


Spring 3-1-2010

Conceiving Plan B: A Proposal to Resolve the Conflict Between Women and Conscientiously Objecting Pharmacists over Access to Emergency Contraceptives

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Joshua T. Shaw, *Conceiving Plan B: A Proposal to Resolve the Conflict Between Women and Conscientiously Objecting Pharmacists over Access to Emergency Contraceptives*, 16 Wash. & Lee J. Civ. Rts. & Soc. Just. 563 (2010).
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Conceiving Plan B: A Proposal to Resolve the Conflict Between Women and Conscientiously Objecting Pharmacists over Access to Emergency Contraceptives

Joshua T. Shaw*

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* J.D., Washington and Lee University School of Law, *magna cum laude*, 2010. I would like to thank my Note advisor, Professor Ann MacLean Massie, for her insightful comments and support. I would also like to thank my fiancée, Kristy Sullivan, for her never-ending patience during the many hours that I spent working on this Note.

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Introduction

In December 2006, Carrie Baker walked into her local pharmacy at the Kroger's grocery store in Rome, Georgia.¹ A forty-two-year-old mother of two, she wanted to purchase the emergency contraceptive Plan B,² but the pharmacist on duty refused to sell it to her.³ Ms. Baker felt hurt, embarrassed, and insulted at the refusal.⁴ In spite of this shocking denial, Ms. Baker had no legal recourse against the pharmacist.⁵ Georgia law permitted pharmacists to refuse, for personal reasons, to sell contraceptives.⁶

Several states away in Illinois, a different legal development was taking place, with the law aimed squarely against pharmacists who would deny women access to contraceptives.⁷ An executive rule issued by Illinois Governor Rod Blagojevich requires all pharmacies to fill prescriptions for

1. See Peter Urban, *Shays: Plan B Contraceptive Must Be Sold*, CONN. POST, June 7, 2007, available at 2007 WLNR 10624652 ("Last December, Carrie Baker was shocked when a pharmacist at her local Kroger's grocery store in Rome, Ga., refused to sell her Plan B.").

2. *Id.* Emergency contraceptives such as Plan B prevent pregnancy after unprotected sex if taken within seventy-two hours after intercourse. See also Sydney Kokjohn, Note, *The Imposition of an Age Restriction on Over-the-Counter Access to Plan B Emergency Contraception: Violating Constitutional Rights to Privacy and Exceeding Statutory Authority*, 9 MINN. J.L. SCI. & TECH. 369, 371–72 (2008) (explaining emergency contraceptives accomplish this outcome by preventing ovulation, union of the sperm and egg, or implantation of the fertilized egg).

3. Urban, *supra* note 1.

4. See *id.* ("[I]t was 'hurtful,' 'embarrassing,' and 'insulting' to have a pharmacist deny her emergency contraceptives while willingly selling Viagra to men.").

5. See *id.* ("The pharmacist, however, was within her legal rights. Georgia law allows pharmacists to refuse, for personal reasons, to sell contraceptives.").

6. *Id.*

7. See *Morr-Fitz, Inc. v. Blagojevich*, 231 Ill. 2d 474, 480–81 (2008) (summarizing the emergency rule issued by former Illinois Governor Rob Blagojevich requiring pharmacies to dispense contraceptives).

contraceptives, including Plan B.⁸ Governor Blagojevich announced that he would enforce the rule vigorously,⁹ to the fear of pharmacist Luke Vander Bleek.¹⁰ Mr. Vander Bleek is a practicing Catholic who strongly believes that life begins at conception.¹¹ As a result, he believes that Plan B, which may prevent implantation of a fertilized egg, is an abortifacient and refuses to stock or to sell it in the pharmacies that he owns.¹² To defend against being forced to dispense Plan B, Mr. Vander Bleek filed a lawsuit seeking declaratory relief that the rule is invalid.¹³ This lawsuit came at a steep price. According to Mr. Vander Bleek, the rule's "chilling effect" forced him to shutter one of his pharmacies because he could not find a pharmacist to staff it, for fear that the pharmacy would lose its license for failing to adhere to the rule.¹⁴

Ms. Baker and Mr. Vander Bleek's stories exemplify the mosaic of state laws and regulations governing access to contraceptives.¹⁵ Some states require pharmacists or pharmacies to dispense properly prescribed medication, whereas others allow pharmacists or pharmacies to refuse to dispense medications based on conscientious objections.¹⁶ The differing state solutions reflected by Ms. Baker and Mr. Vander Bleek's experiences reflect efforts either to ensure access to these medicines or to legislate the protection of health care providers' conscientious objections.¹⁷

8. *Id.*

9. *See id.* at 481–82 ("[O]n April 13, 2005, the Governor issued a press release indicating that he will 'vigorously defend' the emergency rule requiring pharmacists to sell and fill prescriptions for contraceptives without delay.").

10. *See id.* at 482 (stating that Mr. Vander Bleek filed a motion for a temporary restraining order against the rule on September 14, 2005).

11. *Id.* at 478.

12. *See id.* at 478–79 ("He has formed a professional opinion 'about teratogenic or abortifacient drugs and their destruction of what he considers is human life,' and he believes that Plan B has an 'abortifacient mechanism of action.'").

13. *Id.* at 477.

14. *Id.* at 484–85.

