implants, etcetera), and not just pill versions, so long as they can have an abortifacient effect. Cf. *infra* note 23 and text accompanying note 31 (explaining that in spite of their advertised purpose, certain medications would be inappropriate as prescribed for birth control and that those who object to surgical abortions are likely to object to chemical abortions, respectively). This Note’s discussion of oral contraceptives

Gynecologists defines conception as the *implantation* of a blastocyst (the human embryo after six or seven days of development) onto the inner lining of the uterus; traditionally, conception was understood to occur at the moment a sperm fertilized an egg.<sup>19</sup> Oral contraceptives can operate in any of several ways: by suppressing ovulation, the release of an egg from the ovary; by altering the mucus lining of the cervix; or by altering the lining of the uterus to prevent implantation of the fertilized egg.<sup>20</sup> The last scenario presents the most serious moral dilemma to pharmacists who believe that a mechanism that prevents the implantation of a fertilized egg onto the uterus, thereby resulting in its destruction, operates as an abortifacient, not as a contraceptive.<sup>21</sup> As

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should not be interpreted as a limitation on the kinds of contraceptives that can act as abortifacients or to which pharmacists might object.

<sup>19</sup> ALCORN, *supra* note 18, at 7–8. The notion that conception occurs at implantation is an “archaic” one, with “roots in an Aristotelian understanding of human reproduction, which held that the male semen contained the entire human person in potentiality[,]” and that the woman “had a passive part[,]” playing a role “like that of mother earth providing the seed with the nutrition and proper environment in which to grow.” Charles D. Dern, *Speaking Clearly about Early Life*, ETHICS & MEDICS, March 2009, at 3. Dr. Charles D. Dern states that:

defining pregnancy using the archaic definition of *conception* is to insist that somehow a fertilized ovum is more human after implantation. In the normal progression of nascent human life, the milestones of viability and implantation are *distinctions without differences*. Whether one prevents implantation or procures an abortion at any other point during gestation, the natural growth of another human being is stifled.

*Id.* at 4.

<sup>20</sup> JAMES J. RYBACKI, *THE ESSENTIAL GUIDE TO PRESCRIPTION DRUGS* 2006 778 (2006). Alcorn notes that “Magnetic Resonance Imaging studies demonstrate that the lining of the endometrium is dramatically thinned in Pill users. Normal endometrial thickness that can sustain a pregnancy ranges in density from 5 to 13 mm. The average thickness in pill users is 1.1 mm.” ALCORN, *supra* note 18, at 28.

<sup>21</sup> Nicholas Tonti-Filippini differentiates between an abortifacient and a contraceptive:

A contraceptive effect occurs when the natural process of human generation originating in the marital act is prevented, by some form of deliberate intervention in the human body or in the act itself, from resulting in fertilization of an ovum by a sperm.

An abortifacient effect occurs when intervention takes place of a kind which would be likely, if fertilization were to have occurred, to destroy the human zygote, embryo or fetus, to prevent its implantation, or to cause an implanted embryo or fetus to miscarry.

The human zygote is the cell formed by the fusion of the two gametes.

*The Pill: Abortifacient or Contraceptive? A Literature Review*, LINACRE Q., Feb. 1995, 5, available at <http://www.cin.org/life/pillabor.html>.

Even if contraceptives did not sometimes function as abortifacients, some pharmacists might still object to interfacing with them if they believe that their use—regardless of possible abortive effect—is contrary to their religious beliefs about procreation. See, e.g., Pope Paul VI, *Humanae Vitae: On Human Life* (1968), available at <http://www.priestsforlife.org/magisterium/humanaevitae.htm> (asserting that direct interruption of human gestation is to be considered illicit by Catholics). Catholic pharmacists may also be influenced by a

Doctors Walter L. Larimore and Joseph B. Stanford note, “[f]or patients who believe that human life begins at fertilization (conception), a method of birth control that has the potential of interrupting development after fertilization (a postfertilization effect) may not be acceptable.”<sup>22</sup>

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2008 publication in which the Vatican asserted that where medications like Plan-B are concerned, “scientific studies indicate that *the effect of inhibiting implantation is certainly present*, even if this does not mean that such interceptives cause an abortion every time they are used.” Congregation for the Doctrine of the Faith, *Instruction Dignitas Personae on Certain Biotethical Questions* (2008), available at <http://www.priestsforlife.org/magisterium/dignitas-personae.htm>. Thus, “anyone who seeks to prevent the implantation of an embryo which may possibly have been conceived and who therefore either requests or prescribes such a pharmaceutical, generally intends abortion.” *Id.*

In addition, Pedro José María Simón Castellví, President of the International Federation of Catholic Medical Associations (“FIAMC”), has stated that:

the means of contraception violate at least five important rights: the right to life, the right to health, the right to education, all right to information (their spread is at the expense of information on natural resources) and the right to equality between the sexes (the burden of contraception falls mostly on women).

Hilary White, *Vatican Newspaper Publishes Article Detailing Birth Control Pill as Cause of Abortion and Cancer*, Feb. 1995, <http://www.lifesitenews.com/ldn/2009/jan/09010504.html>.

In January, 2009, the FIAMC issued a 100-page report that, by relying on 300 bibliographic citations to mostly specialized medical journals, “‘clearly demonstrates’ that anovulant, low-dose hormonal birth control pills work not only by preventing ovulation but also by causing the death of an already existing child in the uterine wall.” *Id.* Hilary White continues:

This embryonic person, Castellvi wrote, “even in its early days, is something other than an egg or female germ cell.” From the embryonic stage, the child grows in a coordinated way and this development, unless prevented, “ends with its exit from the womb in nine months, ready to devour a litre of milk.”

*Id.*

Dr. Maureen Condic has asserted, in light of the medical research on the subject, that “sperm-egg fusion is indeed a scientifically well defined ‘instant’ in which the zygote (a new cell with unique genetic composition, molecular composition, and behavior) is formed,” and that the zygote “is not merely a unique human cell, but a cell with all the properties of a fully complete (albeit immature) human organism; it is ‘an individual constituted to carry on the activities of life by means of organs separate in function but mutually dependent: a living being.’” Maureen Condic, *When Does Human Life Begin? A Scientific Perspective*, The Westchester Institute for Ethics and the Human Person, available at [www.westchesterinstitute.net/images/wi\\_whitepaper\\_life\\_print.pdf](http://www.westchesterinstitute.net/images/wi_whitepaper_life_print.pdf) (last visited Aug. 16, 2009).

Regardless of their religious beliefs, some pharmacists may believe that contraceptives encourage or facilitate sexual promiscuity. Rob Stein, *‘Pro-Life’ Drugstores Market Beliefs*, WASH. POST, June 16, 2008, at A1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/06/15/AR2008061502180.html?hpid=topnews> (last visited Aug. 16, 2009).

In addition, some pharmacists may be hesitant to prescribe contraceptives because of the serious health risks they can pose. See, e.g., Thaddeus M. Baklinski, *Studies Find*

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Many drugs called contraceptives feature literature explaining that the medication can work by affecting the lining of the uterus and preventing implantation.<sup>23</sup> For instance, the oral contraceptive Lybrel

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*Contraception Makes Women Obese and Newborns Too Thin*, LifeSiteNews.com, March 9, 2009, <http://www.lifesitenews.com/ldn/2009/mar/09030907.html>:

women who had taken the pill within 30 days of getting pregnant were more than three times as likely to have a very low-weight newborn (under 3.3 lbs) and twice as likely to have a child born weighing less than 5.5 pounds or to deliver the child six weeks prematurely.”

*Id.* See also Thaddeus M. Baklinski, *Study: Women Who Use Birth Control Pill 1.5 Times More Likely to Develop Bowel Disease*, LifeSiteNews.com, Mar. 13, 2009, <http://www.lifesitenews.com/ldn/2009/mar/09031311.html> (“women who use the pill are one and a half times more likely to develop Crohn’s disease (CD) or ulcerative colitis (UC) than women who have not used oral contraceptives.”); Catholic News Service, *Birth-Control Pill is Linked to Male Infertility, Says Vatican Paper*, Jan. 5, 2009, <http://www.catholicnews.com/data/briefs/cns/20090105.htm> (explaining that environmental damage caused by the pill is contributing to male infertility and is creating sexual abnormalities in fish and other water-dwelling creatures exposed to sewage containing estrogen and artificial hormones); *Abortion-Causing Birth Control Patch Manufacturer Faces Class-Action Lawsuit*, LifeSiteNews.com, July 27, 2005, <http://www.lifesitenews.com/ldn/2005/jul/05072703.html> (noting that ten women who suffered strokes or serious blood clots filed a class-action lawsuit against Ortho McNeil, maker of the Ortho Evra birth control patch); *Birth Control Pill Raises Heart Attack Risk 100%*, July 12, 2005, LifeSiteNews.com, <http://www.lifesitenews.com/ldn/2005/jul/05071207.html> (“women are at 100% greater risk of heart attack and stroke with the ‘low-dose’ pill, especially for those women with pre-existing medical conditions.”); *Woman Sues “Birth Control” Patch Manufacturer for Pulmonary Embolism*, Sept. 13, 2005, LifeSiteNews.com, <http://www.lifesitenews.com/ldn/2005/sep/05091303.html> (during a twelve month period, the FDA acknowledged forty-four “serious injuries or deaths” associated with Ortho Evra).

<sup>22</sup> Walter L. Larimore & Joseph B. Stanford, *Postfertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent*, 9 ARCH. FAM. MED., Feb. 2000, 126, 126, available at <http://archfami.ama-assn.org/cgi/reprint/9/2/126> (follow “Begin manual download” hyperlink) (last visited Sept. 23, 2009).

<sup>23</sup> See Walter L. Larimore, *The Growing Debate About the Abortifacient Effect of the Birth Control Pill and the Principle of the Double Effect*, ETERNAL PERSPECTIVE MINISTRIES, Oct. 1, 2004, [http://www.epm.org/artman2/publish/prolife\\_birth\\_control\\_pill/The\\_Growing\\_Debate\\_About\\_the\\_Abortifacient\\_Effect\\_of\\_the\\_Birth\\_Control\\_Pill\\_and\\_the\\_Principle\\_of\\_the\\_Double\\_Effect.shtml](http://www.epm.org/artman2/publish/prolife_birth_control_pill/The_Growing_Debate_About_the_Abortifacient_Effect_of_the_Birth_Control_Pill_and_the_Principle_of_the_Double_Effect.shtml).

Dr. Larimore states that:

Both proponents and opponents seem to agree that the risk of an abortifacient effect with intrauterine contraceptive devices (IUDs), the progesterone-only pills (POP), Norplant (subcutaneously implanted progesterone rods) and “emergency contraception” (*sic*) or “the morning after pills” are such that, in general, it would be unethical to use or prescribe these products for birth control.

*Id.*

In November 2008, *Fertility and Sterility* published the pro-choice American Society for Reproductive Medicine (“ASRM”) statement entitled, “Hormonal contraception: recent advances and controversies[.]” a statement conceding that oral contraceptives can operate by modification of the endometrium, preventing implantation. Ellen M. Rice, *American Society of Reproductive Medicine Statement Confirms the Pill Causes Abortion*,

can operate by blocking ovulation or by manipulating the mucus lining the cervix, but it can also alter the endometrium reducing the likelihood of implantation.<sup>24</sup> As a further example, the individual product information for Ortho's Ortho-Cept, Syntex's six varieties of contraceptive pills, Wyeth's Lo/Ovral, Ovral, Nordette and Triphasil, and Organon's Desogen indicates that these pills can function by changing the lining of the uterus in a way to prevent implantation.<sup>25</sup> Likewise, Plan-B, a medication designed to be used within seventy-two hours *after* unprotected sex or the failure of a contraceptive method, is "believed to act" as an emergency contraceptive that "may inhibit implantation . . ." <sup>26</sup> The Food and Drug Administration ("FDA") concedes that Plan-B may "work by preventing fertilization of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the uterus (womb), which usually occurs beginning seven days after release of an egg from the ovary."<sup>27</sup>

RU-486, sold under the brand names of Mifeprex or Early Option and under the generic name of Mifepristone, is an artificial steroid that, when taken with a prostaglandin, ultimately causes a miscarriage.<sup>28</sup> Jennifer E. Spreng explains that "mifepristone operates to terminate the pregnancy by detaching the embryo or fetus from the uterine wall where it had previously implanted, and the [misoprostol] then induces contractions to expel the fetus and other products of conception from the uterus[;]" this can be accomplished up to forty-nine days' gestation.<sup>29</sup> Larimore and Stanford conclude that:

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LifeSiteNews.com, Dec. 12, 2008, <http://www.lifesitenews.com/ldn/2008/dec/08121206.html> (last visited May 19, 2009).

<sup>24</sup> PHYSICIANS' DESK REFERENCE 3367 (62d ed. Medical Economics Co. 2008).

<sup>25</sup> ALCORN, *supra* note 18, at 21-23.

<sup>26</sup> PHYSICIANS' DESK REFERENCE, *supra* note 24, at 1056. There has been some debate among scientists as to whether Plan-B can actually function as an abortifacient in spite of the medication's label to this effect. See Nicanor Pier Giorgio Austriaco, *Is Plan B an Abortifacient? A Critical Look at the Scientific Evidence*, 7 NAT'L CATH. BIOETHICS Q. 703 (2007) (presenting evidence that Plan-B does not produce abortive results). *But see* Patrick Yeung et al., Letter to the Editor, 8 NAT'L CATH. BIOETHICS Q. 218 (2008) (refuting Austriaco's claims).

<sup>27</sup> Food and Drug Administration, *Plan B: Questions and Answers*, <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109783.htm> (last visited Aug. 16, 2009).

<sup>28</sup> RU486Facts.org, *What is RU-486?*, <http://www.ru486facts.org/index.cfm?page=whatis> (last visited Aug. 16, 2009).

<sup>29</sup> Jennifer E. Spreng, *Pharmacists and the 'Duty' to Dispense Emergency Contraceptives*, 23 ISSUES L. & MED. 215, 218, 225 (2008). Misoprostol is a type of prostaglandin. WebMD.com, *Information and Resources: Misoprostol*, <http://www.webmd.com/a-to-z-guides/misoprostol> (last visited Aug. 16, 2009).

Despite the evidence, which suggests that postfertilization effects for OCs are operational at least some of the time, and the fact that a postfertilization mechanism for OCs is described in the *Physicians' Desk Reference*, in *Drug Facts and Comparisons*, and in most standard gynecologic, family practice, nursing, and public health textbooks, we anecdotally find that few physicians or patients are aware of this possibility.<sup>30</sup>

Thus, the potential for medicines labeled contraceptives to function by destroying a living and developing human zygote or embryo means that anyone who has moral reservations about surgical abortions may have the same reservations about chemical abortions.<sup>31</sup> In fact, objecting pharmacists may take issue not only with *dispensing* abortifacients (and perhaps drugs used in euthanasia or capital punishment settings<sup>32</sup>), but with *interfacing* with them at all, as referring a patient or transferring a prescription would make them complicit in activity they find highly immoral.<sup>33</sup>

Moral opposition among healthcare providers to abortion is not a recent development.<sup>34</sup> Dr. James Hitchcock explains that opposition to abortion in the United States was “particularly strong” as early as the nineteenth century and that by the middle of that century, scientific research revealed that human life begins at conception, thereby discrediting as arbitrary the prevailing notion that human life begins at quickening.<sup>35</sup> It was this scientific research—not “religious opposition”—that “was largely responsible for the stricter position on abortion.”<sup>36</sup> Indeed, an effort began in the 1840s to completely prohibit abortion, which had come to be viewed as “the wanton taking of human

<sup>30</sup> Larimore & Stanford, *supra* note 22, at 130.

<sup>31</sup> Cf. text accompanying note 22 (explaining that for those who believe that life begins at conception, a medicine that interrupts development subsequent to conception can be morally problematic). An abortifacient is “a substance that causes pregnancy to end prematurely and causes an abortion.” MedicineNet.com, *Definition of Abortifacient*, <http://www.medterms.com/script/main/art.asp?articlekey=10912> (last visited Aug. 16, 2009).

<sup>32</sup> See Jessica J. Nelson, *Freedom of Choice for Everyone: The Need for Conscience Clause Legislation for Pharmacists*, 3 U. ST. THOMAS L.J. 139, 140–41, 163 (2005) (discussing how pharmacists may object to certain medications because of their medical implications or for the reasons they will be used).

<sup>33</sup> *Id.* at 166.

<sup>34</sup> James Hitchcock, *Respect for Life and the Health Care Professions: A Historical Survey*, in HUMAN LIFE AND HEALTH CARE ETHICS 45, 46 (James Bopp, Jr. ed., 1985).

<sup>35</sup> *Id.* In fact, opposition to abortion pre-dates the nineteenth century as the English common law condemned abortion. *Id.* at 45–46.

<sup>36</sup> *Id.* at 46.

life,” and the primary catalysts behind this endeavor were *physicians*, not clergy.<sup>37</sup> Furthermore, as the medical profession improved in the nineteenth century, “physicians [became] unwilling to simply provide services on demand but wished to impose standards of ethical and scientific judgment on their work.”<sup>38</sup>

Thus, healthcare practitioners’ objections to abortion are real and deep-rooted.<sup>39</sup> Medical evidence makes it clear that contraceptives of different types can have abortive effects on a human embryo, explaining why pharmacists may object to interfacing with these drugs.<sup>40</sup> For anyone who believes that human life begins at conception, providing a drug that can possibly destroy an embryo is essentially the facilitation of killing a human being.<sup>41</sup>

#### B. *Conscientious Objection in the Military and in the Medical Profession*

##### 1. Conscientious Objection throughout the History of the U.S. Military

Conscientious objection has deep roots in American history, particularly in the context of the military, where the government has treated genuine moral objection with respect.<sup>42</sup> In fact, Stephen M. Kohn

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<sup>37</sup> *Id.*

<sup>38</sup> *Id.* Hitchcock observes that:

Professionalization, which in the nineteenth century served to restrict medical practice by forbidding acts deemed unprofessional or unethical, now serves to remove more and more of those restrictions. Although professionalization in the Victorian age was accompanied by humanitarian sentiment, in the end the spirit of professionalization is independent of moral values. The tendency to define professional ethics in terms of professional practice often permits technical possibilities alone to define the limits of action. Put another way, the moral practice of health care professionals always requires the infusion of values from outside the profession itself, and individual professionals may either be “ahead of” or “behind” public opinion on such issues. Health care professionals’ acceptance of the legitimacy, even the desirability, of practices previously considered abhorrent was made possible by the collapse of a socially accepted moral consensus over the past twenty years, leaving an impersonal, largely technical standard of practice dominant.