15. *See* NAT'L WOMEN'S LAW CTR., PHARMACY REFUSALS: STATE LAWS, REGULATIONS, AND POLICIES (2009), <http://www.nwlc.org/pdf/PharmacyRefusalPoliciesMarch2009.pdf> (summarizing state laws and regulations governing access to medication, which vary from requiring pharmacists or pharmacies to dispense medication to allow pharmacist and pharmacy refusals with no protection for patients) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

16. *Id.*

17. *See* Robin Fretwell Wilson, *The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 43 (2008) (noting that some states have taken steps directing health care providers to offer emergency contraceptives to rape victims and also that other states have legislated the protection of

Ms. Baker's and Mr. Vander Bleek's stories provide two examples of recent clashes over access to emergency contraceptives. Indeed, whether pharmacists may refuse to dispense emergency contraceptives is a highly contentious issue, which dominates the broader debate over women's access to all contraceptives.¹⁸ Generally, pharmacists who object to providing emergency contraceptives hold views similar to Mr. Vander Bleek's position that emergency contraceptives are abortifacients.¹⁹ Some pharmacists also believe that certain other contraceptives act as abortifacients,²⁰ or they object to providing all contraceptives on moral grounds other than abortion.²¹ Reflecting the contours of the debate over access to contraceptives, this Note focuses on the issue of access to emergency contraceptives.

Resolving the controversy between women and pharmacists over access to emergency contraceptives is difficult because both sides frame their arguments in terms of competing rights.²² This Note attempts to bridge this divide by arguing that a national level policy solution is needed in order to adequately facilitate women's access to contraceptives while simultaneously protecting the consciences of pharmacists. Part I summarizes the current laws and regulations governing access to emergency contraceptives. Part II makes the case for a national policy solution, and Part III lays out the framework for this solution. Based on the guidelines set forth in Part III, Part IV examines recently proposed policy solutions. The fourth part argues that none of these proposals adequately protects the interests of women and pharmacists. Part V proposes a policy

conscientious refusals by pharmacists and pharmacies).

18. See Wilson, *supra* note 17, at 41 (observing that "[r]efusals by individual pharmacies and pharmacists to fill prescriptions for emergency contraceptives [like Plan B] . . . have dominated news headlines").

19. See *infra* Part II.B (discussing more thoroughly the foundation of pharmacists' objections to providing emergency contraceptives).

20. See Claire A. Smearman, *Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 ARIZ. L. REV. 469, 491 (2006) (noting the Catholic Church's official position that emergency contraceptives and some other forms of birth control such as IUDs and certain oral contraceptives are abortifacients that act to wrongly take a human life).

21. Pharmacists may object to birth control methods in general because they believe that birth control promotes problems like "promiscuity, divorce, the spread of sexually transmitted diseases, and other societal woes." See Rob Stein, *'Pro-Life' Drugstores Market Beliefs*, WASH. POST, June 16, 2008, at A1.

22. See HOLLY FERNANDEZ LYNCH, CONFLICTS OF CONSCIENCE IN HEALTH CARE: AN INSTITUTIONAL COMPROMISE 39 (2008) ("[B]oth sides of the debate claim important rights that defeat those of the other simply by virtue of the fact that they are rights.").

solution designed to protect access to emergency contraceptives and pharmacists who object to providing them.

I. Introduction to the Current Laws and Regulations Governing Access to Emergency Contraceptives

A. History

Under their police powers, individual states have broad authority to promulgate rules governing the conduct of pharmacies and pharmacists.²³ Following the Supreme Court's decision in *Roe v. Wade*,²⁴ decriminalizing abortion,²⁵ most states and the federal government enacted conscientious refusal clauses, aimed mainly at protecting health care providers who did not want to assist in abortion and sterilization procedures.²⁶ At that time, only a few states' clauses covered refusals arising from the dispensation of contraceptives.²⁷

Several events in the 1990's changed the legal landscape inspired by *Roe v. Wade*, and provoked the current laws and regulations governing access to emergency contraceptives. During this time, managed care grew dramatically, which led many Catholic hospitals that oppose providing emergency contraceptives to assume significant roles in health care delivery.²⁸ Following the advent of the popular male impotence drug Viagra, controversy exploded over insurance companies' decisions to cover that drug while maintaining their long-standing policies of denying coverage for prescription oral contraceptives.²⁹ Finally, the Food and Drug

23. *See id.* at 28 ("Under their police powers, states have broad authority to regulate the conduct of the medical profession, including the elements of training and capacity required for permission to engage in the practice of medicine.").

24. *Roe v. Wade*, 410 U.S. 113 (1973).

25. *Id.*

26. *See Smearman, supra* note 20, at 476–78 (tracing the advent of health care provider refusal laws from the federal Church Amendment to the ones that most states subsequently enacted).

27. *Id.* at 477.

28. *See id.* at 484–90 (tracing the growth of religiously-affiliated hospitals and state efforts to mandate the provision of emergency contraceptives to rape victims).

29. *See id.* at 481–84 (describing insurance companies' policies following the release of Viagra and the federal and state equity laws that responded to the controversy over these policies). The federal solution provided federal employees with coverage for all FDA-approved methods of contraception, with exceptions for insurers that objected based on their religious beliefs. *Id.* at 482. At the state level, twenty-two states have adopted laws

Administration's (FDA) approval of the prescription emergency contraceptive Plan B in 1998 catalyzed lawmakers' opposed to contraceptives to draft a "second wave of refusal clauses."³⁰ Each of these developments pitted opponents to emergency contraceptives against those who sought them. These events inspired today's state laws and regulations governing access to emergency contraceptives.³¹

B. Emergency Contraceptives and the Pharmacist's Role in Providing Them

Pharmacists are the "de facto gatekeepers" of emergency contraceptives, even though one contraceptive, Plan B, is most likely safe for use by women of all ages and is now available to some as an over-the-counter drug.³² In August 2006, the FDA approved the over-the-counter disposal of Plan B for women eighteen and older.³³ As a condition of this access, the FDA requires Plan B to be sold only in facilities staffed with health care professionals such as pharmacies.³⁴ Crucially, the FDA also requires health care providers to keep Plan B behind the counter and to require proof of age for purchase.³⁵ The FDA's policy places pharmacists "squarely between the patient and the drug."³⁶

The age restrictions against disposing Plan B are politically controversial, but they currently remain in effect for young women sixteen and under. In January 2005, a group of adolescent girls and the reproductive rights group MAP Conspiracy filed suit in the United States District Court for the Eastern District of New York challenging the FDA's denial of their request to make Plan B available over the counter to all age

requiring private insurance companies to provide coverage for prescription contraceptives if they cover other prescriptions. *Id.* at 483.