*Id.* at 48.

<sup>39</sup> See text accompanying note 35 (explaining that opposition to abortion within the U.S. medical community stretches back to the early nineteenth century).

<sup>40</sup> See *supra* notes 19–33 and accompanying text (explaining that contraceptives can act as abortifacients, making them potentially objectionable to pharmacists on moral grounds).

<sup>41</sup> Cf. text accompanying note 22 (explaining that for those who believe that life begins at conception, a medicine that interrupts development subsequent to conception can be morally problematic).

<sup>42</sup> See *infra* notes 43–66 and accompanying text (discussing conscientious objection in America from its colonial period to the present). Spreng notes that:

relates that conscientious objection stretches back to America's colonial days.<sup>43</sup> For instance, the colonies of Massachusetts, New Hampshire, North Carolina, South Carolina, Virginia, and New York—because of their sizable pacifist populations—recognized conscientious objection to military service.<sup>44</sup> Rhode Island was the first colony to grant a fundamental right of religious liberty and eventually passed a conscientious objection law that exempted from active military duty “all those who for reasons of conscience could not ‘train, arm, rally to fight, to kill.’”<sup>45</sup> Also, a conscientious objector exemption was among the first pieces of legislation passed by the Continental Congress in 1775.<sup>46</sup> This right was paramount even in the most perilous of circumstances, as during the impending invasion of Philadelphia by the British.<sup>47</sup> Thus,

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[c]onscience clauses . . . are as fixed a star in American law as *McCullough v. Maryland*—or maybe even more so. Statutory exemptions from otherwise generally applicable laws—attendance at the services of the relevant state's established church—existed as early as 1675. Prior to the Revolutionary War, many of the colonies extended exemptions from oath taking, tax collection for the established church, and military conscription.

Jennifer E. Spreng, *Conscientious Objectors Behind the Counter: Statutory Defenses to Tort Liability for Failure to Dispense Contraceptives*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 337, 372 (2008) (footnotes omitted).

<sup>43</sup> STEPHEN M. KOHN, *JAILED FOR PEACE: THE HISTORY OF AMERICAN DRAFT LAW VIOLATORS, 1658–1985* 9–12 (Greenwood Press 1986).

<sup>44</sup> *Id.* at 9–10. Delaware, Pennsylvania, New York, and New Hampshire eventually recognized conscientious objection as an absolute right in their individual constitutions in 1776, 1776, 1777, and 1784, respectively. *Id.* at 10. Peter Brock explains that Pennsylvania was well-known for its pacifistic government and remained “virtually unarmed for some seven decades[.]” with an act of 1673 fully exempting genuine objectors from military service but requiring them to provide civilian service in the event of invasion. PETER BROCK, *VARIETIES OF PACIFISM: A SURVEY FROM ANTIQUITY TO THE OUTSET OF THE TWENTIETH CENTURY* 31, 34 (Syracuse Univ. Press 1998). Interestingly, James Madison proposed including a right of conscientious objection in the Bill of Rights that would have read: “no person religiously scrupulous of bearing arms shall be compelled to render military service in person.” KOHN, *supra* note 43, at 10–11. While the clause met approval in the House, it failed in the Senate. *Id.* at 11.

<sup>45</sup> KOHN, *supra* note 43, at 7–8. The law in its entirety read:

Noe person nor persons [within this colony], that is or hereafter shall be persuaded in his, their conscience, or consciences [and by him or them declared], that he nor they cannot nor ought not to trayne, to learned to fight, nor to war, nor kill any person or persons . . . nor shall suffer any punishment, fine, distraint, penalty nor imprisonment.

*Id.* at 8.

<sup>46</sup> *Id.* at 10.

<sup>47</sup> *Id.* Likewise, the governing body of Pennsylvania refused to alter its commitment to a right of conscientious objection at the start of the French and Indian War, “even if the very existence of the colony was at stake.” *Id.* at 9. Kohn reiterates the sentiment of a Pennsylvania legislator who remarked that “[w]e have taken every step in our power, consistent with the just rights of the freemen . . . . Those who would give up essential

most Revolutionary War objectors were exempted from military service, and jail terms for those not exempted were quite short.<sup>48</sup>

During the Civil War, President Abraham Lincoln pardoned some Quakers who had been inducted or jailed, and the Confederacy included an objector provision in its draft law.<sup>49</sup> In general, Lincoln's administration offered exemptions to objectors, requiring them to pay money instead of serve, and these exemptions initially did not differentiate between genuine objectors and those who objected for less conscientious reasons.<sup>50</sup> The Confederacy allowed objectors to pay their way out of service too.<sup>51</sup>

During World War I, 3500 individuals obtained legal objector exemptions and during World War II, around 37,000 of the 72,354 men who applied for objector exemptions were assigned to noncombatant army service or civilian work camps.<sup>52</sup> In 1952, the number of inductees

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liberty to purchase a little temporary safety, deserve neither liberty nor safety.'" *Id.* at 9. By the mid-nineteenth century, the militia system was so degraded that inductions were not enforced and refusals not penalized. BROCK, *supra* note 44, at 61.

George Washington wrote to the Pennsylvania Council of Safety:

As there is not the least doubt at present, that the principal object of the enemy is to get possession of the City of Philadelphia, it is absolutely necessary, that every person able to bear arms [except such as are Conscientiously scrupulous against in every case] should give their personal service.

KOHN, *supra* note 43, at 10.

Nelson, in quoting Professor Lynn Wardle, observes that "the founders recognized that '[i]f you demand that a man betray his conscience, you have eliminated the only moral basis for his fidelity to the rule of law, and have destroyed the foundation for all civic virtue.'" Nelson, *supra* note 32, at 144.

<sup>48</sup> KOHN, *supra* note 43, at 10.

<sup>49</sup> *Id.* at 20.

<sup>50</sup> BROCK, *supra* note 44, at 70.

<sup>51</sup> *Id.* at 71.

<sup>52</sup> KOHN, *supra* note 43, at 25, 46. In fact, conscientious objectors from World War I were eligible again for exemption in World War II. *Id.* at 49. The Draft Act of 1917 exempted from service those affiliated with well-known pacifist religious denominations opposed to all war. *Gillette v. United States*, 401 U.S. 437, 443 n.8 (1971). The Selective Training and Service Act of 1940 recognized "religious scruples against bearing arms . . ." *Girouard v. United States*, 328 U.S. 61, 66 (1946).

Before his ascendancy to the Supreme Court in 1925, Harlan Fiske Stone contributed an article to the Columbia University Quarterly in which he addressed conscientious objection during World War I. Harlan Fiske Stone, *The Conscientious Objector*, 21 COL. UNIV. Q. 253 (1919), available at <http://www.archive.org/details/columbiauniversi21newyuoft> (click on "PDF" under "View the book") (last visited Aug. 16, 2009). Stone notes that During World War I, genuine conscientious objectors could be permitted to accept employment as furloughed soldiers on select farms, although any pay earned beyond the amount they would receive as soldiers had to be given to the civilian branch of the Red Cross. *Id.* at 258. In some rare cases, a conscientious objector could be sent to Europe to aid in reconstruction efforts. *Id.*

who received conscientious objector status was more than ten times the percentage of those who had applied for this status during World War II, and by 1960, the number of exempted objectors reached 18.24%.<sup>53</sup> By 1972, there were more men exempted from service than there were inducted into it.<sup>54</sup> The current Selective Service Act provides an objector exemption for those, “by reason of religious training and belief, [are] conscientiously opposed to participation in war in any form.”<sup>55</sup>

In the 1946 case, *Girouard v. United States*,<sup>56</sup> the Supreme Court decided whether citizenship could be denied to a Canadian who refused to commit to potential combatant military duty despite Congress’s requirement that new citizens pledge an oath to defend the United States.<sup>57</sup> The Court held that Congress has allowed citizens to do their duty in both combatant and non-combatant capacities, and that “[t]his respect by Congress over the years for the conscience of those having religious scruples against bearing arms is cogent evidence of the meaning of the oath.”<sup>58</sup>

The case *United States v. Seeger*<sup>59</sup> brought before the Court the question whether a literal belief in a Supreme Being was necessary to satisfy the exemption provision of the Universal Military Training and Service Act or if mere religious faith was adequate.<sup>60</sup> The Court concluded that a “sincere and meaningful belief which occupies in the life of its possessor a place parallel to that filled by the God of those admittedly qualifying for the exemption” was sufficient.<sup>61</sup> The question as to what exactly constitutes religious belief confronted the Court in *Welsh v. United States*.<sup>62</sup> The Court reasoned that deeply and sincerely held beliefs that are purely ethical or moral, but that conscientiously compel a person to refrain from war, are analogous to religious beliefs in

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<sup>53</sup> KOHN, *supra* note 43, at 70.

<sup>54</sup> *Id.* at 92.

<sup>55</sup> 50 U.S.C. app. § 456(j) (2006).

<sup>56</sup> *Girouard*, 328 U.S. at 61–63.

<sup>57</sup> The Court reversed the denial of the Canadian’s citizenship. *Id.* at 69–70.

<sup>58</sup> *Id.* at 66–67. In addition, the Court noted that “[t]he victory for freedom of thought recorded in our Bill of Rights recognizes that in the domain of conscience there is a moral power higher than the State. Throughout the ages men have suffered death rather than subordinate their allegiance to God to the authority of the State.” *Id.* at 68.

The Court observed that “[o]ver the years, Congress has meticulously respected that tradition [of honoring conscientious objection] and even in time of war has sought to accommodate the military requirements to the religious scruples of the individual.” *Id.* at 69.

<sup>59</sup> 380 U.S. 163 (1965).

<sup>60</sup> *Id.* at 165–66.

<sup>61</sup> *Id.* at 176.

<sup>62</sup> 398 U.S. 333, 335 (1970).

God.<sup>63</sup> The Court affirmed that beliefs not deeply held or of a political or pragmatic nature are inadequate to garner exemption.<sup>64</sup> In siding with a conscientious objector in *Gillette v. United States*,<sup>65</sup> Justice Thurgood Marshall explained that Congress has recognized both the value of conscientious action to the community and the notion that “fundamental principles of conscience and religious duty may sometimes override the demands of the secular state.”<sup>66</sup>

The chief lesson of this history is that while the Constitution does not provide a *right* to be exempt from military service and Congress retains

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<sup>63</sup> *Id.* at 340. In his concurrence, Justice Harlan explained that the Court essentially eliminated “the statutorily required religious content for a conscientious objector exemption.” *Id.* at 345.

<sup>64</sup> *Id.* at 342–43.

<sup>65</sup> 401 U.S. 437 (1971).

<sup>66</sup> *Id.* at 445. The *Gillette* Court held that Congress intended to exempt those who opposed all war, not select wars. *Id.* at 447. Stone contends that:

at least in those countries where the political theory obtains that the ultimate end of the state is the highest good of its citizens, both morals and sound policy require that the state should not violate the conscience of the individual. All our history gives confirmation to the view that liberty of conscience has a moral and social value which makes it worthy of preservation at the hands of the state. So deep in its significance and vital, indeed, is it to the integrity of man’s moral and spiritual nature that nothing short of the self-preservation of the state should warrant its violation; and it may well be questioned whether the state which preserves its life by a settled policy of violation of the conscience of the individual will not in fact ultimately lose it by the process.

Stone, *supra* note 52, at 269.

Furthermore, Stone argues that:

there may be and probably is a very radical distinction between compelling a citizen to refrain from acts which he regards as moral but which the majority of his fellow citizens and the law regard as immoral or unwholesome to the life of the state on the one hand, and compelling him on the other to do affirmative acts which he regards as unconscientious and immoral. The action of the state in compelling the citizen to refrain from doing an act which he regards as moral and conscientious does not in most instances which are likely to occur do violence to his conscience; but conscience is violated if he is coerced into doing an act which is opposed to his deepest convictions of right and wrong. The traditional view of the common law that right motives are no defense for crime and should not stay the hand of the law gives very little clue, therefore, to the sound method of dealing with the conscientious objector to war, in the realm of either morals or policy. However rigorous the state may be in repressing the commission of acts which are regarded as injurious to the state, it may well stay its hand before it compels the commission of acts which violate the conscience.

*Id.* at 268–69.

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the power to compel an objector to serve,<sup>67</sup> the U.S. government has honored the sacredness of individual conscience, even at the risk of reduced military strength at times of critical need for manpower (most notably during the Revolutionary War).<sup>68</sup> Thus, by analogy, the idea that government should respect the consciences of medical professionals, particularly pharmacists, should not be seen as foreign or contrary to American sensibilities.<sup>69</sup>

## 2. Conscientious Objection in the Medical Profession in Twentieth and Twenty-First Century America

### a. *The States*

The right of conscience is also important to the medical community as implied by the fact that more than thirty-five percent of pharmacists say they would refuse to dispense an abortifacient with as many as forty-five percent in certain regions of the U.S. saying they would refuse.<sup>70</sup> While an examination of every state's current right-of-conscience exemptions for medical workers is beyond the scope of this Note, several examples will suffice. Fifteen states provide conscience protection that may explicitly or implicitly benefit pharmacists and even grant them a defense to civil liability in some cases.<sup>71</sup> South Dakota's law is one of the most generous conscience laws currently in force.<sup>72</sup> At the other end of

<sup>67</sup> Georgia Chudoba, Note, *Conscience in America: The Slippery Slope of Mixing Morality with Medicine*, 36 Sw. L.J. 85, 93 (2007).

<sup>68</sup> See *supra* note 47 and accompanying text (noting that conscientious objection was honored even during the impending invasion of Philadelphia during the Revolutionary War and likewise by the colony of Pennsylvania at the beginning of the French and Indian War).

<sup>69</sup> Cf. *supra* note 66 and accompanying text (explaining that the Supreme Court has acknowledged Congress's recognition of the value of conscientious action to the democratic community).

<sup>70</sup> Spreng, *supra* note 29, at 218.

<sup>71</sup> Spreng construes the statutory language of Arkansas, Colorado, Florida, Illinois, Mississippi, and Tennessee to provide exemption from civil liability to pharmacists. *Id.* at 218 n.20. California, Maine, New York, North Carolina, Oregon, West Virginia, and Wyoming also offer conscience legislation that may benefit pharmacists. Spreng, *supra* note 42, at 374. South Dakota has passed a broad conscience law for pharmacists, affording them protection from civil liability. S.D. CODIFIED LAWS § 36-11-70 (2008); Georgia's conscience law also provides protection from civil liability. GA. CODE ANN. § 16-12-142 (2008). Thus, approximately fifteen states offer conscience legislation of potential use to pharmacists as of 2008. Spreng, *supra* note 42, at 374. Nelson stated in 2005 that, every state except Vermont offered healthcare providers at least some conscience protections in at least some contexts. Nelson, *supra* note 32, at 149. For instance, forty-five states allowed healthcare providers to refuse to participate in abortions. *Id.* at 142.

<sup>72</sup> The South Dakota law reads as follows:

the spectrum are “must-fill” laws, such as that of New Jersey.<sup>73</sup> Spreng notes that New Jersey’s law features some loopholes pharmacists could exploit (similar loopholes exist in other must-fill laws).<sup>74</sup> For instance,

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[n]o 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 [ . . . ]; or
- (3) Cause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.

No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist.

S.D. CODIFIED LAWS § 36-11-70 (2008).

<sup>73</sup> The New Jersey law provides that:

a. A pharmacy practice site has a duty to properly fill lawful prescriptions for prescription drugs or devices that it carries for customers, without undue delay, despite any conflicts of employees to filling a prescription and dispensing a particular prescription drug or device due to sincerely held moral, philosophical or religious beliefs.

b. If a pharmacy practice site does not have in stock a prescription drug or device that it carries, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer:

(1) to obtain the drug or device under its standard expedited ordering procedures; or

(2) to locate a pharmacy that is reasonably accessible to the patient and has the drug or device in stock, and transfer the prescription there in accordance with the pharmacy practice site’s standard procedures.

The pharmacy practice site shall perform the patient’s chosen option without delay. If the patient so requests, the pharmacist shall return an unfilled prescription to the patient.

c. If a pharmacy practice site does not carry a prescription drug or device, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer to locate a pharmacy that is reasonably accessible to the patient and has the drug or device in stock.

N.J. STAT. ANN. § 45:14-67.1 (West 2008).