30. *Id.* at 477 (noting the link between the controversies over emergency contraceptives and insurance coverage of contraceptives and the rise of new laws and regulations extending the reach of conscience clauses to cover situations involving these medications).

31. *See id.* at 477–81 (summarizing the development of laws allowing pharmacists to refuse to dispense contraceptives and of laws directing pharmacists to dispense contraceptives).

32. *See Wilson, supra* note 17, at 47 (observing that pharmacists remain "de facto gatekeepers of Plan B" due to the FDA's policy on access to Plan B).

33. *Id.* at 46.

34. Kokjohn, *supra* note 2, at 377.

35. *Id.*

36. Wilson, *supra* note 17, at 47.

groups.³⁷ Vacating the FDA's decision, Judge Edward R. Korman ordered the agency to approve the over-the-counter use of Plan B for women seventeen and older under the same conditions originally permitting Plan B's distribution to women eighteen and older.³⁸ The court found that the FDA arbitrarily and capriciously denied the plaintiffs' request to change the Plan B dispensation guidelines.³⁹ The decision cited two reasons in support of the holding:

The FDA . . . [demonstrated] a lack of good faith regarding its decision on the Plan B [over the counter status] switch application. This lack of good faith is evidenced by, among other things, (1) repeated and unreasonable delays, pressure emanating from the [Bush] White House, and the obvious connection between the confirmation process of two FDA Commissioners and the timing of the FDA's decisions; and (2) significant departures from the FDA's normal procedures and policies in the review of the Plan B switch applications as compared to the review of other switch applications in the past 10 years.⁴⁰

One finding in support of the court's decision particularly underscores the politically-charged nature of the debate over access to Plan B. The court found that "political and ideological factors played a determinative role in the nomination and selection process for membership" on one of the committees empanelled to advise the FDA on how to respond to the over-the-counter status switch applications.⁴¹ The court emphasized that such action did not advance the FDA's "obligation to examine the safety and effectiveness of . . . [Plan B's] use in self-medication."⁴²

The court acknowledged that nearly all of the FDA's scientific review staff concluded that women of all ages could use Plan B without a prescription safely and effectively.⁴³ The court declined to substitute its own judgment for the FDA's judgment, so it did not grant the full relief sought by the plaintiffs.⁴⁴ The court, however, did conclude that no evidence justified denying seventeen year olds over the counter access to the medication.⁴⁵ Following the court's decision, on April 22, 2009, the

37. *Tummino v. Torti*, 603 F. Supp. 2d 579, 538 (E.D.N.Y. 2009).

38. *Id.* at 550.

39. *Id.* at 523.

40. *Id.* at 544.

41. *Id.* at 527.

42. *Id.* at 547 (citing 21 U.S.C. §§ 353(b)(1), 355(d)).

43. *Id.* at 523.

44. *Id.* at 543.

45. *Id.* at 550. The FDA's own findings acknowledged as much, concluding that "the

FDA implemented the Eastern District of New York's order by issuing a statement that it would allow Plan B's sale to women seventeen and older without a prescription.⁴⁶

Since the Eastern District of New York's 2009 decision, an alternative to Plan B has been approved for commercial use.⁴⁷ In August 2010, the FDA approved ella, which is available only by prescription.⁴⁸ The drug's ability to prevent pregnancy after unprotected sex for a longer time period than Plan B and chemical similarity to "abortion pill" RU-486 are controversial.⁴⁹ However, the drug may be legally obtained through the online pharmacy KwikMed.⁵⁰ KwikMed does not accept health insurance, though.⁵¹ Without the option of using health insurance, some women may find that purchasing ella online is prohibitively expensive given that they would be purchasing it on short notice.⁵² Additionally, a significant number

'scientific data [is] sufficient to support the safe use of Plan B as an OTC product . . . for women who are 17 years of age and older.'" *Id.* The court rejected as "simply untenable," the FDA's explanation that the difficulty of enforcing the age-based restriction necessitated keeping the eighteen-and-older age requirement. *Id.* The FDA presented no evidence that the age restriction would be unenforceable if set at age seventeen. *Id.*

46. Press Release, U.S. Food and Drug Admin., Updated FDA Action on Plan B (Levonorgestrel) Tablets (Apr. 22, 2009), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2009/ucm149568.htm> (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

47. See *Tummino*, 603 F. Supp. 2d 579, 522 (E.D.N.Y. 2009) (observing that at the time, Plan B was the only contraceptive drug available in the United States).

48. Press Release, U.S. Food and Drug Admin., FDA Approves Ella™ Tablets for Prescription Emergency Contraception (Aug. 13, 2010), <http://www.fda.gov/NewsEvents/NewsRoom/PressAnnouncements/ucm222428.htm> (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

49. Posting of Rob Stein to THE CHECKUP, voices.washingtonpost.com/checkup/2010/12/controversial_contraceptive_av.html (Dec. 1, 2010, 09:57 EST) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

50. *Watson Pharmaceuticals Inc. – December 1, 2010, Watson Pharmaceuticals Inc. Launches Ella Emergency Contraceptive*, STANDARD & POOR'S DAILY NEWS, Dec. 1, 2010, available at 2010 WLNR 23967848. Plan B is available online, as well. *E.g.*, *Buy Plan B Online*, DRUGSTORE.COM, http://www.drugstore.com/qxp161395/plan_b_one_step/emergency_contraceptive_must_be_17_or_over_to_purchase_without_a_prescription.htm (last visited Dec. 9, 2010, 23:00 EST) (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The considerations supporting the need to ensure access to ella at brick-and-mortar stores apply equally to Plan B.