<sup>74</sup> Spreng, *supra* note 29, at 264. Washington’s statute requires pharmacies to stock and distribute prescription and non-prescription medications; the pharmacist may return or transfer medications only if he has made a good-faith effort to stock and distribute the drug. *Id.* Massachusetts, Nevada, and New Jersey feature must-fill laws; Pennsylvania requires that pharmacists not abandon patients and that pharmacies “ensure timely access” to contraceptives. NATIONAL WOMEN’S LAW CENTER, PHARMACY REFUSALS: STATE LAWS, REGULATIONS, AND POLICIES, (2009), <http://www.nwlc.org/pdf/PharmacyRefusalPoliciesJanuary2009.pdf>). The pharmacy boards of six states (Alabama, Delaware, New York, North Carolina, Oregon, and Texas) have interpreted professional obligations so as to prohibit pharmacists from obstructing access or refusing to refer or transfer prescriptions, but these interpretations are not legally binding. *Id.* California has a must-fill law, but it provides an exemption for an objecting pharmacist. CAL. BUS. & PROF. CODE § 733 (West 2008). Maine also has a must-fill law, but it too provides a conscience exemption. ME. REV. STAT. ANN. tit. 22, § 1903 (2008). Illinois, while providing some protection and liability immunity for healthcare workers (including pharmacists), has a conflicting must-fill law.

this law applies only to prescriptions, not over- or behind-the-counter medicines; it applies to pharmacies and not pharmacists; and it is not facially neutral in how it targets the religious beliefs of pharmacists; Spreng claims that this law is “not a sufficient basis in which to ground a duty to sell a non-prescription drug.”<sup>75</sup>

Illinois, a state that makes for a good study of the conscience law controversy, features the Right of Conscience Act, the purpose of which is to ensure protection for the consciences and job security of health care workers.<sup>76</sup> The court in *Vandersand v. Wal-Mart Stores, Inc.*,<sup>77</sup> held that the Right of Conscience Act covers pharmacists because dispensing medicines “constitutes health care services.”<sup>78</sup>

However, in 2005, then-Governor of Illinois Rod Blagojevich issued an Emergency Amendment to part of the state’s administrative code that obligates Division I pharmacies to dispense contraceptives.<sup>79</sup> This

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*See infra* notes 76–85 and accompanying text (discussing pertinent Illinois laws). Jessica D. Yoder notes that from a practical perspective, stocking contraceptives may not be a wise business decision as there may be little demand for them at a particular pharmacy or their presence at the pharmacy may repel potential customers. Jessica D. Yoder, Note, *Pharmacists’ Right of Conscience: Strategies for Showing Respect for Pharmacists’ Beliefs While Maintaining Adequate Care for Patients*, 41 VAL. U. L. REV. 975, 1014–15 (2006). She explains that with about 10,000 drugs on the market, pharmacies have to decide which of those will be most profitable and that the cost of stocking a drug for which there is little demand may be higher than the losses from turning away the few people who might want it. *Id.* at 1015.

<sup>75</sup> Spreng, *supra* note 29, at 263. In analyzing laws that allegedly impose a duty to dispense, Spreng points out that there is some key language to look for. *Id.* at 262. First, does the law target pharmacies or pharmacists? *Id.* Obviously, one that addresses only pharmacies does not create a duty to dispense for individual pharmacists. *Id.* Secondly, does the law deal only with prescription medications? *Id.* If so, a pharmacist may still be able to avoid interfacing with Plan-B because it is now most commonly available behind-the-counter like many cough syrups and may not require a prescription (of course, this does not help a pharmacist avoid dispensing prescription-only drugs used in euthanasia or execution settings). *Id.* at 238, 262. Finally, does the language of the statute expressly or by implication target religion or religious believers? *Id.* at 262. If so, the law could be attacked for violating the Free Exercise Clause of the First Amendment or similar state provisions. *Id.*

<sup>76</sup> 745 ILL. COMP. STAT. 70/2 (2008). The law exempts healthcare providers from civil or criminal liability for refusing to “perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.” *Id.* § 70/4.

<sup>77</sup> 525 F. Supp. 2d 1052 (C.D. Ill. 2007).

<sup>78</sup> *Id.* at 1057. *Vandersand* involved a suit by a pharmacist against his employer, Wal-Mart, after it placed him on leave without pay because he refused to dispense the morning-after pill. *Id.* at 1053.

<sup>79</sup> The pertinent part of ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2008), reads:

- 1) Upon receipt of a valid, lawful prescription for a contraceptive, a retail pharmacy serving the general public must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient’s agent without delay, consistent with

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the normal timeframe for filling any other prescription, subject to the remaining provisions of this subsection (j). If the contraceptive, or a suitable alternative, is not in stock, the pharmacy must obtain the contraceptive under the pharmacy's standard procedures for ordering contraceptive drugs not in stock, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. However, if the contraceptive, or a suitable alternative, is not in stock and the patient prefers, the prescription must be transferred to a local pharmacy of the patient's choice under the pharmacy's standard procedures for transferring prescriptions for contraceptive drugs, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. Under any circumstances an unfilled prescription for contraceptive drugs must be returned to the patient if the patient so directs.

- 2) Each retail pharmacy serving the general public shall use its best efforts to maintain adequate stock of emergency contraception to the extent it continues to sell contraception (nothing in this subsection (j)(2) prohibits a pharmacy from deciding not to sell contraception). Whenever emergency contraception is out-of-stock at a particular pharmacy and a prescription for emergency contraception is presented, the pharmacist or another pharmacy registrant shall attempt to assist the patient, at the patient's choice and request, in making arrangements to have the emergency contraception prescription filled at another pharmacy under the pharmacy's standard procedures for transferring prescriptions for contraceptive drugs, including the procedures of any entity that is affiliated with, owns or franchises the pharmacy.
- 3) Dispensing Protocol—In the event that a licensed pharmacist who objects to dispensing emergency contraception (an "objecting pharmacist") is presented with a prescription for emergency contraception, the retail pharmacy serving the general public shall use the following dispensing protocol:
  - A) All other pharmacists, if any, then present at the location where the objecting pharmacist works (the "dispensing pharmacy") shall first be asked to dispense the emergency contraception (any pharmacist that does not object to dispensing these medications is referred to as a "non-objecting pharmacist").
  - B) If there is an objecting pharmacist and no non-objecting pharmacist is then available at the dispensing pharmacy, any pharmacy (the "remote pharmacy") or other non-objecting pharmacist shall provide "remote medication order processing" (RMOP) to the dispensing pharmacy. RMOP includes any and all services that a licensed pharmacist may provide, as well as authorizing a non-pharmacist registrant at the dispensing pharmacy, to dispense the emergency contraception to the patient under the remote supervision of a non-objecting pharmacist. For purposes of this subsection (j) and the Pharmacy Practice Act, a registered pharmacy technician is authorized to engage in RMOP involving emergency contraception.

*Id.* Division I pharmacies are those that engage in general community pharmacy practice and that are open to, or offer pharmacy service to, the general public. ILL. ADMIN. CODE tit. 68, § 1330.5 (2006).

amendment was the crux of *Menges v. Blagojevich*,<sup>80</sup> a suit against the governor and other state officials by Walgreens pharmacists who lost their jobs for not abiding by the amendment's provisions.<sup>81</sup> The *Menges* court denied the governor's motion to dismiss the pharmacists' complaint and held that the pharmacists' allegations substantiated a claim.<sup>82</sup> The court further explained that the amendment was passed in response to pharmacists who had moral and religious objections to dispensing emergency contraceptives and that Blagojevich "reaffirmed publicly his position that the Rule was directed at individual pharmacists who object to dispensing certain drugs on moral grounds[,] and he stated that such pharmacists "should find another profession."<sup>83</sup>

The court questioned the amendment's constitutional validity, noting that even a facially neutral law—like the amendment—cannot have the hidden purpose of attacking religious beliefs, lest the Free Exercise Clause of the First Amendment be violated.<sup>84</sup> The court held that the amendment could fail strict scrutiny analysis for unconstitutionally targeting pharmacists engaging in free exercise rights because Governor Blagojevich's comments suggested that the law was intended to coerce objecting pharmacists and because the law did not cover hospitals or emergency rooms and burdens pharmacists in ways it does not burden pharmacies.<sup>85</sup>

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<sup>80</sup> 451 F. Supp. 2d 992 (C.D. Ill. 2006).

<sup>81</sup> *Id.* at 998.

<sup>82</sup> *Id.* at 1005, 1003.

<sup>83</sup> *Id.* at 997.

<sup>84</sup> *Id.* at 999–1000. The First Amendment of the United States Constitution provides in part that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . ." U.S. CONST. amend. I. Yoder points out that Illinois' must-fill law's directive that emergency contraception be dispensed "'without delay'" could hinder pharmacists' duties to "screen for drug-drug interactions, drug-food interactions, drug-allergy interactions, incorrect dosage, incorrect duration, and clinical abuse or misuse, all of which naturally involve some 'delay.'" Yoder, *supra* note 74, at 1018.

<sup>85</sup> *Menges*, 451 F. Supp. 2d at 1000–02. In December 2008, the Illinois Supreme Court held that two pharmacists had standing to bring a suit against Governor Blagojevich and several other Illinois state officials on a First Amendment claim. *Morr-Fitz v. Blagojevich*, 901 N.E.2d 373, 387 (Ill. 2008). The pharmacists claimed that the Emergency Amendment burdened their free exercise of religion, was not narrowly tailored or the least restrictive means of serving a government interest, and was intended to coerce objecting pharmacists to fill Plan-B prescriptions despite their objections. *Id.* The court noted that "[c]ourts have specifically found that pharmacists and pharmacies in similar cases involving state regulation requiring the dispensing of Plan B contraception have sufficiently stated causes of action that could be considered by the judiciary." *Id.* The court further explained that "[i]f a rule is facially neutral as to the text, a court must then look beyond the face of the rule to determine the true object of the statute," and "[w]here the object of the rule is to infringe upon or restrict practices because of their religious motivation, the law is not neutral, and it is invalid unless it is justified by a compelling interest and is narrowly

The Supreme Court upheld a right-of-conscience clause for physicians in *Doe v. Bolton*,<sup>86</sup> the companion case to *Roe v. Wade*.<sup>87</sup> While the Court struck down several provisions of Georgia's criminal law dealing with abortion, it left intact a section providing that any physician or hospital staff member could, for moral or religious reasons, refuse to participate in an abortion procedure without civil or employment-related repercussions.<sup>88</sup>

In sum, state law remains a cornucopia of provisions both friendly and hostile toward conscientious healthcare workers.<sup>89</sup> Practically every state offers exemptions to those healthcare providers who object to participating in abortions or sterilizations.<sup>90</sup> Consequently, a state's desire to protect pharmacists' consciences should not be seen as an unprecedented overture to the healthcare community in light of the conscience protection many states already offer to health practitioners.<sup>91</sup>

*b. The Federal Government*

Shortly after the Supreme Court produced its *Roe v. Wade* decision in 1973, Congress passed the Church Amendment, which prohibits both coercing public officials to participate in acts contrary to their beliefs, particularly abortions and sterilizations, and discriminating against them.<sup>92</sup> Granted, the power of the Act extends only as far as the funds attached to it.<sup>93</sup>

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tailored to advance that interest." *Id.* at 389 (citing *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 533–34 (1993)).

On April 6, 2009, a Sangamon county judge temporarily barred the Governor of Illinois and other state officials from enforcing Blagojevich's Emergency Amendment, holding that two Illinois pharmacists who refused to pledge to comply with the order had a meritorious claim and that the Emergency Amendment violated the state's Right of Conscience Act. Kathleen Gilbert, *Illinois Judges [sic] Upholds Pharmacists' Conscience Rights*, LifeSiteNews.com, April 6, 2009, <http://www.lifesitenews.com/ldn/2009/apr/09040604.html> (last visited May 19, 2009).

<sup>86</sup> 410 U.S. 179, 201 (1973).

<sup>87</sup> 410 U.S. 113 (1973).

<sup>88</sup> *Bolton*, 410 U.S. at 201, 205. Spreng explains that "[f]ederal constitutional protection for religious liberty has waxed and waned in the past few decades, but the Supreme Court has consistently upheld federal and state statutory accommodations of religious practice and belief, including some analogous to pharmacist conscience clauses." Spreng, *supra* note 42, at 383 (footnotes omitted).

<sup>89</sup> See *supra* notes 71–75 and accompanying text (discussing conscience laws and must-fill laws in the United States).

<sup>90</sup> See *supra* note 71 (explaining that almost every state offers at least some conscience protection in at least some contexts).

<sup>91</sup> See *supra* Part II.B.2.a (describing state conscience laws).

<sup>92</sup> Nelson, *supra* note 32, at 148. The Act is named for Senator Frank Church, its sponsor. *Id.* The Act reads, in part:

Per the Public Health Service Act, the federal government and any state or local government receiving federal funds is prohibited from discriminating against healthcare workers who refuse to participate in training for, provision of, or referral for abortions.<sup>94</sup> In discussing a

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(b) Prohibition of public officials and public authorities from imposition of certain requirements contrary to religious beliefs or moral convictions.

The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C. 201 et seq.], the Community Mental Health Centers Act [42 U.S.C. 2689 et seq.], or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. 6000 et seq.] by any individual or entity does not authorize any court or any public official or other public authority to require—

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to—

(A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

(c) Discrimination prohibition.

(1) No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C. 201 et seq.], the Community Mental Health Centers Act [42 U.S.C. 2689, or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. 6000 et seq.] after the date of enactment of this Act [enacted June 18, 1973] may—

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.

42 U.S.C. § 300a-7 (2006).

<sup>93</sup> See 42 U.S.C. §§ 300a-7(b)-(e) (2006) (indicating that these sections of the U.S. Code apply to federally funded programs and entities).

<sup>94</sup> 42 U.S.C. § 238n provides, in part, that:

(a) In general

regulation in the state of Washington that would require objecting pharmacists to refer patients elsewhere, the district court in *Stormans Inc. v. Selecky*<sup>95</sup> noted that “[f]ederal and state law provide a clear right to health care providers to not participate in abortion procedures.”<sup>96</sup> Further, as part of its Title X regulations, the federal government has prohibited requiring public or private persons to provide or pay for abortion services.<sup>97</sup> In 2005, Congress passed the Hyde-Weldon Amendment as part of the Appropriations Bill for the Departments of Labor, Health and Human Services, and Education, thereby denying Title X funds to any federal agency or program and any state or local

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The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—

- (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;
- (2) the entity refuses to make arrangements for any of the activities specified in paragraph (1); or
- (3) the entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

42 U.S.C. § 238n (2006).

<sup>95</sup> 524 F. Supp. 2d 1245 (W.D. Wash. 2007), *motion to stay injunction denied*, 526 F.3d 406, 408 (9th Cir. 2008), *vacated and remanded*, 571 F.3d 960, 964 (9th Cir. 2009), *petition for rehearing en banc denied*, Nos. 07-36039, 07-36040, 2009 WL 3448435, at \*1 (9th Cir. Oct. 28, 2009). The Ninth Circuit held that the district court applied the wrong level of review to the must-fill law and that the injunction it issued was overbroad. 571 F.3d 960, 964.

<sup>96</sup> *Id.* at 1263–64. The district court in *Stormans* granted a preliminary injunction pending appeal against regulations that would have prohibited a pharmacist from refusing to fill a prescription even if the pharmacist immediately referred the patient to another pharmacy. *Id.* at 1266. Wendy Wright explains that over the past thirty-five years, the Department of Health and Human Services has held that programs it funds cannot discriminate against healthcare providers for refusing to participate in acts to which they object. Wendy Wright, *HHS Secretary Addresses Abortion Groups’ Lies, Seeks to Protect Pro-Life Doctors and Patients*, CONCERNED WOMEN FOR AMERICA, Aug. 12, 2008, <http://www.cwfa.org/articledisplay.asp?id=15631&department=CWA&categoryid=freedom> (last visited Aug. 16, 2009).

<sup>97</sup> 20 U.S.C. § 1688 (2006). The statute provides that:

[n]othing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion. Nothing in this section shall be construed to permit a penalty to be imposed on any person or individual because such person or individual is seeking or has received any benefit or service related to a legal abortion.

*Id.*

program that discriminates against any healthcare entity that refuses to provide, pay for, provide coverage for, or refer for abortions.<sup>98</sup>

Title VII of the Civil Rights Act of 1964 provides the clearest prohibition against discrimination based on religious beliefs and encompasses public and private actors.<sup>99</sup> Thus, 42 U.S.C. § 2000e-2(a)(1) unequivocally states that employers may not “discharge any individual” or “discriminate against any individual . . . because of such individual’s race, color, religion, sex, or national origin.”<sup>100</sup> The statute defines religion as “all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee’s or prospective employee’s religious observance or practice without undue hardship on the conduct of the employer’s business.”<sup>101</sup> To illustrate, one of the claims put forward in *Vandersand v. Wal-Mart Stores* was religious discrimination in violation of Title VII.<sup>102</sup> The court explained that “[a]n undue hardship is anything that imposes more than a *de minimus* [sic] burden on the employer” and that the pharmacist bringing the claim in the case would need to show that he “engages in . . . a religious observance . . . that conflicts with an employment requirement[,]” that he informed his employer of this observance, and that the observance was the employer’s basis for

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<sup>98</sup> Consolidated Appropriations Act Pub. L. No. 110-161, § 508(a)-(d), 121 Stat. 1844, 2209 (2007). The Amendment states:

(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage for, or refer for abortions.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

*Id.*

<sup>99</sup> See 42 U.S.C. § 2000e-2(a)(1) (2006) (providing that failing or refusing to hire someone on account of religion is unlawful). Amy Bergquist explains that:

[a]bsent legislation, the federal government has little influence over employment policies relating to religion. The First Amendment constrains government employers, but it has a negligible effect on the policies of private employers . . . Title VII of the Civil Rights Act restricts both private and public employers’ right to terminate, discipline, or refuse to hire employees on religious grounds.

Bergquist *supra*, note 17, at 1078.

<sup>100</sup> 42 U.S.C. § 2000e-2(a)(1) (2006).

<sup>101</sup> *Id.* § 2000e(j).

<sup>102</sup> 525 F. Supp. 2d 1052, 1053 (C.D. Ill. 2007).

adverse employment action.<sup>103</sup> Thus, an objecting pharmacist, in order to have his or her moral objections accommodated, could not demand concessions that would impose an undue burden on the employer.<sup>104</sup>

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<sup>103</sup> *Id.* at 1055 (citing *Reed v. Great Lakes Cos.*, 330 F.3d 931, 935 (7th Cir. 2003)). The court held that Vandersand stated a claim and that it was not impossible for Wal-Mart to comply with Governor Blagojevich's Emergency Amendment while also accommodating Vandersand because the amendment required pharmacies and not pharmacists individually to dispense contraceptives. *Id.* at 1056. The court in *Menges* also had to decide if the Governor's amendment violated Title VII. *Menges v. Blagojevich*, 451 F. Supp. 2d 992, 1002-03 (C.D. Ill. 2006). The court explained that "[a] rule that mandates religious discrimination by employers would conflict with Title VII and would be preempted" and that "[i]f the Plaintiffs can prove that the burden of accommodating their beliefs is so slight, then the Plaintiffs' religious beliefs in opposition to Emergency Contraceptives may be within Title VII's definition of religion." *Id.* at 1003.

<sup>104</sup> As an example, Maxine M. Harrington cites to *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141 (5th Cir. 1982), a case in which a pharmacist refused to work on the Sabbath. Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779, 792 (2007). The employer accommodated the pharmacist and traded his Saturday shifts. *Id.* Ultimately, when the pharmacist was unable to trade shifts on several religious holidays, the employer terminated him. *Id.* The pharmacist sued the employer for religious discrimination, but the court upheld the termination because the employer had made a reasonable attempt at accommodation. *Id.* The pharmacist's demands disrupted the pharmacy's work routines and lowered morale; hiring another pharmacist would have created an undue hardship on the employer. *Id.*

Likewise, the accommodations sought by pharmacist Neil Noesen were, according to the Seventh Circuit, too burdensome. *Noesen v. Med. Staffing Network, Inc.*, 232 Fed. App'x 581, 584 (2007). Although his employer, Wal-Mart, was able and willing to accommodate him to an extent, Noesen refused to answer telephone calls from individuals with birth control inquiries. *Id.* at 583. The Seventh Circuit held that "an accommodation that requires other employees to assume a disproportionate workload (or divert them from their regular work) is an undue hardship as a matter of law." *Id.* at 584-85.

On the other hand, in *Hellinger v. Eckerd Corp.*, 67 F. Supp. 2d 1359 (S.D. Fla. 1999), the court held that a pharmacist's employer had failed to reasonably accommodate his objection to selling condoms. Harrington, *supra* at 792. The employer claimed that hiring another pharmacist would be an undue burden, but the court "rejected as speculative the [employer's] suggestion that asking customers to go to another register to pay for the condoms would cause a loss of customers, goodwill, and revenue." *Id.* at 792.

An example of a claim outside the pharmaceutical context comes from *Am. Postal Workers Union v. Postmaster Gen.*, a case where two postal workers challenged the accommodations offered to them by the post office after they indicated that processing draft registration forms conflicted with their religious beliefs. 781 F.2d 772, 774-75 (9th Cir. 1986). The Ninth Circuit cited two cases, *Anderson v. Gen. Dynamics Convair Aerospace Div.*, 589 F.2d 397, 401 (9th Cir. 1979) (holding that the plaintiff employee established a prima facie case of religious discrimination and that the burden then shifted to the employer to prove that it made a good faith effort to accommodate the employee's beliefs or to explain why it could not successfully do so), and *Burns v. S. Pac. Transp. Co.*, 589 F.2d 403, 406 (9th Cir. 1979) (holding, in part, that "[o]nce the employer has made more than a negligible effort to accommodate the employee . . . and that effort is viewed by the worker as inadequate, the question becomes whether the further accommodation requested would constitute 'undue hardship[]'") in concluding that an employer must offer a reasonable

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In August, 2008, the Department of Health and Human Services (“HHS”) issued a proposed rule that was intended to “ensure that Department funds do not support morally coercive or discriminatory practices or policies in violation of federal law” and “that recipients of Department funds know about their legal obligations under . . . nondiscrimination provisions . . .”<sup>105</sup> This proposal was published in the Federal Register on December 19, 2008, and took effect thirty days thereafter with certain components to be phased in by October 1, 2009.<sup>106</sup>

In response to the American College of Obstetricians and Gynecologists’ new guidelines that could require a doctor to receive training for and actually perform abortions in order to be deemed competent, Secretary of HHS, Michael O. Leavitt, explained that federal law is unequivocal in its protection of the consciences of federally-funded healthcare workers and asserted that compelling doctors or those who assist them to violate their consciences contravenes federal law.<sup>107</sup>

The regulation issued by HHS is intended both to increase compliance with already existing federal laws that attach anti-discrimination provisions to certain federal funds and to make clear that these rules apply to healthcare providers *and* the employees of recipients of certain HHS funds.<sup>108</sup> Failure to comply with federal law could result in the termination of funding to the entity and a demand for the return of funds already paid while the entity was in violation.<sup>109</sup> Although the regulation does not mention pharmacists specifically, it defines “health care entity” by adopting the definitions articulated in the Public Health Service Act and the Weldon Amendment, which include “other healthcare professional”—language that presumably encompasses pharmacists.<sup>110</sup>

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accommodation to an employee but that the employee in turn must be reasonable in accepting or refusing that accommodation. *Am. Postal Workers Union*, 781 F.2d at 776. In the case at hand, the post office made a reasonable accommodation and the employees’ declination stemmed not from a bona fide religious objection, but from a dislike for the new position. *Id.*

<sup>105</sup> Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50274 (proposed Aug. 26, 2008) (to be codified at 45 C.F.R. pt. 88).

<sup>106</sup> U.S. Department of Health and Human Services, News Release: HHS Issues Final Regulation to Protect Health Care Providers from Discrimination, <http://www.hhs.gov/news/press/2008pres/12/20081218a.html> (last visited Dec. 26, 2008).

<sup>107</sup> Posting of Michael O. Leavitt to Physician Conscience Blog III, [http://archive.hhs.gov/secretarysblog/my\\_weblog/physician\\_conscience/index.html](http://archive.hhs.gov/secretarysblog/my_weblog/physician_conscience/index.html) (Aug. 21, 2008).

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> See 45 C.F.R. § 88.2 (2009) (defining “health care entity”). The Public Health Service Act defines health care entity as an “individual physician, a postgraduate physician training program, [or] a participant in a program of training in the health professions” 42

On February 27, 2009, President Barack Obama's administration took steps to rescind this conscience rule, claiming that although the rule was intended to bring clarity to current federal law, it instead has created confusion and compromises access by women to "care they need," including "family planning[.]"<sup>111</sup> The public comment period for the initiative to rescind the rule ended at midnight on April 9, 2009, and if the administration formally decides to rescind the rule, it will have to begin a rule-making process to issue a new rule.<sup>112</sup>

Controversy over the regulation stemmed, in part, from a provision that enables healthcare workers to abstain from participating in abortions that they may define as terminating a human life before or

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U.S.C. § 238n(c)(2) (2006). The Weldon Amendment defines the term as "'includ[ing] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.'" Consolidated Appropriations Act, Pub. L. No. 110-161, § 508(d)(2), 121 Stat. 1844, 2209 (2007).

<sup>111</sup> Noam Levey, *Obama Dropping Abortion Conscience Rule*, THE SWAMP, Feb. 27, 2009, [http://www.swamppolitics.com/news/politics/blog/2009/02/obama\\_drops\\_abortion\\_conscienc.html](http://www.swamppolitics.com/news/politics/blog/2009/02/obama_drops_abortion_conscienc.html) (last visited Aug. 16, 2009).

Obama may sign into law the Freedom of Choice Act ("FOCA"), a piece of legislation that would

invalidate any "statute, ordinance, regulation, administrative order, decision, policy, practice, or other action" of any federal, state, or local government or governmental official (or any person acting under government authority) that would "deny or interfere with a woman's right to choose" abortion, or that would "discriminate against the exercise of the right . . . in the regulation or provision of benefits, facilities, services, or information."

Denise M. Burke, *The Freedom of Choice Act: A Radical Attempt to Prematurely End Debate Over Abortion*, <http://www.aul.org/FOCA> (last visited Jan. 4, 2009).

Under FOCA, "no healthcare provider will be able to conscientiously object to a woman's request to have an abortion." *Deborah Sturm, Whose Choice? Protecting Healthcare Providers' Conscience Rights*, <http://www.cuf.org/Laywitness/LWonline/jf09sturm.asp> (last visited Jan. 4, 2009).

<sup>112</sup> Kathleen Gilbert, *Last Chance to Ask Obama Administration to Retain Conscience Protections for Pro-Life Doctors*, LifeSiteNews.com, April 6, 2009, <http://www.lifesitenews.com/ldn/2009/apr/09040608.html> (last visited May 19, 2009); Levey, *supra* note 111.

Dr. Donald Thompson of the Christian Medical Association argues that "repealing the rules would only exacerbate the shortage of doctors the nation is experiencing" and that repealing conscience protection "'could drive thousands of faith-based physicians out of medicine and close faith-based hospitals that provide over 17% of the health care delivered in the United States.'" Steven Ertelt, *Pro-Life Doctor: Obama's Repealing Conscience rules would Hurt Health Care*, LifeSiteNews.com, May 8, 2009, <http://www.lifenews.com/nat5033.html> (last visited May 19, 2009). A poll taken in March, 2009, indicated that 78% of participants who support legal abortions favor conscience protections for medical staff and centers and that 62% of respondents opposed revocation of the rule enacted under the Bush Administration. Steven Ertelt, *Poll: Americans Want Obama to Keep Abortion Conscience Clause in Place*, LifeSiteNews.com, April 8, 2009, <http://www.lifenews.com/nat4975.html> (last visited May 19, 2009).

after implantation.<sup>113</sup> Someone in HHS leaked the proposed regulation to the *New York Times*, claiming that it redefined abortion to include contraception.<sup>114</sup> Leavitt emphasized that this regulation is not intended to redefine or change abortion rights, but is about preventing coercion of doctors to engage in practices they find conscientiously objectionable.<sup>115</sup> Leavitt has observed that “[o]ur nation was built on a foundation of free speech. The first principle of free speech is protected conscience. Th[e] proposed rule is a fundamental protection for medical providers to follow theirs.”<sup>116</sup>

Indeed, because the First Amendment of the federal Constitution provides in part that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof[,]” it may be the ultimate refuge for pharmacists and other healthcare workers seeking protection from coercive laws.<sup>117</sup> Maxine M. Harrington states that “[l]egislative accommodations are reasonable and consistent with the Establishment Clause when they have a secular purpose and do not serve primarily to advance religion or foster an excessive entanglement with religion[,]” and that an incidental benefit to religion or even an explicit reference to it does not make the law violative of the Establishment Clause.<sup>118</sup> Although absolute religious accommodations

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<sup>113</sup> Wright, *supra* note 96.

<sup>114</sup> *Id.*

<sup>115</sup> Posting of Michael O. Leavitt to Physician Conscience Blog II, [http://archive.hhs.gov/secretarysblog/my\\_weblog/physician\\_conscience/index.html](http://archive.hhs.gov/secretarysblog/my_weblog/physician_conscience/index.html) (Aug. 11, 2008).

<sup>116</sup> *Id.* HHS expressly exempted the conscience regulation from Title VII’s provision that an employer must accommodate an employee only to the extent that doing so would not be an undue burden. Kim Worobec & Jennifer Gray, *HHS’ New Provider Conscience Regulations*, 21 NO. 4 HEALTH LAW 35, 36 (2009).

<sup>117</sup> U.S. CONST. amend. I.

<sup>118</sup> Harrington, *supra* note 104, at 828. See *infra* notes 179–93 and accompanying text (explaining that there is a distinction between laws that alleviate government-imposed burdens on religious believers and laws that expand the rights of believers).

Matthew White suggests that although there are ways of challenging conscience clauses’ constitutionality, they are well-established in state law and thus protections for pharmacists are unlikely to be overturned. Matthew White, Note, *Conscience Clauses for Pharmacists: The Struggle to Balance Conscience Rights with the Rights of Patients and Institutions*, 2005 WIS. L. REV. 1611, 1631–34 (2005). See *infra* notes 168, 182 (discussion of White’s arguments). Tom C. W. Lin also believes that pharmacist conscience laws would pass a religious establishment test. Tom C. W. Lin, *Treating an Unhealthy Conscience: A Prescription or Medical Conscience Clauses*, 31 VT. L. REV. 105, 114 (2006). See *infra* note 182 (brief discussion of Lin’s observation).

However, Melissa Duvall has also examined the constitutionality of pharmacist conscience laws and suggests that they should fail if they do not contain referral or emergency provisions. Melissa Duvall, Note, *Pharmacy Conscience Clause Statutes: Constitutional Religious “Accommodations” or Unconstitutional “Substantial Burdens” on Women?* 55 AM. U. L. REV. 1485, 1506, 1517–18 (2006). See *infra* note 185 (further discussing Duvall’s argument).

run afoul of the Establishment Clause, recent health conscience laws are probably not unconstitutional because they do not endorse or advance religion or religious practices, respectively, despite the fact that some of these laws grant health practitioners an absolute right to refuse services.<sup>119</sup>

The key to effective and successful conscience laws is ensuring that they protect secular ethical or moral refusals in addition to religious conscientious objections, thereby making the laws more likely to withstand a First Amendment challenge.<sup>120</sup> If a conscience law implies

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<sup>119</sup> Harrington, *supra* note 104, at 829. Spreng argues that “the protections the United States Constitution provides to refusing pharmacists are uncertain at this time. Therefore, statutory conscience protections from legal liability could be crucial to dissenting pharmacists’ futures in the profession.” Spreng, *supra* note 42, at 354. Furthermore, conscience clauses are underutilized in direct challenges to must-fill requirements. But with good drafting and in light of recent Supreme Court Establishment Clause precedent, they could be more productive protection than the Free Exercise Clause or, at minimum, provide an additional line of attack against a liability suit in an area where federal constitutional law is increasingly complicated.

*Id.* at 371 (footnotes omitted).

<sup>120</sup> Harrington, *supra* note 104, at 829–30. As is discussed at length in Part III, objecting pharmacists must be aware of the fact that use of contraceptives is a fundamental right and that the free exercise of religion may not necessarily exempt a person from compliance with a neutral and generally applicable law. See *infra* notes 166–93 and accompanying text (discussing constitutional issues related to pharmacist conscience laws); Employment Div., Dept. of Human Res. of Or. v. Smith, 494 U.S. 872, 879 (1990) (holding that religious believers may be subject to neutral and generally applicable laws); *Griswold v. Conn.*, 381 U.S. 479, 484–86, 503–04 (1965) (White, J., concurring) (holding that the right to use contraceptives is grounded in a constitutional right to privacy).

However, a general constitutional right to healthcare does not exist. Cf. *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 265, 278 (1990) (holding that parents did not have authority to withdraw disabled daughter’s artificial feeding and hydration equipment because there was no clear and convincing evidence of daughter’s desire to have life-sustaining treatment withdrawn). States can, pursuant to the Tenth Amendment, enact conscience laws consistent with their police powers to ensure the health, safety, and welfare of their citizens. See Brian P. Kneestout, Note, *An Essential Prescription: Why Pharmacist-Inclusive Conscience Clauses are Necessary*, 22 J. CONTEMP. HEALTH L. & POL’Y 349, 351 (2006); *infra* notes 150–59 and accompanying text (discussing fact that health care is not a right and inconvenience may not be adequate basis for demanding dispensing of medicines).

Furthermore, an incidental burden on a constitutional right is different from a substantial burden on that right. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (distinguishing between substantial and incidental burdens). The federal government can, consistent with the Establishment Clause, relieve an entity from a burden on its religious expression imposed by the government itself. See *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005) (holding that the Religious Land Use and Institutionalized Persons Act of 2000 is “compatible with the Establishment Clause because it alleviates exceptional government-created burdens on private religious exercise[.]”); *Corp. of the Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334–35 (1987)

that its main thrust is to protect religious beliefs, the law may be viewed as endorsing religion in spite of any protection it may afford to secular beliefs.<sup>121</sup> Harrington contends that extending conscience laws to include (and perhaps emphasize) non-religious secular and moral convictions is wise and constitutional, an observation consistent with the Supreme Court's holding in *Welsh v. United States*, whereby the Court determined that beliefs purely *ethical* or *moral* in substance are sufficient to merit exemption from military service.<sup>122</sup>

In sum, the limited examples of federal medical conscientious objector protections discussed above demonstrate that government has identified healthcare providers as human beings with moral convictions who should not be conscripted into service against their consciences, even in spite of their monopoly on healing and their status as the exclusive source of society's often-needed cures and remedies.<sup>123</sup>

*c. Professional Standards*

Not surprisingly, the American Pharmacists Association ("APhA") has commented on right-of-conscience laws for pharmacists; APhA describes its two-part policy, dating back to 1998, as supporting "the ability of the pharmacist to step away from participating in activity to which they have personal objections—but not step in the way."<sup>124</sup> While APhA condones a pharmacist's refusal to dispense a drug on moral or ethical grounds, it strives to ensure that patients' needs are met.<sup>125</sup> Thus,

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(holding that the Establishment Clause permits religious exercise without sponsorship or interference by the government so long as the accommodation does not morph into fostering of religion); *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (holding that a law that has "a primary effect that impermissibly advances a particular religious practice" is unconstitutional because "the statute goes beyond having an incidental or remote effect of advancing religion[]"); *infra* notes 179-93 and accompanying text (distinguishing the granting of greater free exercise rights from alleviating a government-imposed burden on religious believers).

<sup>121</sup> Harrington, *supra* note 104, at 830.

<sup>122</sup> 398 U.S. at 340 (emphasis added).

<sup>123</sup> See *supra* notes 92-120 and accompanying text (describing conscience protection at the federal level). International consensus has begun to recognize conscientious objection as a human right. See Emily N. Marcus, *Conscientious Objection as an Emerging Human Right*, 38 VA. J. INT'L L. 507, 514-15 (1998) (stating that the International Covenant on Civil and Political Rights recognizes a right to conscience).

<sup>124</sup> American Pharmacist Association, AMA Rules on Pharmacist Conscience Clauses, <http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisplay.cfm&ContentID=8688> (last visited Aug. 16, 2009).