51. *The FAQ's of Buying Medicine Online*, KWIKMED, https://www.kwikmed.com/_faqs.asp#8 (last visited Dec. 9, 2010) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

52. The price of ella is \$55, plus shipping. *Ella (Ulipristal Acetate) – Buy Ella Online from KwikMed*, KWIKMED, <https://www.kwikmed.com/ella.asp> (last visited Dec. 9, 2010) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

of women may not know about KwikMed, trust an online pharmacy, or have reliable internet access. Problems like these could easily prevent many women from ordering the drug in time to receive it during the short period when it is effective.⁵³ Women will still need to obtain emergency contraceptives at traditional brick-and-mortar pharmacies. Pharmacists' continued control over access to emergency contraceptives will remain an important issue.⁵⁴

C. Current State Policies

Thirty-two states have no regulations or laws targeting access to Plan B,⁵⁵ despite controversy over access to the medication. These states' laws and regulations may implicitly prohibit conscientious refusals to provide contraceptives.⁵⁶ The states permit pharmacists to refuse to dispense medications for medically valid reasons, such as a dangerous drug interaction, or for legally valid reasons, such as a failure to produce a valid prescription.⁵⁷ By failing to excuse objections based on religious, moral, or personal beliefs, these states presumably bar conscience-based refusals.⁵⁸

In the absence of guidelines regarding the provision of emergency contraceptives, pharmacists still may have the flexibility to refuse drugs for reasons of conscience. An incident in Ohio, a state with no set policy on pharmacist refusals,⁵⁹ demonstrates why this is true.⁶⁰ In that state, a Wal-

53. See *infra* Part II.A.1 (discussing how emergency contraceptives are effective for only three to five days after unprotected sexual intercourse).

54. Stein, *supra* note 49. Indeed, the litigation over Plan B's age restrictions in the case before Judge Korman has not ceased. On November 16, 2010, the plaintiffs filed a motion for civil contempt, accusing the FDA of contempt of court for failing to reconsider the age restriction for the drug. Memorandum of Law in Support of Plaintiffs' Motion for Civil Contempt, *Tummino v. Hamburg*, 603 F. Supp. 2d 519 (2009) (CV-05-0366), available at <http://www.washingtonpost.com/wp-srv/nation/pdfs/Motionforcontempt.pdf> (on file with the Washington and Lee Journal of Civil Rights and Social Justice). As of the date this Note went to press, Judge Korman had yet to rule on the motion.

55. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1.

56. See JILL MORRISON & GRETCHEN BORCHELT, NAT'L WOMEN'S LAW CTR., DON'T TAKE "NO" FOR AN ANSWER: A GUIDE TO PHARMACY REFUSAL LAWS, POLICIES, AND PRACTICES 4 (2007), <http://www.nwlc.org/pdf/DontTakeNo2007.pdf> (noting that in states without specific policies addressing access to contraceptives, pharmacists only may refuse to dispense medications for medically or legally valid reasons) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

57. *Id.*

58. *Id.*

59. See NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1 (identifying Ohio as one of the

Mart pharmacist refused to provide Plan B to a couple after a "contraceptive mishap."⁶¹ The pharmacist relied on Wal-Mart's policy that allows any employee who does not feel comfortable dispensing a product to refer customers to another pharmacist, pharmacy worker, or sales associate.⁶² State Governor Ted Strickland disapproved of the pharmacist's actions, but at the same time, stated that he had no specific plans concerning the incident.⁶³ Based on the state's present laws and regulations, Governor Strickland could not have accomplished much, anyway. Ohio's pharmacy laws and regulations provide no clear guidelines addressing the issue of pharmacist conscientious refusals.⁶⁴

states where pharmacists have an implicit duty to provide medications to patients).

60. See Wilson, *supra* note 17, at 47 (using the example discussed in this paragraph to point out how the FDA's over the counter policy on Plan B gives pharmacists the power to exercise their gatekeeper role over it and deny access to this drug).

61. Misti Crane, *Some Still Refuse to Dispense Plan B*, COLUMBUS DISPATCH, Jan. 15, 2007, at A1, available at 2007 WLNR 815433.

62. *Id.*

63. *Id.*

64. Pharmacists in Ohio have much professional discretion over the decision to dispense a particular medication. Ohio defines the practice of pharmacy as "providing pharmacist care requiring specialized knowledge, judgment, and skill derived from the principles of biological, chemical, behavioral, social, pharmaceutical, and clinical sciences." OHIO REV. CODE ANN. § 4729.01(B) (2009). As a result, Ohio pharmacists may presumably draw upon their understanding of when life begins in refusing Plan B—assuming they relate their conclusion on when life begins to the biological process of fertilization. The State's enumerated list of activities that constitute "pharmacist care" does not explicitly preclude or condone such decisions. The list includes interpreting prescriptions, dispensing drugs and drug therapy related devices, compounding drugs, counseling patients with regard to their drug therapy, performing drug regimen reviews, discussing a patients' drug regimens with their prescribers, and advising patients and those treating them with regard to the patients' drug therapy. § 4729.01(B)(1)–(7). In fact, Ohio's regulation on dispensing drugs only requires that a pharmacist or pharmacy intern dispense medications in accordance with State law. OHIO ADMIN. CODE 4729:5-25(A) (2009). Finally, Ohio does not single out conscience-based medication refusals as protected activity or as sanctionable unprofessional conduct. The State administrative code recognizes the following five activities as unprofessional conduct:

- (1) Advertising or displaying signs that promote dangerous drugs to the public in a manner that is false or misleading;
- (2) Except as provided in section 4729.281 of the Revised Code, the sale of any drug for which a prescription is required, without having received a prescription for the drug;
- (3) Knowingly dispensing medication pursuant to false or forged prescriptions;
- (4) Knowingly failing to maintain complete and accurate records of all dangerous drugs received or dispensed in compliance with federal laws and regulations and state laws and rules;
- (5) Obtaining any remuneration by fraud, misrepresentation, or deception.