<sup>125</sup> *Id.* Pharmacists are also guided by a code of ethics and an oath that both compel the pharmacist to promote the welfare of the patient. American Pharmacists Association, Code of Ethics for Pharmacists, <http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisplay.cfm&ContentID=2903> (last visited Aug. 16, 2009);

APhA agrees with the American Medical Association (“AMA”) that professional service to patients is essential, a concept articulated by an AMA resolution providing, in part, that if a pharmacist conscientiously objects to dispensing a drug, he or she will refer the patient to a dispensing pharmacy.<sup>126</sup>

In 2005, Susan C. Winckler, APhA Staff Counsel and Vice President for Policy and Communications, stated that APhA believed that no pharmacist should have to participate in things he or she finds morally objectionable, but that policies should be implemented whereby the needs of both the pharmacist and patient can be met, meaning that transferring a prescription or referring it to a partner might be necessary; ultimately, Winckler asserts that “[c]onflict between the pharmacist and the patient is never acceptable.”<sup>127</sup>

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American Pharmacists Association, The Oath of a Pharmacist, <http://www.pharmacist.com/Content/NavigationMenu2/LeadershipProfessionalism/ProfessionalDevelopment/OathofaPharmacist/default.htm> (last visited Aug. 16, 2009). However, a duty to dispense medications does not exist (see *infra* notes 194–201 and accompanying text (discussing same)). Spreng, Harrington, and Maria Teresa Weidner have noted that a professional relationship between a pharmacist and patient could give rise to a duty to dispense if the patient has come to rely on that pharmacist for his or her medicines and does not have notice of that pharmacist’s moral objections. See *infra* notes 194–201 and accompanying text (discussing same); Maria Teresa Weidner, Note, *Striking a Balance Between Faith and Freedom: Military Conscientious Objection as a Model for Pharmacist Refusal*, 11 J. GENDER RACE & JUST. 369, 376–77 (2008). Thus, pharmacists have fiduciary duties, including a duty to provide informed consent that requires pharmacists to inform patients about their moral objections. See *infra* note 194 and accompanying text (discussing pharmacist duties); cf. William L. Allen and David B. Brushwood, *Pharmaceutically Assisted Death and the Pharmacist’s Right of Conscience*, 5 J. PHARMACY & L. 1, 14 (1996) (arguing that “transactions between pharmacists and consumers are circumscribed by fiduciary duty.”).

<sup>126</sup> American Pharmacist Association, *supra* note 124.

<sup>127</sup> Ed Lamb, *Dispensing with the Dilemma*, PHARMACY TODAY (Aug. 2005), available at <http://www.pharmacist.com> (search “Dispensing with the Dilemma”; then click on the first result returned) (last visited Aug. 16, 2009). As is discussed at length in Part III.A, proponents of must-fill laws commonly argue that because of pharmacists’ unique monopoly on distribution of prescription drugs, pharmacists should not hinder patient access to those drugs, especially when a woman has limited means or is living in a rural community with limited access to pharmacists. See National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, (May 2005), available at <http://www.ruralhealthweb.org/index.cfm?objectid=4075DEAB-1185-6B66-88E95A371EF681D6> (last visited Aug. 16, 2009) (discussing limited number of pharmacies in rural communities); see, e.g., Nelson, *supra* note 32, at 157; Spreng, *supra* note 29, at 229; Holly Teliska, Note, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 247 (2005) (all addressing perceived plight of women in rural areas with limited access to pharmacies); *infra* notes 137–49 and accompanying text (discussing opposition to conscience laws).

However, the common law has never recognized a duty to dispense medication. See *infra* notes 194–201 and accompanying text (discussing same). By analogy, an incidental

However, granting a pharmacist a right of conscience, but expecting him or her to refer a patient or transfer a prescription may not be much of a concession from the perspective of pharmacists who are no more willing to refer a patient than to fill her prescription.<sup>128</sup> Respect for the “autonomy and dignity of each patient” is a part of the Code of Ethics for Pharmacists, listed third after the required promotion of “the good of every patient in a caring, compassionate, and confidential manner.”<sup>129</sup> Likewise, the pharmacist’s oath requires consideration of “the welfare of humanity and relief of human suffering [as] primary concerns,” and maintenance of the “highest principles of [the] profession’s moral, ethical and legal conduct.”<sup>130</sup>

In 1995, APhA’s Pharmaceutical Care Guidelines Advisory Committee issued “Principles of Practice for Pharmaceutical Care[.]” a collection of guiding principles intended to facilitate the profession’s goal of optimizing the patient’s health-related quality of life, among other objectives.<sup>131</sup> Conscientious pharmacists may find some of the

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lack of abortion providers in a particular community has never been considered a violation of the right of a woman to have an abortion. See Yoder, *supra* note 74, at 1016 (discussing same); *infra* text accompanying notes 150–59 (discussing same). Spreng has also acknowledged this parallel, noting that “[o]nly state statutes substantially limiting access to contraception” are a problem and that there is a difference between a substantial and incidental government burden on rights. Spreng, *supra* note 42, at 400–01 (discussing same); *infra* text accompanying notes 160–65 (discussing same).

Not everyone believes that pharmacists should be able to object to dispensing legally prescribed medications. See, e.g., Minh N. Nguyen, Note, *Refusal Clauses & Pro-Life Pharmacists: How Can We Protect Ourselves from Them?* 8 SCHOLAR 251, 253 (2006); NARAL Pro-Choice America, *Guarantee Women’s Access to Prescriptions* 5 (Dec. 1, 2007), available at <http://www.prochoiceamerica.org/assets/files/Birth-Control-Pharmacy-Access.pdf>; Elizabeth Rose, *The Tip of the Spear: Defending Pharmacists’ Rights of Conscience*, [http://www.aul.org/Tip\\_of\\_the\\_Spear](http://www.aul.org/Tip_of_the_Spear) (last visited Jan. 4, 2009); Rebecca Wind, *Health Care Providers Cross the Line when They Obstruct Women’s Access to Legal Medication*, <http://www.guttmacher.org/media/nr/2005/08/02/index.html> (last visited Jan. 5, 2009) (all discussing opposition to the implications of conscience laws).

<sup>128</sup> Nelson, *supra* note 32, at 166. In establishing a standard of care for objecting pharmacists, courts may apply APhA’s professional expectation that pharmacists somehow ensure patients’ access to their requested medications. Heather A. Weisser, Note, *Abolishing the Pharmacist’s Veto: An Argument in Support of a Wrongful Conception Cause of Action Against Pharmacists Who Refuse to Provide Emergency Contraception*, 80 S. CAL. L. REV. 865, 895–96, 897–902 (2007).

<sup>129</sup> American Pharmacists Association, Code of Ethics for Pharmacists, <http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisplay.cfm&ContentID=2903> (last visited Sept. 29, 2008).

<sup>130</sup> American Pharmacists Association, The Oath of a Pharmacist, <http://www.pharmacist.com/Content/NavigationMenu2/LeadershipProfessionalism/ProfessionalDevelopment/OathofaPharmacist/default.htm> (last visited Sept. 29, 2008).

<sup>131</sup> American Pharmacist Association, Principles of Practice for Pharmaceutical Care, [http://www.pharmacist.com/AM/Template.cfm?Section=Practice\\_Resources&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=2906](http://www.pharmacist.com/AM/Template.cfm?Section=Practice_Resources&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=2906) (last visited Aug. 16, 2009).

provisions in these principles helpful and others harmful; for instance, “[i]nteraction between the pharmacist and the patient must occur to assure that a relationship based upon caring, trust, open communication, cooperation, and mutual decision making is established and maintained[,]” and “[t]he pharmacist develops mechanisms to assure the patient has access to pharmaceutical care at all times.”<sup>132</sup> However, the patient is to be apprised of the pros and cons of prescribed medical treatment, including opportunities to improve its safety, and “instances where one option may be more beneficial based on the pharmacist’s professional judgment.”<sup>133</sup>

### III. ANALYSIS

Against the backdrop of the historical and contemporary significance of conscience protection, this Part of the Note first examines arguments against pharmacist conscience laws and then explores whether patients’ inconvenience justifies requiring pharmacists to dispense medications to which they object.<sup>134</sup> Next, this Part addresses the distinctions between substantial and incidental burdens on constitutional rights, the extent of free exercise rights after the *Smith* decision, and the differences between *alleviating* a government-imposed burden on free exercise rights and *extending* the rights of religious believers.<sup>135</sup> Finally, this Part discusses the fact that a duty to dispense has never been a part of the common law.<sup>136</sup>

#### A. Opposition to Pharmacist Conscience Laws

Not everyone is unified in the belief that pharmacists deserve right-of-conscience protection.<sup>137</sup> The principal objections that opponents of conscience laws present are interrelated; opponents claim that pharmacists have a duty to dispense medications and patients have a right to obtain these medications as part of a health plan they and their

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<sup>132</sup> *Id.* at A. The pharmacist is also supposed to “assume ultimate responsibility for assuring that his/her patient has been able to obtain, and is appropriately using, any drugs and related products or equipment called for in the drug therapy plan.” *Id.* at D.

<sup>133</sup> *Id.* at C, E (2).

<sup>134</sup> *See infra* Part III.A-B (discussing same). Part III intentionally relies heavily on the research of Jennifer E. Spreng as Professor Spreng has extensively researched the constitutional implications of conscience laws and has made unique and compelling observations and arguments.

<sup>135</sup> *See infra* Part III.C-E (discussing same).

<sup>136</sup> *See infra* Part III.F (discussing same).

<sup>137</sup> *See supra* note 127 (referencing several commentators who have expressed skepticism or opposition to pharmacist conscience laws).

doctors have designed.<sup>138</sup> Conscience law critic Holly Teliska has stated that “[a] patient should never be expected to shoulder the burden of a pharmacist’s personal religious philosophy” and that any conscience provision “should be limited by thoughtful consideration of patients’

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<sup>138</sup> Nelson suggests that there are four main arguments directed against conscience laws: [t]he opponents of conscience protection for pharmacists pose four main arguments for why pharmacists should be forced to dispense all legal prescriptions. First, they argue that a patient’s autonomy should trump a pharmacist’s right to conscience. A second argument is that a pharmacist should not be allowed to impose his or her views on the patient. Third, opponents argue that conscience clauses have potential for abuse. Finally, advocates against conscience protection argue that pharmacists will block access to certain drugs.

Nelson, *supra* note 32, at 160 (footnotes omitted).

In response to these arguments, Nelson contends, respectively, that “allowing a patient to order the pharmacist to fill a prescription severely infringes upon the pharmacist’s own right to autonomy[,]” and that “unfettered” patient autonomy can lead to “disastrous effects[;] . . . [f]orcing a pharmacist to provide a medication that the pharmacist believes will lead to the death of a person is imposing the patient’s views onto the pharmacist, not the other way around[.] . . . conscientious objection *can* be limited through the wording of the legislation” to avoid discrimination problems, and “just because conscience clauses have potential for abuse is no reason to ban conscience clauses all together[.]” and finally, the argument that objecting pharmacists will block access to needed drugs is “flawed” because it “presupposes that abortifacients and lethal drugs are ‘needs’ of the patient[.]” patients may be wrong about what they truly need, and conscience clauses will still accommodate access to contraceptives, they will just prohibit someone from being required to dispense them. *Id.* at 161-65.

NARAL Pro-Choice America has argued that:

[w]hen a woman and her doctor have made the decision that a prescription for birth control is in her best interest, a third party has no right to override that decision. Pharmacies have a duty to dispense and have an ethical obligation not to endanger their patients’ health by withholding basic health care.

NARAL Pro-Choice America, *supra* note 127, at 5.

Conscience law opponent Minh N. Nguyen argues that “[e]very patient is entitled to have his or her prescriptions filled for medications that licensed physicians and healthcare providers have prescribed[.]” and that “under no circumstances should [pharmacists’] beliefs infringe upon the rights of others.” Nguyen, *supra* note 127, at 253, 271.

However, another commentator has explained that:

[o]pponents of freedom of conscience contend that a pharmacist’s right to conscientious objection must be subordinated to the needs of patients; however, conscientious objection does not prevent patients from obtaining contraceptives from other sources. Just as the exercise of freedom of speech does not force others to agree with the speaker, the exercise of freedom of conscience does not force others to agree with an objector. Objectors act primarily to preserve their own moral integrity, not to block access to services or to punish or control patients.

Rose, *supra* note 127.

medical needs.”<sup>139</sup> Yet, as Jessica D. Yoder has stated, “pharmacists should be able to incorporate moral decisions into the operation of their businesses because they are not discriminating against the patient; they are simply choosing not to be involved with the patient’s decisions and exercising their business judgment.”<sup>140</sup>

Teliska argues that a refusal should be permitted only if alternative access to the medication is available because a woman should neither have to travel in search of dispensing pharmacists nor wait an unreasonable length of time for her prescription, and an objecting pharmacist should be required at least to refer a patient seeking a contraceptive.<sup>141</sup> Nonetheless, an incidental burden on the constitutional right to access contraceptives may very well be permissible, meaning that inconvenience in obtaining contraceptives might not be adequate grounds for a constitutional claim against conscientious pharmacists.<sup>142</sup>

Finally, Teliska emphasizes that to save patients an unnecessary trip to a particular pharmacy, an objecting pharmacist there should be required to post his or her work schedule along with a notice describing his or her opposition to interfacing with specific prescriptions.<sup>143</sup> Indeed, this measure may be necessary in order for objecting pharmacists to accommodate hostile laws or judicial opinions.<sup>144</sup>

To illustrate why they believe must-fill laws are necessary, proponents of such laws often present a certain hypothetical situation that usually depicts a woman in a rural or remote setting going to the nearest pharmacy to obtain either a refill of her birth control pills or to have a new prescription filled.<sup>145</sup> Perhaps she urgently needs the new pills as she has only one pill left and missing the next dosage would

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<sup>139</sup> Teliska, *supra* note 127, at 247.

<sup>140</sup> Yoder, *supra* note 74, at 1015.

<sup>141</sup> Teliska, *supra* note 127, at 231, 247.

<sup>142</sup> See *infra* text accompanying notes 160–65 (explaining the difference between an incidental and a substantial burden on constitutional rights).

<sup>143</sup> Teliska, *supra* note 127, at 247.

<sup>144</sup> Cf. *infra* text accompanying note 214 (explaining that some jurisdictions already require notice).

<sup>145</sup> See, e.g., Teliska, *supra* note 127, at 231 (discussing rural hypothetical). The National Rural Health Association states that:

rural America gets fewer pharmacists than what might be considered its fair share. According to a study by the American Pharmacists Association, 20 percent of the nation’s population lives in rural America but only 12 percent of its pharmacists practice there. Like other rural health care providers, pharmacists who wish to set up shop in the small towns and countryside face the obstacles that come from remoteness, isolation, and a higher percentage of lower income clientele.

upset her birth control framework.<sup>146</sup> Nevertheless, she is shocked to learn that the pharmacist on duty refuses to dispense the pills, and there is no one else in the employ of the pharmacy who can fill her prescription.<sup>147</sup> In addition, the next closest pharmacy is thirty miles away and the woman cannot, without great hardship, travel to this pharmacy for her pills.<sup>148</sup> Thus, the argument is made that because pharmacists have voluntarily chosen to accept the role of “gatekeepers” of medication, they are obligated to simply dispense medications in exchange for a valid prescription.<sup>149</sup>

*B. Inconvenience May Not be Adequate Justification for Compelling Conscientious Pharmacists to Dispense*

While access to pharmacists in rural or remote locations may not be generous, by analogy, the Supreme Court has never declared that if there is only one doctor to serve a rural or remote community that that doctor must learn how to perform abortions or sterilizations and provide those services to local patients.<sup>150</sup> If there is no doctor available to provide

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National Rural Health Association, *supra* note 127.

Yoder has noted that “[p]harmacists in small rural towns have found that demand for emergency contraception is particularly low because women actually prefer to go out of town to have their prescriptions filled in order to better protect their privacy[,]” and that “[o]n a nationwide level, refusals also seem to be a statistically minor problem.” Yoder, *supra* note 74, at n.145. Furthermore, “[n]early 3.3 billion prescriptions are dispensed each year in the outpatient setting, . . . averaging about 9 million prescriptions per day. Proponents of ‘duty to fill’ laws document approximately twelve examples of refusals to fill since 1996[, as of 2005].” *Id.* (quoting *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Small Business Comm.*, 109th Cong. 7 (2005) (statement of Linda Garrelts MacLean)).

<sup>146</sup> *Cf.* Teliska, *supra* note 127, at 31, 238.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *See, e.g.,* Nelson, *supra* note 32, at 157; Spreng, *supra* note 29, at 229; Teliska, *supra* note 127, at 247. Spreng writes that there is currently a shift occurring within the pharmaceutical community whereby pharmacists are no longer acting as automated dispensers of medications but instead as providers of “pharmaceutical care, . . . [taking] a lead role in planning and administering patients’ drug therapy as well as substantial responsibility for the results.” Spreng, *supra* note 29, at 228–32. Weidner explains that recent cases have recognized “‘expanded dut[ies]’” for pharmacists who are now expected not just to avoid harm to patients, but to promote their welfare. Weidner, *supra* note 125, at 376–77 (alteration in original).

<sup>150</sup> Yoder explains that:

[t]he Supreme Court has made clear through its abortion funding cases, such as *Beal v. Doe* and *Maher v. Roe*, that the government is only required to avoid unduly burdening the right to an abortion; it is not required to take affirmative steps to make abortions available or easier to access. Although the scope of the right to contraception is broader, there is no indication that this right creates any duties either; in

these services in that community, its residents will have to travel—perhaps hundreds of miles—to the nearest doctor who can provide the services, and while such travel may be inconvenient, such an incidental burden has never been viewed as an unconstitutional burden on the right to abortion, so long as local or state laws are not the cause of this predicament.<sup>151</sup> Thus, a woman confronted with an objecting pharmacist and a lack of easy access to alternative sources of medication may face inconvenience in obtaining her pills.<sup>152</sup>

Just as inconvenience in obtaining an abortion has not been considered sufficient cause to coerce doctors to provide such service, mere inconvenience in obtaining contraceptives may not be adequate justification for compelling a pharmacist to dispense such medication in violation of his or her conscience.<sup>153</sup> In other words,

[t]here is no reason to think a woman has a right to have access to a particular type of contraception or even to any contraception in any particular moment if all a regulation limiting access does is make her decision about whether to bear a child ‘more difficult or more expensive.’<sup>154</sup>

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general, the Court has not required the government to subsidize the exercise of constitutional rights.

Yoder, *supra* note 74, at 1004 (footnotes omitted).

Thus, one could argue that the government is not obligated to facilitate access to contraceptives. *Cf. id.* Although the government cannot *hinder* access to contraceptives, the possibility that the objection of some pharmacists might make access more inconvenient to others is not the same as government denial of the right to use contraceptives. *See infra* text accompanying notes 160–65 (discussing same).

<sup>151</sup> *Cf. infra* text accompanying notes 152–65 (discussing same).

<sup>152</sup> It is quite possible that another pharmacist on duty might be able to fill the prescription or that one of the technicians on duty could fill the prescription while being supervised via a webcam or similar technology, something that is required by Illinois law if a non-objecting pharmacist is not available at a pharmacy. *See* 68 IL ADC 1330.91(j)(3)(B) (2008) (allowing webcam technology to be used if a non-objecting pharmacist is not on staff). Additionally, contraceptives are typically available online, at hospitals, and at medical clinics. Nelson, *supra* note 32, at 165. Yoder proposes that perhaps willing physicians could dispense emergency contraception themselves. Yoder, *supra* note 74, at 1013. Furthermore, there is a hotline and website that provide information about where women can obtain emergency contraceptives: 1-888-not-2-late and <http://not-2-late.com>, respectively. *Id.* at 1014.

<sup>153</sup> *Cf. supra* notes 150–52 and accompanying text (discussing Supreme Court abortion jurisprudence); *cf. infra* text accompanying notes 154–65 (discussing Supreme Court abortion jurisprudence and distinctions between substantial and incidental burdens on constitutional rights).

<sup>154</sup> Spreng, *supra* note 42, at 401.

Because the Supreme Court has held that the use of contraceptives is a fundamental right, ordinarily a state law that potentially burdens this right would have to pass strict scrutiny.<sup>155</sup> However, conscience laws do not suspend the right to use contraceptives by a woman (who still has the right even if she has been inconvenienced by an objecting pharmacist), and regardless, the Tenth Amendment permits states to use their police power to preserve the welfare (in this case, the freedom of conscience) of their people.<sup>156</sup>

From a constitutional perspective, “access to health care in the United States is not generally a ‘right.’”<sup>157</sup> The Supreme Court has never held that the Constitution affords a fundamental right to healthcare or medication.<sup>158</sup> At most, patients have a constitutional right to refuse unwanted medical treatment.<sup>159</sup>

*C. There are Distinctions Between Substantial and Incidental Burdens on Constitutional Rights*

There is a difference between a substantial and an incidental government burden on “the right to decide whether to bear a child.”<sup>160</sup> Only state statutes that substantially limit access to contraception violate a woman’s “fundamental right ‘to be free from unwarranted governmental intrusion into . . . the decision whether to bear or beget a child’ because such statutes substantially limit her access to the means of

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<sup>155</sup> See *Griswold v. Connecticut*, 381 U.S. 479, 484–86, 503–04 (1965) (White, J., concurring) (holding that the right to use contraceptives is grounded in a constitutional right to privacy).

<sup>156</sup> Brian P. Knestout argues that:

[s]ince the regulation of the pharmaceutical and medical professions is reserved to the states by the 10th Amendment, conscience clauses are constitutionally permissible. Common law police power doctrine recognizes that states have the power to enact laws for the preservation of the health, safety, and welfare of the people, provided that those laws do not conflict with superseding federal, or constitutional, law. Neither the 14th Amendment’s protections of access to birth control and abortion, nor any individual’s First Amendment right to free exercise of religion, compel or forbid the existence of such liability-shielding statutes.

Knestout, *supra* note 120, at 351.

<sup>157</sup> Harrington, *supra* note 104, at 801.

<sup>158</sup> *Id.* at 802.

<sup>159</sup> See *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 265, 278 (1990) (holding that parents did not have authority to withdraw their disabled daughter’s artificial feeding and hydration equipment because there was no clear and convincing evidence of the daughter’s desire to have life-sustaining treatment withdrawn).

<sup>160</sup> Spreng, *supra* note 42, at 400.

effectuating that decision, whether through contraception or abortion.”<sup>161</sup> The Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*<sup>162</sup> articulated that:

[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman’s ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause.<sup>163</sup>

Hence, any incidental burden on a woman’s ability to access contraceptives because of legal protection for pharmacists’ consciences stems not from a legislative attempt to violate the rights of women, but results from an effort simply to protect pharmacists’ religious liberties.<sup>164</sup> In addition, if any burden exists, “it emanates from the pharmacist herself, not the state. Thus, a customer’s Fourteenth Amendment substantive due process rights do not protect her anyway because a pharmacist does not qualify as a ‘state actor.’”<sup>165</sup>

#### D. Free Exercise After the Smith Decision

Perhaps the biggest potential challenge to pharmacists seeking conscience protection is the Supreme Court’s decision in *Employment Division, Department of Human Resources of Oregon v. Smith*,<sup>166</sup> a case in which the Court reaffirmed the principle that “the right of free exercise does not relieve an individual of the obligation to comply with a ‘valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).’”<sup>167</sup> Thus, a must-fill law, if worded broadly enough and

<sup>161</sup> *Id.* (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (holding that a ban on the distribution of contraceptives to unmarried individuals is unconstitutional) (footnotes omitted)).

<sup>162</sup> 505 U.S. 833 (1992).

<sup>163</sup> *Id.* at 874.

<sup>164</sup> Spreng, *supra* note 42, at 400–01.

<sup>165</sup> *Id.* at 401.

<sup>166</sup> 494 U.S. 872, 888–90 (1990).

<sup>167</sup> *Id.* at 879 (quoting *United States v. Lee*, 455 U.S. 252, 263 n.3 (1982) (Stevens, J., concurring)).

without evidence of an anti-free exercise purpose, could be upheld in spite of its incidental burden on religious expression.<sup>168</sup>

However, *Menges v. Blagojevich* implied, a must-fill law passed in response to expressions of conscientious objection by pharmacists could present a First Amendment problem.<sup>169</sup> The *Smith* Court explained that neutral and generally applicable laws may violate the First Amendment if the religiously motivated action also involved another constitutional protection, such as freedom of speech.<sup>170</sup> Thus, objecting pharmacists could challenge must-fill laws on the grounds that they are not truly neutral or that such laws present burdens on both the free exercise of pharmacists and their free speech rights.<sup>171</sup> The Court stated that to excuse a person from abiding by a valid law because of his religious beliefs would “permit every citizen to become a law unto himself.”<sup>172</sup> Consequently, conscience laws should be tailored to discourage arbitrary and sudden religious objections or objections not grounded in deeply-held moral convictions.<sup>173</sup>

After the Court affirmed “that the Free Exercise Clause still bars states from targeting or persecuting religious believers after *Smith*” in

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<sup>168</sup> Cf. *id.*; *supra* text accompanying note 163 (quoting the *Casey* Court’s holding that an incidental burden on access to abortion is not necessarily enough to invalidate a law).

Matthew White argues that narrow conscience clauses, those that “only protect health care providers who wish to refuse to provide a specific health care service or services specifically enumerated in the statute[.]” fail under the Establishment Clause. White, *supra* note 118, at 1631–32 (2005). White suggests that narrow conscience clauses “fail their essential purpose” because they “do not protect the conscience of all religious adherents from the consequences of conscientiously objecting to job duties[.]” only those objecting to abortion, sterilization, euthanasia, or contraception. *Id.* at 1631. This could be a potential problem for objecting pharmacists, but states have had for many years constitutional laws exclusively protecting the consciences of doctors and nurses, a fact even White acknowledges. *Id.* at 1634; see *supra* notes 86–88 and accompanying text (discussing the Supreme Court’s approval of conscience-protecting laws). Furthermore, if a conscience law serves to alleviate a government-imposed duty to dispense, this may very well be permissible. See *infra* note 182 and accompanying text (explaining the difference between government extending the rights of religious believers and simply relieving a government-imposed burden on those believers).

<sup>169</sup> 451 F. Supp. 2d 992, 997 (C.D. Ill. 2006). Although the Supreme Court has also said that “governmental actions that substantially burden a religious practice must be justified by a compelling governmental interest[.]” this standard (called the *Sherbert* Test—arising from *Sherbert v. Verner*) has never been applied outside unemployment compensation cases. *Smith*, 494 U.S. at 884. See *Sherbert v. Verner*, 374 U.S. 398, 403 (1963) (discussing the need for a compelling state interest).

<sup>170</sup> *Smith*, 494 U.S. at 881.

<sup>171</sup> Cf. Spreng, *supra* note 42, at 367.

<sup>172</sup> *Smith*, 494 U.S. at 879.

<sup>173</sup> One way this can be done is by limiting a conscience law to specific medications. See *infra* Part IV.C (discussing same).

*Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*,<sup>174</sup> a pharmacist likely must now “show that a duty burdening her religious liberties resulted from religious bigotry to qualify for constitutional protection.”<sup>175</sup> Justice Anthony Kennedy’s concurrence in *City of Hialeah* put forward a purposeful discrimination theory that makes the subjective motives of lawmakers a significant component in determining the constitutionality of a law.<sup>176</sup> Thus, a pharmacist may have to show that a law is unconstitutional not merely because it *targets* religious believers, thereby violating the Free Exercise Clause, but because it *discriminates* against religious believers in violation of equal protection rights.<sup>177</sup> The comments made by Governor Blagojevich are a good example of a lawmaker’s subjective intent to discriminate against religious believers.<sup>178</sup>

*E. The Distinctions Between Alleviating a Government-Imposed Burden on Free Exercise and Simply Extending Free Exercise Rights*

The fact that pharmacist conscience laws may only *alleviate* a government-imposed burden on religious expression as opposed to *extending* free exercise rights might bolster the constitutionality of these laws.<sup>179</sup> In striking a Connecticut law that prohibited employers from firing workers who refused to work on whatever day of the week they claimed as their Sabbath, the Supreme Court reasoned that a law that has “a primary effect that impermissibly advances a particular religious practice” is unconstitutional because “the statute goes beyond having an incidental or remote effect of advancing religion.”<sup>180</sup> Additionally, third parties (the co-workers of the worshipping employees) were burdened by the law which, in its entirety, implicated *state action*.<sup>181</sup>

On the other hand, the Court has held that “[t]here is ample room under the Establishment Clause for ‘benevolent neutrality which will permit religious exercise to exist without sponsorship and without interference[,]’” so long as the accommodation does not devolve into “an unlawful fostering of religion.”<sup>182</sup> The Court articulated this principle of

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<sup>174</sup> 508 U.S. 520 (1993).

<sup>175</sup> Spreng, *supra* note 42, at 368–69.

<sup>176</sup> *Id.* at 369.

<sup>177</sup> *Id.* at 369–71.

<sup>178</sup> *Id.* at 370.

<sup>179</sup> *Id.* at 385–86.

<sup>180</sup> Estate of Thornton v. Caldor, Inc., 472 U.S. 703, 710 (1985).

<sup>181</sup> Spreng, *supra* note 42, at 388.

<sup>182</sup> Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-day Saints v. Amos, 483 U.S. 327, 334–35 (1987) (quoting Walz v. Tax Comm’n, 397 U.S. 664, 669 (1970); Hobbie v. Unemployment Appeals Comm’n of Fla., 480 U.S. 136, 145 (1987)). Lin explains

law in *Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-day Saints v. Amos*,<sup>183</sup> a case in which a Mormon church dismissed an employee on religious grounds, something the Court held was permissible because a provision in the Civil Rights Act of 1964 exempted religious employers from anti-discrimination laws, and this exemption neither extended a government benefit on the church nor was it government advancing religion.<sup>184</sup> Thus, state action that bestows rights on a set of religious believers and burdens third parties without alleviating a government-imposed burden is constitutionally problematic compared to laws that simply relieve an entity from a government-imposed burden in the form of a facially neutral and generally applicable law.<sup>185</sup>

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that in *Lemon v. Kurtzman*, 411 U.S. 192 (1973), the Supreme Court developed a three-prong test for determining whether a law violates the Establishment Clause: the statute must have a secular purpose; it must neither advance nor inhibit religion; and it must not create an excessive government entanglement with religion. Lin, *supra* note 118, at 113. White argues that a narrow conscience law could fail the second prong of the test because such a law “protects the religious conscience of a pharmacist only if that pharmacist happens to possess a set of legislatively approved religious beliefs[,]” thereby advancing a particular religious view. White, *supra* note 118, at 1633. However, Lin suggests that because these conscience laws do not favor or disfavor religion, they generally comply with the *Lemon* Test. Lin, *supra* note 118, at 114.

White asserts that narrow conscience laws could also be challenged under the endorsement test or the coercion test, two other means (in addition to the *Lemon* Test) by which a violation of the Establishment Clause can be identified. White, *supra* note 118, at 1632, 1633–34. The endorsement test asks whether a “reasonable objective observer would perceive a state endorsement of a religion or religious practice in the challenged state action[,]” and because a conscience law only protects certain religious objections, White argues, a reasonable observer might perceive government endorsement of those particular religious views. *Id.* at 1633. A narrow conscience law could fail the coercion test because such a law “has the potential to compel an unwilling person to adhere to a sectarian religious belief by restricting availability of contraception, particularly in a locale where travel to another pharmacy is impractical.” *Id.* at 1633–34. To be successful under the coercion test, a person challenging the conscience law must demonstrate that the pharmacist’s objection is associated with a particular sect and is not merely secular in substance. *Id.* at 1634.

Again, White acknowledges that because narrow conscience clauses “are well established in state law in the context of abortion, sterilization, and euthanasia[,] . . . it seems unlikely that similar protections for pharmacists would be overturned.” *Id.*

<sup>183</sup> 483 U.S. 327 (1987).

<sup>184</sup> Spreng, *supra* note 42, at 387–88.

<sup>185</sup> *Id.* at 386–89. Duvall notes that while the Supreme Court has permitted states to exempt religious adherents from generally applicable laws burdening their free exercise rights, these exemptions are limited. Duvall, *supra* note 118, at 1506. Duvall explains that in determining the constitutionality of an accommodation, a court must first ask if the law implicates the religion clauses of the First Amendment or if the law has a legitimate secular purpose. *Id.* If the law has a secular purpose, meaning that it protects religious and non-religious citizens alike, then the law probably does not present an accommodation problem (unless the law was passed for truly religious purposes) and Establishment Clause analysis

Spreng likens pharmacist conscience laws to exemptions from the government-imposed burden on free exercise rights resulting from must-fill laws, meaning that *Amos* analysis applies.<sup>186</sup> She explains that “a tort duty to sell emergency contraception would burden a dissenting pharmacist’s religious liberty by leaving her open to liability[,]” but a “statutory conscience accommodation alleviates that burden” without giving pharmacists “additional legal benefit by virtue of being religious.”<sup>187</sup>

The Court’s distinction between laws that *bestow* special benefits on select religious believers and laws that *alleviate* government-imposed burdens on religious believers was reiterated in *Cutter v. Wilkinson*,<sup>188</sup> a case that upheld the Religious Land Use and Institutionalized Persons

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stops. *Id.* at 1506–07. Duvall argues that while most pharmacist conscience laws broadly cover religious and moral objectors, a court would likely find that the laws have the purpose of benefiting religious adherents. *Id.* at 1507–08.

Duvall explains that if the court determines a conscience law is an accommodation, it will first look to see if the law creates a religious inducement, something Duvall says is not a problem in the case of pharmacist conscience laws. *Id.* at 1508. Second, the court will ask if the law bestows any favored or disfavored statuses on any religions, something else Duvall doubts would be a problem with pharmacist conscience laws. *Id.* Finally, the court would inquire into whether the law benefits religious believers at the cost of substantially burdening non-beneficiaries, a factor that Duvall believes could be a problem if the court finds that the law substantially burdens a woman’s reproductive rights. *Id.* at 1509.

In determining what a substantial burden is, Duvall states that the court would look at: “the nature of the burden imposed on a non-beneficiary, the magnitude of the burden, and its disproportionality.” *Id.* Thus, Duvall contends, the nature of the burden imposed on a woman by pharmacist conscience laws is not merely economic, but an encumbrance on her personal autonomy rights regarding family planning. *Id.* at 1511. Furthermore, increased costs, travel, or medical risks stemming from a local pharmacist’s refusal to dispense might enhance the magnitude of the burden on a woman seeking contraceptives, *Id.* at 1514–16, and an accommodation might disproportionately burden non-beneficiaries if it “dictates that non-beneficiaries must accommodate religious adherents’ interests at the expense of their own significant interests, without any exceptions.” *Id.* at 1516. Duvall argues that pharmacy conscience laws that do not contain referral or emergency provisions without exception unconstitutionally place pharmacists’ religious interests ahead of women’s reproductive rights and health interests. *Id.* at 1517–18.

However, Duvall has suggested that “[j]ust as the [Supreme] Court found that RLUIPA [the Religious Land Use and Institutionalized Persons Act of 2000], on its face, was merely an accommodation and not an establishment of religion, it likely would perceive pharmacy conscience clause statutes in the same light.” Duvall, *supra* note 118, at 1505; see *infra* text accompanying notes 188–93 (discussing RLUIPA).

<sup>186</sup> Spreng, *supra* note 42, at 389.

<sup>187</sup> *Id.* Spreng continues by stating that “a statutory accommodation hardly advances religion by encouraging other pharmacists to adopt beliefs that would discourage them from selling emergency contraception; instead, others would probably realize that with dissenting pharmacists out of the business, their own profits would rise.” *Id.*

<sup>188</sup> 544 U.S. 709 (2005).