OHIO REV. CODE ANN. § 4729.16(C) (2009).

In contrast to states with no particular pharmacist refusal policy, California, Illinois, Maine, Massachusetts, Nevada, New Jersey, and Washington have policies directing pharmacists or pharmacies to provide legally available medication.⁶⁵ Of these states, California is the only one that requires both pharmacists and pharmacies to dispense medications.⁶⁶ California law specifically states that no pharmacist shall obstruct a patient's access to a legally prescribed medication.⁶⁷ However, the law in California does attempt to protect conscientiously objecting pharmacists, provided that they notify their employer in advance of their objections to any drugs or class of drugs.⁶⁸ A pharmacist may decline to provide a drug, though, if the pharmacist's employer can provide a reasonable accommodation of the pharmacist's refusal without imposing an undue hardship on the employer.⁶⁹ In accommodating an objecting pharmacist, pharmacies in California have the duty to ensure that patients have timely access to the medications that the objecting pharmacist refuses to dispense.⁷⁰

Maine, Massachusetts, and Nevada place the duty to dispense medications on pharmacists.⁷¹ For example, Maine permits pharmacists to refuse to dispense a drug only for non-conscience based reasons, such as the failure of the patient to present a valid prescription.⁷² Similarly, Nevada's administrative regulations allow pharmacists to decline to fill a prescription only if filling it is unlawful or potentially harmful to the patient's health, or if the prescription is fraudulent or not for a legitimate medical purpose.⁷³ The Massachusetts Board of Pharmacy⁷⁴ has set forth a

65. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

66. *Id.*

67. CAL. BUS. & PROF. CODE § 733(a) (West 2007).

68. *Id.* § 733(b)(3).

69. *Id.* (citing CAL. GOV'T CODE § 12940(l) (West 2004)).

70. *Id.*

71. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

72. *See* 02-392 ME. CODE R. ch. 19, § 11 (West 2009) (citing ME. REV. STAT. ANN. tit. 32, § 13795 (West 2008)). Section 13795 grants pharmacists the discretion to refuse to fill prescriptions or to dispense drugs for a variety of non-conscience based reasons, such as if the pharmacist believes that the patient will use a drug to manufacture methamphetamine or that the prescription is invalid or inappropriate. *Id.*

73. NEV. ADMIN. CODE § 639.753(1) (West 2008).

74. The Massachusetts Board of Pharmacy is empowered by law to enforce the laws relating to pharmacy and to create and to enforce the rules of professional conduct in pharmacy. *See* MASS. GEN. LAWS ANN. ch. 112, § 42A (West 2003) (setting forth the Board of Pharmacy's enforcement powers for carrying out the provisions of law relating to the drug and pharmacy business and for creating and enforcing the rules of professional conduct).

policy that pharmacists are required to fill all valid prescriptions, including those for emergency contraceptives.⁷⁵ These three states do not recognize in any way pharmacists' conscientious objections to filling prescriptions.

Illinois, New Jersey, and Washington place the duty to dispense medications on pharmacies.⁷⁶ Illinois has a targeted regulation that requires all pharmacies to dispense contraceptives.⁷⁷ If an Illinois pharmacy stocks contraceptives, then it must use its best efforts to maintain an adequate stock of emergency contraceptives.⁷⁸ If a pharmacist objects to disposing emergency contraceptives, then the Illinois regulation requires pharmacies to inquire whether another pharmacist on duty would object to providing the drug.⁷⁹ If no such pharmacist is available, then the pharmacy still must provide the emergency contraception by contacting an off-site pharmacy or non-objecting pharmacist.⁸⁰ Pharmacies have the responsibility of ensuring either that a non-objecting pharmacist is on duty or that an off-site non-objecting pharmacist is available.⁸¹

In contrast, New Jersey and Washington have broader rules requiring pharmacies to dispense all drugs.⁸² Pharmacies in New Jersey and Washington must assist patients in gaining access to a drug if the pharmacy is out of stock or does not carry it.⁸³ However, unlike Illinois, neither New

75. MORRISON & BORCHELT, *supra* note 56, at 5 (citing a letter issued by the Massachusetts Board of Pharmacy stating its policy that pharmacists are required to fill all valid prescriptions and that no class of drugs is exempt from the general requirement of dispensation).

76. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

77. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1) (West 2009).

78. § 1330.91(j)(2).

79. § 1330.91(j)(3)(A).

80. § 1330.91(j)(3)(B).

81. § 1330.91(j)(4).

82. *See* N.J. STAT. ANN. § 45:14-67.1(a) (West 2007) ("A pharmacy practice site has a duty to properly fill lawful 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."); WASH. ADMIN. CODE § 246-869-010(1) (West 2008) ("Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies, or provide a therapeutically equivalent drug or device in a timely manner . . .").

83. *See* N.J. STAT. ANN. § 45:14-67.1(b)-(c) (requiring pharmacies either to obtain the drug using expedited ordering procedures or to locate another pharmacy with the drug in stock that is reasonably accessible to the patient); WASH. ADMIN. CODE § 246-869-010(1), (3) (requiring pharmacies to deliver the drug or provide a "therapeutically equivalent drug . . . in a timely manner consistent with reasonable expectations for filling the prescription" or to provide a "timely alternative for appropriate therapy which, consistent

Jersey nor Washington provides detailed procedures to pharmacies for handling situations involving pharmacists who object to providing Plan B.⁸⁴

States that impose duties to dispense medications facilitate women's access to contraceptives. However, Maine, Massachusetts, and Nevada offer no protection to pharmacists' conscientious objection to providing these medications. And unlike Illinois, New Jersey's and Washington's rules directing pharmacies to dispense all medications offer little guidance in how to address the concerns of pharmacists' conscientious objection to providing contraceptives while simultaneously serving the needs of women seeking those medications.