Act of 2000 (“RLUIPA”).<sup>189</sup> The Court held that a disputed provision in the RLUIPA is “compatible with the Establishment Clause because it alleviates exceptional government-created burdens on private religious exercise” and further held that the Act’s provisions must “be administered neutrally among different faiths” and that “courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries[.]”<sup>190</sup>

There may be difficulty in understanding whether the Court’s requirement that lower courts take account of burdens on non-beneficiaries applies in the context of a pharmacist conscience law because the Court does not define what an adequate account is and because *Cutter*, in which the plaintiffs were seeking religious free exercise benefits from the state, was not an *Amos* case.<sup>191</sup> Regardless, “in an *Amos* pharmacist-accommodation case, ‘adequate account’ could be essentially no account at all because the pharmacist herself, not the state’s accommodation statute, burdens third parties such as customers.”<sup>192</sup> Thus, when a pharmacist exercises his or her rights under a conscience law, any burden on a customer or co-worker or any advancement of religion stems from the choice of the pharmacist, a private actor, not from state action, and “no state-imposed burden on third-parties exists to take into ‘adequate account’ under *Cutter*.”<sup>193</sup>

#### F. *A Duty to Dispense has Never been a Part of the Common Law*

In the end, the fact remains that a “duty to dispense” has never been a part of the common law (a duty to dispense *accurately* has), and statutes *requiring* that pharmacists dispense medications are a more recent development.<sup>194</sup> Some have argued that when a patient develops a

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<sup>189</sup> Spreng, *supra* note 42, at 393.

<sup>190</sup> *Cutter*, 544 U.S. at 709.

<sup>191</sup> Spreng, *supra* note 42, at 396–97. The plaintiffs in *Cutter* were present and former inmates seeking the ability to dress and worship according to their non-mainstream religious beliefs and have access to literature. 544 U.S. at 712–13.

<sup>192</sup> Spreng, *supra* note 42, at 398.

<sup>193</sup> *Id.* at 399–400.

<sup>194</sup> Spreng, *supra* note 29, at 218, 253–57. Spreng explains that “[a]s to duties to warn, . . . courts have often held that pharmacists had no duty to customers based on the learned intermediary doctrine[.]” and that “the prescribing physician, not the pharmacist, was the learned intermediary with the duty to warn. Courts considered the physician-patient relationship virtually inviolate and did not want pharmacists to interfere in any way.” Spreng, *supra* note 42, at 343–44 (internal citation omitted). Spreng further explains the duties of a pharmacist:

[a] pharmacist has no duty to warn the customer or notify the physician that the drug is being prescribed in dangerous amounts, that the customer is being over medicated, or that the various drugs in their

professional relationship with a specific pharmacist on whom the patient has come to rely for his or her prescriptions and for sundry medical advice, a duty to that patient might arise, and a pharmacist cannot, after serving that patient for such a length of time, suddenly refuse to fill that patient's prescription without at least referring the patient to a pharmacist who will.<sup>195</sup> Pharmacists need to be aware of how the development of such relationships can potentially influence a *court* to decide that a duty to dispense has arisen.<sup>196</sup> Such relationships are

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prescribed quantities could cause adverse reactions to the customer. It is the duty of the prescribing physician to know the characteristics of the drug he is prescribing, to know how much of the drug he can give his patient, to elicit from the patient what other drugs the patient is taking, to properly prescribe various combinations of drugs, to warn the patient of any dangers associated with taking the drug, to monitor the patient's dependence on the drug, and to tell the patient when and how to take the drug. Further, it is the duty of the patient to notify the physician of the other drugs the patient is taking. Finally, it is the duty of the drug manufacturer to notify the physician of any adverse effects or other precautions that must be taken in administering the drug. Placing these duties to warn on the pharmacist would only serve to compel the pharmacist to second guess every prescription a doctor orders in an attempt to escape liability.

*Id.* at 344.

<sup>195</sup> Spreng, *supra* note 29, at 218, 253–57. Harrington observes that “[a]bsent state or federal regulation, . . . a health care professional is free to define the parameters of his or her practice and may refuse to provide services to prospective patients[,]” and that “[f]acilities, although subject to more regulatory standards, are generally not required to provide specific treatments. Thus, an obstetrician-gynecologist may decline to treat a woman who seeks an abortion, a private hospital may refuse to admit patients for elective sterilizations, and a pharmacy may refuse to stock contraceptives.” Harrington, *supra* note 104, at 803–04.

<sup>196</sup> Harrington also addresses the concept of the duty to disclose information to patients, a duty that “may arise out of the fiducial responsibilities of the physician-patient relationship, the duty to provide informed consent, or general negligence standards.” Harrington, *supra* note 104, at 809. A fiduciary relationship inheres deep trust between physician and patient and requires that a physician refrain from “undue influence or coercion over patients, abuse of the patient’s trust, breach of confidences, and abandonment.” *Id.* at 810. Informed consent has to do with the patient having all pertinent medical information—all the risks and benefits—in order to “determine for himself the direction in which his interests seem to lie.” *Id.* at 811 (quoting *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972)). Thus, while a pharmacist may not have to recommend services to which he or she objects, there is an expectation he or she will disclose this fact to patients and still advise them about healthcare options or refer them to someone who will. *Id.* at 813–14 (quoting Am. Coll. of Physicians, *Ethics Manual*, Fifth Edition, 142 Ann. Intern. Med. 560, 564 (2005)). Again, that a pharmacist should refer a patient or transfer a prescription presents concerns of complicity in immoral acts to objecting pharmacists. See *supra* text accompanying notes 32–33.

Allen and Brushwood write:

[p]harmacists are directly involved in the provision of an essential component of the procedure. Pharmacists not only have personal

becoming more common as the pharmaceutical profession transitions from being a group of pill dispensers servicing *customers* to a community of healthcare providers offering medical advice and information to *patients*.<sup>197</sup> In fact, “pharmacists in many professional settings [have] morphed into drug therapy managers, patient educators, and physicians’ treatment partners.”<sup>198</sup> Thus, pharmacists’ duties correlate to the customers’ expectations arising from their relationship, and the greater the expectations, the greater the duty; although the law does not grant the patient an entitlement to all desired services.<sup>199</sup>

Harrington argues that if a relationship exists, health practitioners “owe duties to their patients according to accepted standards of care and, in the absence of a conscience clause, cannot simply refuse to treat or counsel their patients without exposure to liability for abandonment, malpractice suits, or disciplinary action.”<sup>200</sup> Thus, a well-written conscience law and the act of putting patients on notice of a pharmacist’s objections are indispensable to avoiding liability.<sup>201</sup>

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ethical convictions that deserve consideration, they also have the same professional ethical duties of non-maleficence and beneficence to patients that bind physicians, nurses, and other health professionals. Caveat emptor (let the buyer beware) may control in the commercial aspects of non-pharmaceutical products sold in “drugstores” and the supermarkets or discount stores in which pharmacies are located, but in the pharmacy itself transactions between pharmacists and consumers are circumscribed by fiduciary duty. These factors provide strong support for pharmacists’ claims to be included in provisions to protect conscientious objections.

Allen and Brushwood, *supra* note 125, at 14.

<sup>197</sup> Spreng, *supra* note 29, at 228–32. APhA states that “[p]harmaceutical care is a process of drug therapy management that requires a change in the orientation of traditional professional attitudes and re-engineering of the traditional pharmacy environment[.]” and that “[t]he implementation of pharmaceutical care is supported by patient-centered communication. Within this communication, the patient plays a key role in the overall management of the therapy plan.” American Pharmacists Association, *supra* note 131, at Appendix.

<sup>198</sup> Spreng, *supra* note 42, at 347.

<sup>199</sup> *Id.* at 350–51. Harrington explains that

[a]lthough patients’ rights have evolved considerably over the past fifty years, the law is not so expansive as to grant an individual the privilege to insist that a health care provider deliver all desired services. Barring an agreement between patient and provider or a statute mandating access, there is no legal duty to treat. Thus, professionals and facilities are generally free to turn away prospective patients or limit the scope of their services without fear of liability.

Harrington, *supra* note 104, at 782.

<sup>200</sup> Harrington, *supra* note 104, at 804

<sup>201</sup> See *infra* Part IV.A, C (discussing what the contents of pharmacist conscience laws should be).

## IV. CONTRIBUTION

Considering the inconsistency of existing conscience laws and the arguments over their appropriateness, pharmacists need guidance in balancing their moral beliefs and their professional duties. This Part of the Note first emphasizes the importance of preserving both medical ethics and the ability of healthcare providers to exercise their consciences, and then offers recommendations to pharmacists on how to avoid conflicts with their patients over conscientious objection.<sup>202</sup> This Part then proposes a model right-of-conscience statute for pharmacists.<sup>203</sup>

A. *The Importance of Conscience Protection*

The American public must realize that all persons involved in the healthcare process—doctors, nurses, physician assistants, pharmacists, and patients—are human beings with diverse and frequently divergent beliefs about a variety of issues, morality included. Naturally, there has to be some give-and-take as patients and healthcare providers interact; while mutual respect is essential, neither party should be compelled to act contrary to personal moral convictions. Society as a whole would certainly expect a pharmacist to exercise his or her moral principles about the value of human life by alerting a patient if there was reason to believe that a prescription contained an error or a prescribed medicine would harm the patient. Yet, some individuals would expect a pharmacist to stifle those very same moral principles when it comes to dispensing contraceptives. How can pharmacists be expected to turn their principles on and off according to the predilections of customers? Pharmacists should not have to suppress their moral convictions if they have reason to believe a contraceptive might harm someone, particularly nascent human life.

Opponents of right-of-conscience laws often complain that a pharmacist's refusal to fill a prescription, or at least refer a patient to someone who will, is an imposition of that pharmacist's beliefs on the patient.<sup>204</sup> On the contrary, a pharmacist's *passive* refusal to interface with a particular medication or to assist in the patient's acquisition of the medication is not tantamount to the pharmacist forcing the patient to think or act as he or she does. However, forcing a pharmacist to fill an objectionable prescription or refer a patient to someone who will results in a direct imposition of the patient's desires on the pharmacist,

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<sup>202</sup> See *infra* Part IV.A-B (discussing same).

<sup>203</sup> See *infra* Part IV.C (proposing model statute).

<sup>204</sup> See, e.g., Harrington, *supra* note 104, at 814; Nelson, *supra* note 32, at 162 (both discussing same).

requiring an affirmative act on his or her part in furtherance of that patient's wishes.<sup>205</sup> Imposing beliefs on others is a two-way street; pharmacists should not harass or slander patients or *obstruct* their access to medication, but patients should not walk into a pharmacy thinking that they are entitled to medication.<sup>206</sup> The idea that "the customer is always right" does not really hold water.<sup>207</sup> A customer (patient) can just as easily proselytize as the proprietor (pharmacist) can.

One could argue that must-fill laws and the mentality that supports them have the ultimate goal or effect of transforming the pharmaceutical industry by pressuring pharmacists with the threat of job loss to change or suspend their attitudes or spiritual or mental dispositions toward contraceptives or other medications to which they object. Through laws or a change in cultural thinking, medical science can be turned into

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<sup>205</sup> See Spreng, *supra* note 29, at 241–43 (discussing same). Nelson states that, "[f]orcing a pharmacist to provide a medication that the pharmacist believes will lead to the death of a person is imposing the patient's views onto the pharmacist, not the other way around." Nelson, *supra* note 32, at 162.

<sup>206</sup> Patients are certainly free, pursuant to their free speech rights, to request that their pharmacists stock and dispense certain medications. The market will undoubtedly respond to this consumer demand, perhaps by providing another pharmacy to service this customer base. One commentator has suggested that

[i]n medicine where two people are involved, autonomy is always a two-way street. Yes, the patient or "client" has his or her autonomy; but so, too, does the practitioner. There is no good reason (except perhaps one grounded in an anti-religious bias) to advocate that a patient's autonomy should trump the autonomy of the professional health-care worker just because the two views conflict.

Nelson, *supra* note 32, at 161 (quoting Iain T. Benson, "Autonomy," "Justice" and the Legal Requirement to Accommodate the Conscience and Religious Beliefs of Professionals in Health Care, <http://www.consciencelaws.org/Examining-Conscience-Legal/Legal04.html> (updated March, 2001)).

A passive refusal to dispense a contraceptive or to refer a patient or transfer her prescription is not the same as *obstructing* her access to contraceptives. Obstruction connotes an active effort to thwart access or to completely block all means of access, perhaps by withholding or destroying a doctor's prescription. See Spreng, *supra* note 42, at 351–52 (distinguishing passive refusal from civil disobedience).

<sup>207</sup> Nelson quotes Susan Martinuk who quipped that, "[t]he 'customer is always right' philosophy may be the best guiding principle for McDonald's, but it is an inappropriate standard for medical ethics." Nelson, *supra* note 32, at 161–62. Nelson suggests that:

[o]ur culture equates autonomy with freedom *from* a given thing: "freedom from constraint, from rules, from direction, from guidance, from immutable principles." With this understanding of freedom, patient autonomy becomes the patient's right to do anything he or she desires. However, this definition of autonomy is dangerous and misplaced.

*Id.* at 160 (quoting Sean Murphy, *Freedom of Conscience and the Needs of the Patient* (Banff, Alberta, Nov. 2001) (available at <http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical23.html>)) (footnote omitted).

something ugly, something that can harm or destroy life, as occurred in Nazi Germany; thus, respect for healthcare providers' consciences and encouragement for loud objection to ethical abuses that occur are paramount to preserve medical science's objective of healing.<sup>208</sup> Right-

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<sup>208</sup> Preservation of and respect for medical ethics are vital given the potential for medical science to harm or destroy life. Perhaps nothing better illustrates the grotesque abuse of medical science and the Hippocratic Oath than the integral role of healthcare providers in the experiments, sterilizations, euthanasia, and genocide of Nazi Germany. Robert Jay Lifton has researched what he describes as the "Nazification of the medical profession" and the development of "medicalized killing." ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE* 30, 15 (Basic Books 1986). Through a combination of "ideological enthusiasm and systematic terror," many physicians and nurses transformed from healers into killers; some of these practitioners thoroughly agreed with and endorsed Nazi racial philosophy while others took employment from the Nazis for financial gain. *Id.* at 30.

The Nazis pursued transformation of the medical field as a policy goal. *Id.* at 33. As Rudolf Ramm of the medical faculty of the University of Berlin explained, Nazi medical policy aimed at achieving "'a change in the attitude of each and every doctor, and a spiritual and mental regeneration of the entire medical profession.'" *Id.* Lifton relates that Gerhard Wagner, "then the leading Nazi medical authority and a zealous advocate of sterilization," denied that any doctors objected to sterilization; at the same time, a Nazi newspaper printed a column entitled "Life or Death," which explained that "the life of the nation took precedence over 'dogma and conflicts of conscience,' and . . . that opposition to the government's program would be met with strong retaliation." *Id.* at 29. Dr. Arthur Guett suggested that "[t]he doctor, like everyone in Nazi Germany, was expected to become 'hardened,' to adopt what [Adolf] Hitler himself called the 'ice-cold logic' of the necessary." *Id.* at 33.

Lifton also takes note of Karl Saller, an anthropologist at the University of Munich, who criticized certain of the Nazis' racial ideas and was consequently forced out of the university. *Id.* at 39. Lifton suggests that "[w]hile many anthropologists, as well as biologists and physicians, must have agreed with his views, they tended to remain silent, and [Saller] found himself generally rejected and avoided by former colleagues and friends." *Id.* Thus, fear of government reprisal chilled both support for Karl Saller and vocal criticism of Nazi ideas among the academia of the University of Munich. *Id.*

Against this backdrop of generally coercive conformity, surprisingly the Nazis did accommodate personal decisions not to participate in certain medical or killing operations, although such choices may not have stemmed from moral objections. HENRY FRIEDLANDER, *THE ORIGINS OF NAZI GENOCIDE: FROM EUTHANASIA TO THE FINAL SOLUTION* 217, 225, 231, 237, 244 (1995). Nazi killing centers "required voluntary participation, and no one was forced to join the killing operations." *Id.* at 232. Furthermore, "after almost fifty years of postwar proceedings, proof has not been provided in a single case that someone who refused to participate in killing operations was shot, incarcerated, or penalized in any way, except perhaps through transfer to the front," although "putative duress" was certainly prevalent. *Id.* at 235-36. *See also* CLAUDIA KOONZ, *THE NAZI CONSCIENCE* 264 (2003) ("The existence of a doubter here or a rescuer there did not retard the inexorable process of expulsion and extermination. By treating individual objections as private matters and not as moral protests, Nazi administrators minimized their political fallout.").

This brief appraisal of Nazi medical abuses and Nazi accommodation of certain unwilling officials is not intended to equate proponents of must-fill laws with Nazis or to suggest that Nazis were keen proponents of conscience rights. Quite simply, should government prohibit or squelch moral dissent or objection by medical providers, the effects

minded societies that respect the individuality and diversity of their citizens and afford them the freedom of religious exercise should not engage in squelching moral objection by healthcare providers and pressuring them to “go along with” the medical establishment and “be team players”—the potential for ethical abuse is considerable.<sup>209</sup> If government action stymies conscientious objection within the medical field, nothing will prevent the medical profession from silencing dissent when it plunges into ethical turpitude.

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would be alarming; just as fear of reprisal chilled both support for Karl Saller and vocal criticism of Nazi ideas among the academia of the University of Munich, one can imagine that healthcare providers fearful of job loss or civil penalties might become reluctant to expose what they view as moral or ethical wrongs.

Christian Pross asserts that:

[T]he search for truth, for new ideas, has motivated scientists and doctors for centuries. Without it there would be no progress, no modern diagnostic and therapeutic knowledge or techniques. In the nineteenth century, however, this search became, for science, more and more a search for objective truths. The search for truth in medicine turned into destruction when medicine abandoned both the Hippocratic *nil nocere* and its true purpose of healing the sick individual, of alleviating suffering—and when this was done for science’s own “superior” aims.

GOTZ ALY, PETER CHROUST & CHRISTIAN PROSS, *CLEANSING THE FATHERLAND: NAZI MEDICINE AND RACIAL HYGIENE 2* (Belinda Cooper, trans. 1994).