Other states do not impose duties to dispense medications but still include some measures to protect women's access to Plan B. Alabama, Delaware, New York, North Carolina, Oregon, Pennsylvania, and Texas allow pharmacist or pharmacy refusals but prohibit obstructions against access to medications and refusals to transfer or to refer customers.⁸⁵ Of the states in this group, Alabama, North Carolina, and Texas direct their policies solely toward pharmacists by requiring them to meaningfully refer or transfer a patient's request for medication.⁸⁶ The pharmacy boards of these states have interpreted their professional obligations to require an objecting pharmacist to provide a meaningful referral or transfer to a patient seeking contraceptives.⁸⁷ These opinions carry the force of law because these states' laws grant the boards the power to enforce the laws governing the pharmacy business in those states.⁸⁸

In Delaware, New York, Oregon, and Pennsylvania, pharmacists and pharmacies have duties to prevent the obstruction of a patient seeking

with customary pharmacy practice, may include obtaining the drug or device"). On top of its pharmacies' duty to dispense medications, Washington requires pharmacies to maintain a stock of contraceptives, so long as doing so reflects the pharmaceutical needs of its patients. *See* WASH. ADMIN. CODE § 246-869-150(1) (West 2008) ("The pharmacy must maintain at all times a representative assortment of drugs in order to meet the pharmaceutical needs of its patients.").

84. *Compare* N.J. STAT. ANN. § 45:14-67.1, *and* WASH. ADMIN. CODE § 246-869-010, *with* ILL. ADMIN. CODE tit. 68, § 1330.91(j).

85. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

86. *Id.*

87. *Id.*

88. *See* ALA. CODE § 34-23-90(a) (2009) (vesting in the Alabama State Board of Pharmacy the authority to carry out and to enforce the pharmacy profession); N.C. GEN. STAT. ANN. § 90-85.6(a) (West 2008) (granting responsibility for enforcing the laws pertaining to pharmacy to the North Carolina Board of Pharmacy); TEX. OCC. CODE ANN. § 554.001 (Vernon 2008) (giving the Texas State Board of Pharmacy the powers to administer and enforce the rules and laws governing the practice of pharmacy).

contraceptives.⁸⁹ These states prohibit pharmacists from interfering with a patient's access to medications.⁹⁰ Oregon adds the requirement that pharmacists must provide a meaningful referral or transfer of prescription to a patient seeking contraceptives.⁹¹ As for the pharmacies in these four states, they must ensure that patients have timely access to the medications they seek.⁹² These states also rely on pharmacy board statements that carry the force of law.⁹³

Compared to the states imposing duties to dispense medications, these states provide more balance between the interests of women in obtaining contraceptives and pharmacists who may have conscientious objections to providing those medications. Even though pharmacists may object to providing these medications, either they or the pharmacies where they work must provide women access to the drugs.

Finally, Arkansas, Georgia, Mississippi, and South Dakota have sweeping statutes or regulations that permit pharmacists or a whole host of institutions to refuse to dispense medications.⁹⁴ The main difference between these states is the number of types of providers who are allowed to refuse dispensing Plan B.⁹⁵

Georgia and South Dakota allow only pharmacists to refuse the provision of a medication.⁹⁶ Georgia protects pharmacist refusals to fill prescriptions based on ethical or moral beliefs by specifically considering

89. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2. *See also* 49 PA. CODE § 27.103 (2009) (setting forth in the Pennsylvania Code the State Board of Pharmacy's policy statement on matters of conscience allowing pharmacists to refuse to fill prescriptions yet directing them not to abandon or neglect a patient).

90. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

91. *Id.*

92. *Id.*

93. *See* DEL. CODE ANN. tit. 24, § 2501 (2009) (setting forth the Delaware Board of Pharmacy's objectives of overseeing the pharmacy trade and of maintaining professional standards in pharmacy); N.Y. EDUC. LAW § 6804 (McKinney 2009) (granting the New York Board of Pharmacy the power to regulate the practice of pharmacy); OR. REV. STAT. § 689.135 (2008) (giving the Oregon Board of Pharmacy the duties and power to regulate pharmacy in the state); 63 PA. CONS. STAT. ANN. § 390-6(k) (West 2008) (providing the Pennsylvania State Board of Pharmacy the power and duty to regulate the practice of pharmacy).

94. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

95. *See id.* (identifying Georgia and South Dakota as states allowing pharmacists to refuse provision of contraceptives, and Arkansas and Mississippi as states permitting even institutions like pharmacies to refuse to dispense contraceptives).

96. *Id.*

such refusals not to be unprofessional conduct.⁹⁷ As a result, the Georgia Board of Pharmacy may not subject refusing pharmacists to disciplinary actions.⁹⁸ South Dakota tailors its refusal statute to allow pharmacist refusals only when "there is reason to believe that the medication would be used to: (1) Cause an abortion; or (2) Destroy an unborn child."⁹⁹ This statute would protect pharmacists, such as Mr. Vander Bleek, who object to giving out emergency contraceptives on the basis of their beliefs that such medications are abortifacients.¹⁰⁰ In contrast to Georgia, South Dakota provides bulletproof protection to such pharmacists by exempting them from any claim of damages or disciplinary action—even any such action by their employers—that may arise from their refusals.¹⁰¹

Arkansas and Mississippi extend the broad protections found in Georgia and South Dakota beyond pharmacists.¹⁰² In Arkansas, most health care bodies—from private institutions and physicians, including their agents and employees, to employees of public institutions acting under directions of a physician—are permitted to refuse to provide contraceptive procedures, supplies, and information based on religious or conscientious objections.¹⁰³ Similarly, Mississippi allows health care providers, health care institutions, and health care payers, such as insurance companies, to

97. See GA. CODE ANN. § 480-5-.03(n) (2008) ("It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs.").

98. See *id.* § 480-5-.03(o) (setting forth that "[v]iolation of [the Code of Professional Conduct] may subject the violator to suspension or revocation of any license issued to him/her by the Board and/or public reprimand, fines, probation, letters of concern or other disciplinary actions deemed appropriate by the Board").