The original Hippocratic Oath reads, in part, as follows:

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly *I will not give to a woman an abortive remedy*. In purity and holiness I will guard my life and my art.

NOVA Online, *Hippocratic Oath—Classical Version*, [http://www.pbs.org/wgbh/nova/doctors/oath\\_classical.html](http://www.pbs.org/wgbh/nova/doctors/oath_classical.html) (last visited Feb. 4, 2010) (emphasis added).

<sup>209</sup> Marcus argues that “[s]tates have responsibilities to the individuals they govern not only as subjects, but also as human beings[.]” and that “all individuals are guaranteed the rights recognized and enforced by the international community as human rights.” Marcus, *supra* note 123, at 511. Consequently, “[r]ecognizing conscientious objection as a human right would embody the philosophy, increasingly embraced in international law, that certain human rights are so fundamental” that they outweigh “deference to the domestic practices” of individual states. *Id.* Thus, the International Covenant on Civil and Political Rights states that:

[e]veryone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

*Id.* at 514–15 (alterations in original).

The Universal Declaration of Human Rights does not address a right to conscientious objection by name, but it does recognize certain “human rights principles” that form “a foundation for identifying the right of conscientious objection as a human right under international law.” *Id.* at 513.

The hypothetical situation described in Part III involving women with allegedly limited access to pharmacies underscores the importance of giving customers advance notice of their pharmacist's ethical beliefs, avoiding conflict through better planning by the pharmacy and the patient.<sup>210</sup> Ultimately, though, in a conflict between a patient who has the right to make personal healthcare decisions and a pharmacist who has a right of free exercise of religion, the pharmacist should prevail: while the patient may incur hardship or inconvenience occasioned by a delay in obtaining her prescription, a delay would not deny the ultimate right to use contraceptives. If the patient were to prevail, the pharmacist's compelled act would *constitute* violation of his or her right of free exercise. In other words, the patient's hardship would not result in the suspension of her (or his) rights, but the pharmacist's hardship would itself be a violation of his or her rights.<sup>211</sup>

While some areas of the United States have a dearth of pharmacies, the hypothetical above fails to grasp the deeper ethical considerations at stake. Ultimately, a deficiency in the marketplace should not translate into compelling a pharmacist to violate his or her conscience. Just because there may be few pharmacies from which to choose in a given

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<sup>210</sup> This is a measure intended merely to *accommodate* hostile laws or court decisions, not an endorsement of obligatory disclosure.

<sup>211</sup> While some have argued that a pharmacist's refusal to fill a prescription or refer a patient to someone who will harm the patient contrary to the pharmacist's duty of care, the pharmacist could argue that his or her refusal stems from a belief that the drug in question would *itself* be a harm to the patient. If the pharmacist believes that a contraceptive could cause an abortion, this is a harm—both to the woman and her unborn child—the pharmacist may want to prevent. In addition, the pharmacist may believe that use of the pill creates too great a risk for the development of blood clots or cardiovascular problems (particularly among women over 30 who smoke) or that the use of estrogens during pregnancy can put a female child at greater risk of developing vaginal or cervical cancer after puberty. RYBACKI, *supra* note 20, at 781-82. Some pharmacists may believe that contraceptives “promote promiscuity, divorce, the spread of sexually transmitted diseases and other societal woes.” Stein, *supra* note 21, at A1. There are many other potential side effects harmful to women that pharmacists may want them to avoid by not using contraceptives. See *supra* note 21 (citing a number of reports of harmful and even deadly side effects from the use of certain contraceptives).

Again, while respect for the “autonomy and dignity of each patient” is a part of the Code of Ethics for Pharmacists, it is listed third after the required promotion of “the good of every patient in a caring, compassionate, and confidential manner.” American Pharmacists Association, *supra* note 125. Thus, a pharmacist may very well be acting consistently with his or her commitment to “promote the good of every patient” when refusing to dispense or refer for potentially abortive contraceptives.

If a woman is seeking a *refill* of her prescription for contraceptives and encounters an objecting pharmacist, one might wonder how she managed to have the first prescription filled. If her prescription is new and she is delayed for a short time until she can find a pharmacist who will fill it, she is in no worse a position than before she obtained the prescription.

area should not mean that the pharmacists located there should be “punished” by this twist of fate.

*B. Recommendations for Objecting Pharmacists*

While objecting pharmacists may believe that they are helpless in the face of hostile government action, a somewhat unsympathetic professional association, and a general public uninformed about moral dilemmas at pharmacies, there may be things a pharmacist can do to avoid litigation and *accommodate* must-fill laws or hostile court decisions.<sup>212</sup> Because right-of-conscience laws for pharmacists are a largely uncharted area of law, there is no guarantee an objecting pharmacist can always escape a lawsuit by taking preventive measures. However, a few simple actions can work to the pharmacist’s advantage.

First, immediately upon accepting employment or as soon as possible after having begun employment, a conscientious pharmacist should notify the employer about his or her moral beliefs; the employer should then, consistent with Title VII, take steps to develop a protocol for servicing patients that accommodates the pharmacist’s rights. This protocol should provide for an appropriate response by the objecting pharmacist: either the pharmacist will *refuse* to accept, fill, transfer, or refer a prescription for an objectionable drug or the pharmacist *will* refer the patient to another pharmacist on duty or to another pharmacy. Of course, referring or transferring a prescription may be a problem for some pharmacists, and some pharmacies may not have another pharmacist on duty to fill the prescription.

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<sup>212</sup> The arguments and recommendations that follow implicate those things a pharmacist could do to *accommodate* must-fill laws or unfriendly court decisions. In the absence of such legal barriers, if a pharmacist believes the contraceptive is a harm to the patient or her unborn child, he or she should not be required to publicize personal views to put patients on notice because there is technically no duty to dispense anyway, and thus there should be no reason to justify or apologize for a refusal to dispense. However, the recommendations that follow could be helpful in avoiding potential Title VII problems.

A notice to be distributed and posted could include the following rudimentary elements:

Attention Customers: Effective May 1, 2010, a pharmacist on staff at this facility will not dispense medicines or devices X, Y, or Z. This pharmacist is on staff Monday through Friday from 9am to 5pm. If you need a prescription or refill for medicines or devices X, Y, or Z, please be aware that this pharmacist will not handle requests for these medicines or devices. Another pharmacist will be on duty during those times, but there may occasions when this pharmacy will not be able to provide medicines or devices X, Y, or Z. Please be aware of this and plan accordingly. The McGillicutty Pharmacy on Route 6 can also provide these medicines or devices. If you have questions, contact Joe Smith at 555-5555.

An objecting pharmacist needs to know from his or her employer what expectations the employer has and what accommodations the employer will provide in light of the fact that Title VII only requires an accommodation of *minimal* burden. The employer who can successfully claim that hiring another pharmacist or transferring a workload to another pharmacist or technician imposes too large a burden on itself is, therefore, not required by Title VII to hire or retain the objecting pharmacist.<sup>213</sup>

Nevertheless, an objecting pharmacist, in order to accommodate potentially hostile laws or courts and possibly to reduce the risk of complaints or lawsuits, should post at the pharmacy and on the entrance doors of the store signs that provide unambiguous notice that a pharmacist with conscientious objections is on staff and that he or she will not dispense, transfer, or refer any prescription for the objectionable medications in question. Including notices with every new and old prescription that potentially could be filled would also be helpful. Once patients are notified of the pharmacist's beliefs, they cannot claim that they came to rely on him or her to dispense *all* possible prescriptions. Some jurisdictions already require notice that "provides established customers, who are otherwise most likely to have a claim against the pharmacist's assistance, with the proper expectations."<sup>214</sup>

It would also be to the pharmacist's benefit not even to physically accept a patient's prescription for an objectionable drug. Once the pharmacist physically accepts the prescription, one could argue that he or she has assumed a duty at least to transfer the prescription or refer the patient elsewhere. If, on the other hand, the pharmacist refuses even to accept the prescription when it is tendered, he or she might be able to avoid assuming *any* duty. Of course, a patient could claim that as a pharmacist, he or she *still* has a professional obligation to see that the patient's needs are satisfied by *someone*. If the pharmacist's policy has also been posted on signs at the pharmacy and on the building's entrance doors by the time a patient tenders a prescription for an objectionable

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<sup>213</sup> Again, HHS expressly exempted the conscience regulation from Title VII's provision that an employer must accommodate an employee only to the extent that doing so would not be an undue burden. Worobec & Gray, *supra* note 116, at 36.

<sup>214</sup> Spreng, *supra* note 42, at 353. Including with every new prescription or every refill a flyer explaining that an objecting pharmacist is on staff at the pharmacy may be impractical because of costs or because of the volume of prescriptions dispensed. Granted, once a patient has received a notice either because he or she has obtained a new prescription or a refill, he or she need not continue to receive notices subsequently. In the least, posting a flyer at the pharmacy and on the doors of the building in which the pharmacy is located is not impractical or costly and may very well be adequate to alert customers.

drug, it becomes harder to argue that the pharmacist arbitrarily or prejudicially refused to fill the patient's prescription.

In the end, *putting patients on notice is absolutely vital*; the impression that a pharmacist "sprang" his or her objections on a patient does not make the pharmacist more sympathetic in the eyes of the patient—or a court.<sup>215</sup> Also crucial is that a pharmacist not *obstruct* a patient's access to medication. Passive refusal to interface with a medication is one thing, but destroying or refusing to return a prescription, harassing patients, or engaging in civil disobedience deeply hurts a pharmacist's case.<sup>216</sup> Ultimately, though, not even stocking the medications in question may be the best thing a pharmacist can do if he or she has control over the pharmacy's inventory.<sup>217</sup>

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<sup>215</sup> In spite of Neil Noesen's writing to his employer about his objections and total refusal to interface with contraceptives, he and his employer lacked a formal and fail-safe protocol for handling requests for contraceptives. *Noesen v. Medical Staffing Network, Inc.*, 232 Fed. Appx. 581, 583 (2007). The patient who requested from him a refill of her oral contraceptives was not on notice that he would refuse to refill the prescription so that Noesen's refusal came as a surprise to her. *Harrington*, *supra* note 104, at 807. Had better precautions been taken, perhaps Noesen and this patient could have avoided conflict altogether. Then again, his desired accommodations may simply have been too burdensome for any employer to provide in light of Title VII's acknowledgement that accommodations need not impose more than a *de minimis* burden on the employer.

The Supreme Court's holding in the *Smith* decision is a reasonable recognition that there have to be some limits on the extent to which the government must accommodate religious believers, but it should have articulated a distinction between *denying* a believer an exemption from a neutral and generally applicable law and *coercing* him to act contrary to his conscience. While the former may be inevitable in a pluralistic society, the latter is much harder, if not impossible, to justify. *See Stone*, *supra* note 52. Stone notes that there may be and probably is a very radical distinction between compelling a citizen to refrain from acts which he regards as moral but which the majority of his fellow citizens and the law regard as immoral or unwholesome to the life of the state on the one hand, and compelling him on the other to do affirmative acts which he regards as unconscientious and immoral.

*Id.*

<sup>216</sup> *Cf. Spreng*, *supra* note 29, at 241–43.

<sup>217</sup> *Cf. Yoder*, *supra* note 74, at 1014–15. A growing number of pharmacies have made the choice not to stock products they find objectionable, including DMC Pharmacy in Chantilly. The pharmacy is part of Divine Mercy Care, a Catholic-affiliated nonprofit organization, whose chairman stated that "[w]e're trying not to leave our faith at the door . . .", and "[w]e're trying to create an environment where belief and professionalism come together." *Stein*, *supra* note 21, at A1.

C. *A Proposed Conscience Law for Pharmacists*

South Dakota's conscience law, while not perfect, should serve as the base for a model pharmacist conscience law for all states.<sup>218</sup> The law provides a pharmacist an unfettered exemption from dispensing any medication that could be abortifacient in nature or be used in a euthanasia, assisted-suicide, or mercy-killing context.<sup>219</sup> The law also provides the pharmacist with civil immunity and protection from discrimination.<sup>220</sup>

However, the law does not provide any explicit exemption for pharmacists who object to transferring prescriptions or referring patients to other pharmacies.<sup>221</sup> This omission could be used by courts to conclude that, particularly in light of the expectations of APhA, pharmacists should at least refer patients or transfer their prescriptions, and a refusal to do so is an abdication of their duties. In addition, South Dakota exempts a pharmacist if he or she has *reason to believe* a medication *would be used as an abortifacient*, but the means to make this determination would almost require clairvoyance on the part of the pharmacist.<sup>222</sup> Furthermore, "the statutory language almost invites a battle of experts on whether an emergency contraceptive interferes with the implantation of a fertilized egg."<sup>223</sup> Thus, a model law should include an explicit provision exempting pharmacists from having to interface with *contraceptives* so as to avoid creating both ambiguity and room for a hostile court or jury to find liability on the part of the pharmacist; the Arkansas Family Planning Act features such a provision and the model law proposed below incorporates this provision, with modification.<sup>224</sup>

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<sup>218</sup> S.D. CODIFIED LAWS § 36-11-70 (2008). See Nelson, *supra* note 32, at 163 (discussing South Dakota statute).

<sup>219</sup> S.D. CODIFIED LAWS § 36-11-70 (2008).

<sup>220</sup> *Id.*

<sup>221</sup> The law also does not include drugs used in capital punishment among those that pharmacists are exempt from dispensing, but a model law should provide such an exemption.

<sup>222</sup> Spreng, *supra* note 42, at 379.

<sup>223</sup> *Id.* at 378.

<sup>224</sup> The pertinent part of the Arkansas Family Planning Act provides that:

(4) Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information; and

(5) No private institution or physician, nor any agent or employee of the institution or physician, nor any employee of a public institution acting under directions of a physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious

As Jessica J. Nelson suggests, a conscience law should be expressly limited to specific drugs that create conscience problems for pharmacists, namely those that can act as abortifacients or that are used in life-ending contexts.<sup>225</sup> Indeed, South Dakota's law appears to be limited to just these types of medications. Additionally, a model conscience law should make it clear that the pharmacist is not permitted to harass or slander a patient or sabotage the patient's access to the medication he or she seeks;<sup>226</sup> such a standard should discourage arbitrary objections and ensure that an objection is rooted in deeply-held moral or religious beliefs. Yoder rightly includes in her own model law a provision permitting a pharmacy not to stock medications to which its management objects or for which there would be little demand; such a provision should be in every pharmacist conscience law.<sup>227</sup> Finally, a model law should require that a pharmacist discuss any reservations with his or her employer and develop a protocol for dealing with requests for objectionable drugs and this policy should be posted at the pharmacy and at the entrance of the building in which the pharmacy is located.<sup>228</sup> By taking these last steps, patients can be placed on notice, and pharmacists and their employers will have an easier time denying any duty to dispense the medication in question.

Here this Note uses South Dakota's law as a basis and adds the above-mentioned recommendations. The Author's additions are italicized.<sup>229</sup>

*Model Right-of-Conscience Protection for Pharmacists Statute*

A. No pharmacist or pharmacy may be required to *stock or dispense medication if, in the professional judgment of the pharmacist or pharmacy, the medication could be used to:*

- (1) Cause an abortion *anytime after the union of a sperm and egg; or*

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objection. No such institution, employee, agent, or physician shall be held liable for the refusal.

ARK. CODE ANN. § 20-16-304(4)-(5) (2008).

<sup>225</sup> Nelson, *supra* note 32, at 163.

<sup>226</sup> *Id.* Again, passive refusal to interface with a certain drug should be protected by law, but destroying or refusing to return a doctor's prescription, lying to a patient, or slandering her character are all inappropriate acts and are probably already illegal throughout the United States. See Spreng, *supra* note 42, at 351-52 (distinguishing passive refusal from civil disobedience).

<sup>227</sup> Yoder, *supra* note 74, at 1021.

<sup>228</sup> Again, this is a measure intended merely to *accommodate* hostile laws or court decisions, not an endorsement of obligatory disclosure.

<sup>229</sup> The provision in part B of the proposed statute is taken from the Arkansas Family Planning Act. See ARK. CODE ANN. § 20-16-304(4)-(5) (2008).

- (2) Destroy an unborn child; or
- (3) Cause the death of any *human being, regardless of age, health, or condition of dependency*, by means of an assisted suicide, euthanasia, mercy killing, execution, or any other means.

B. *A pharmacist shall not be prohibited from refusing to furnish any contraceptive procedures, supplies, or information and no private institution or pharmacist, nor any agent or employee of the institution or pharmacist, nor any employee of a public institution acting under directions of a pharmacist, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or pharmacist shall be held liable for the refusal.*

C. *No such refusal to dispense medication pursuant to this section or to refer a patient or transfer a prescription to an entity that will provide the medication may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist.*

D. *No pharmacist may be permitted to harass or slander a patient who requests a medication to which the pharmacist objects. A pharmacist may not be permitted to obstruct a patient's access to medication but may passively refuse to facilitate access to it.*

E. *Every pharmacist who objects to interfacing with medications he or she believes will be used consistent with A or B above must discuss such objections with his or her employer and the employer shall take steps, consistent with Title VII, to develop a protocol to accommodate objecting pharmacists.*

F. *A notice indicating that an objecting pharmacist is on staff at a pharmacy and a copy of the pharmacy's protocol explaining in understandable terms that the pharmacist or pharmacy does not stock or will not dispense, refer patients, or transfer prescriptions when certain drugs are involved shall be posted clearly on the entrance doors of the building in which the pharmacy is located and at the pharmacy counter.*

## V. CONCLUSION

In closing, both history and common sense point to the appropriateness and logic of affording pharmacists a right of conscience. This issue will no doubt become more publicized and debated in the years to come as legislatures, courts, pharmacists, and the public they serve further develop and chart pertinent laws and rights. Out of respect for the dignity, heartfelt moral beliefs, and First Amendment rights of pharmacists, and in order to preserve the ethics of the medical profession at large, right-of-conscience laws are absolutely fundamental for

pharmacists (and healthcare workers in general). It is the Author's hope that both the law and public sentiment will more fully reflect these considerations in the immediate future.

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