99. S.D. CODIFIED LAWS § 36-11-70 (2008).

100. See *Morr-Fitz, Inc. v. Blagojevich*, 231 Ill. 2d 474, 478 (2008) (summarizing Mr. Vander Bleek's understanding of how the emergency contraceptive Plan B works as an abortifacient).

101. See S.D. CODIFIED LAWS § 36-11-70 ("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."). Indeed, South Dakota law even protects the pharmacy of the refusing pharmacist from liability for damages. *Id.*

102. See NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2 (noting that other health care providers, like pharmacies, are protected too).

103. See ARK. CODE ANN. § 20-16-304(5) (West 2009), which provides:

No private institution [like a pharmacy] or physician, nor any agent or employee [like a pharmacist] 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 objection.

abstain from providing health care services—such as dispensing contraceptives—that violate their consciences.¹⁰⁴ The sweeping provisions of Arkansas and Mississippi law cover pharmacists, pharmacies, and other health care providers.¹⁰⁵ These laws extend the liability protections found in South Dakota and exempt pharmacists and pharmacies in Arkansas and Mississippi from liability for their refusals.¹⁰⁶

With no provisions directing pharmacists or pharmacies to assist patients in gaining access to medicine in the face of health care providers' conscientious refusals, these four states do not facilitate women's access to Plan B. Indeed, the decisions of these states to exempt health care providers from liability for conscientious objection make it impossible for women to seek legal recourse for consequences stemming from refusals to provide emergency contraceptives.

II. A National Policy Solution Is Necessary

A national level solution is necessary to resolve the conflict between women seeking contraceptives and providers who conscientiously object to dispensing them. The argument for a national solution stems from the need to ensure protection of the interests of both women and pharmacists, wherever they may be located. On the one hand, a national policy would advance important women's health interests in obtaining contraceptives. This kind of solution also would democratize women's access to contraceptives, such that the ease of obtaining them is not contingent on the state where a woman lives. On the other hand, pharmacists are concerned about whether they are able to adhere to their conscientious objections against dispensing contraceptives while continuing to serve as professionals. A national policy solution accommodating this interest would ensure that all pharmacists' consciences are protected, no matter where they practice.

104. See MISS. CODE ANN. § 41-107-5-9 (West 2008) (allowing health care providers [like pharmacists], institutions [like pharmacies], and payers to decline to participate in providing "health care services" like the provision of contraceptives).

105. ARK. CODE ANN. § 20-16-304(5) (West 2009); MISS. CODE ANN. § 41-107-5-9 (West 2008).

106. See ARK. CODE ANN. § 20-16-304(5) (West 2009) ("No such institution, employee, agent, or physician shall be held liable for the refusal [to provide contraceptive procedures, supplies, and information]."); MISS. CODE ANN. § 41-107-5-7 (West 2008) (relieving pharmacists and pharmacies from civil, criminal, or administrative liability for declining to participate in health care services in violation of their consciences).

A. *How a National Policy Solution Would Assist Women*

1. *Women Have an Important Interest in Controlling the Timing of Their Pregnancies*

Women have a vital health interest in controlling their pregnancies. Millions of women use contraceptives to accomplish this. As of 2008, the United States had approximately sixty-two million women of reproductive age.¹⁰⁷ Sixty-two percent of them are currently using some form of contraceptive.¹⁰⁸ Of all contraceptive means, the drug version dispensed by pharmacists is the number one method.¹⁰⁹ It is the most popular method because it provides a "steady form" of birth control.¹¹⁰ Indeed, oral contraceptives are crucial to women's health care needs, because many women use them to time their pregnancies. Forty-three million women of reproductive age are sexually active and do not want to become pregnant.¹¹¹ The typical U.S. woman wants only two children; to achieve this goal, she must use contraceptives for approximately three decades.¹¹² Moreover, preventing unintended pregnancies is vital to women and society in general.¹¹³ Such pregnancies often lead to tragic societal consequences, such as single parenthood, the failure of women to finish their educations, and abortions.¹¹⁴

107. GUTTMACHER INST., FACTS ON CONTRACEPTIVE USE 1 (2008), http://www.guttmacher.org/pubs/fb_contr_use.pdf (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

108. *Id.*

109. *See id.* About thirty percent of U.S. women who practice contraception use the oral pharmaceutical contraceptive, the "pill." *Id.* This statistic means that over 11.5 million women in the U.S. use the pill. *Id.*

110. *See* Holly Teliska, *Recent Development: Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 233 (2005) (noting that oral contraceptives provide a steady form of contraception that lowers pregnancy risks).

111. *See* GUTTMACHER INST., *supra* note 107, at 1 ("43 million women of reproductive age, or 7 in 10, are sexually active and do not want to become pregnant, but could become pregnant if they or their partners fail to use a contraceptive method.").

112. *Id.*

113. *See* Erica S. Mellick, *Time for Plan B: Increasing Access to Emergency Contraception and Minimizing Conflicts of Conscience*, 9 J. HEALTH CARE L. & POL'Y 402, 404 (2006) (arguing that that timely access to emergency contraception is crucial for American women and general public health and noting, for example, the statistic on how long women should use birth control).

114. *See id.* at 403 (observing that "[m]any societal problems can be traced back to unwanted pregnancy: teenage pregnancy, single parenthood, incomplete education of

Many women in need of birth control are already economically vulnerable.¹¹⁵ Approximately 17.5 million women in need of contraceptives are economically disadvantaged and likely to need government support in gaining access to these medicines.¹¹⁶ In 2006, over nine million women received publicly supported contraceptive care.¹¹⁷ Seven million of these women received care from publicly funded family planning centers, which receive federal funding from Title X and Medicaid.¹¹⁸ Over two million women received publically supported contraceptive care through Medicaid.¹¹⁹

Emergency contraceptives constitute an especially vital form of birth control.¹²⁰ They have major potential to curb unwanted pregnancies and abortions.¹²¹ These pharmaceutical products reduce the pregnancy risk for a woman who has had unprotected intercourse between approximately sixty-six and seventy-five percent.¹²² However, emergency contraceptives must be taken within five days after unprotected sex to be effective.¹²³

women, welfare dependency, poverty, lack of prenatal care, substance abuse in early pregnancy, low birth weight, infant mortality, and child abuse." Unwanted pregnancy also may lead to abortions, with attendant health risks that could make the unwanted pregnancy deadly. *Id.*

115. *See* Teliska, *supra* note 110, at 233 (concluding that low-income women predominantly rely on oral contraceptives to meet their family planning needs).

116. GUTTMACHER INST., FACTS ON PUBLICLY FUNDED CONTRACEPTIVE SERVICES IN THE UNITED STATES 1 (2010), http://www.guttmacher.org/pubs/fb_contraceptive_serv.pdf (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

117. *Id.* at 2.

118. *See id.* at 1–2 (showing public funding sources for family planning client services and noting the number of women receiving publicly subsidized care from publicly supported family planning centers).

119. *See id.* at 2 (noting that "[m]ore than two million women were Medicaid enrollees who received contraceptive services from private physicians in 2006").

120. *See* Mellick, *supra* note 113, at 403–05 (arguing that not having access to emergency contraceptives leads to unintended pregnancies, which have negative consequences, such as poverty, and that having access to emergency contraceptives is necessary based on the crucial role birth control plays in women's health).

121. *See* Heather Boonstra, *Emergency Contraception: The Need to Increase Public Awareness*, 5 THE GUTTMACHER REP. PUB. POL'Y, Oct. 2002, at 3, available at <http://www.guttmacher.org/pubs/tgr/05/4/gr050403.pdf> (urging that the widespread use of emergency contraceptives could reduce the number of abortions and unwanted pregnancies in the United States significantly) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

122. If taken properly, the effectiveness of Plan B (levonorgestrel) at preventing pregnancy is approximately seventy-five percent. *Id.* The effectiveness of ella at preventing pregnancy, if taken properly, is about sixty-six percent. Stein, *supra* note 49.

123. *See* Boonstra, *supra* note 128, at 3 (explaining that Plan B must be taken within

Every year, three million pregnancies in the United States are unintended.¹²⁴ More than half of these end in abortions.¹²⁵ Widespread use of emergency contraceptives has the potential to reduce unintended pregnancies and abortions significantly.¹²⁶

2. *Current Pharmacy Disposal Laws Do Not Provide Women Sufficient Protection*

The current mosaic of state laws governing pharmacists do not provide sufficient protection to women. The majority of states do not have policies protecting women from pharmacist refusals to provide medications. Only fourteen states require either pharmacists or pharmacies to dispense medications or to ensure in some way that women obtain the drugs they need.¹²⁷ Thirty-two states do not have policies on conscientious drug refusals.¹²⁸ These states' regulations imply a duty to dispense medications in the absence of legally proscribed circumstances of dispensation, such as when a harmful drug interaction could occur.¹²⁹ Women may not be protected in these states because pharmacists still may refuse to provide contraceptives to them.¹³⁰ Four states allow medication refusals based on

seventy-two hours of unprotected intercourse). In contrast, ella may prevent pregnancy if taken up to five days after unprotected intercourse. Stein, *supra* note 49.

124. *See id.* (estimating that "[a]bout half of the 6.3 million pregnancies every year in the United States are unintended").

125. *See id.* ("[A]nd more than half of those [unintended pregnancies] end in abortion.").

126. *See id.* (estimating that "1.7 million unintended pregnancies could be avoided, and the number of abortions each year could be cut by as much as half").

127. *See* NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1 (summarizing the fact that seven states "explicitly require pharmacists or pharmacies to ensure that valid prescriptions are filled [and that seven others] have policies that prohibit a pharmacist from obstructing patient access to medication or from refusing to transfer or refer prescriptions to another pharmacy").

128. This number equals the total number of states, less the fourteen states with some policy facilitating women's access to drugs and those four states with policies protecting drug refusals with no concomitant protection for women. *Id.*

129. *See* MORRISON & BORCHELT, *supra* note 56, at 4 (explaining that by "omitting religious, moral or personal beliefs from the enumerated reasons for refusals, most state pharmacy laws implicitly prohibit such refusals").

130. *See supra* note 64 and accompanying text (discussing a pharmacist's refusal to provide emergency contraceptives in Ohio, even though it is one of the states listed as having no set pharmacist refusal policy).

conscience with no protection for the patient.¹³¹ Because only a minority of states protect women's access to contraceptives, millions of women have uncertain access to Plan B.

Rural areas magnify the challenges, especially where the law already may impede women's ability to obtain these drugs.¹³² Mississippi and South Dakota are two states with policies permitting refusal to dispense without patient protections.¹³³ Both states, especially South Dakota, have low population densities.¹³⁴ In both, dozens of communities have only one pharmacy.¹³⁵ Further compounding the problem is the fact that many women in need of contraceptive services in these states have low incomes.¹³⁶ Low-income women have fewer transportation options, further hindering their access to emergency contraceptives.¹³⁷ Mississippi and

131. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

132. *See* Teliska, *supra* note 110, at 232 (considering specifically the low-population states of Mississippi and South Dakota to argue how their conscientious refusal policies are "particularly dangerous to women living in those states").

133. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

134. Mississippi has a population density of approximately 60.6 persons per square mile. U.S. CENSUS BUREAU, STATE AND COUNTY QUICKFACTS: MISSISSIPPI (2009), <http://quickfacts.census.gov/qfd/states/28000.html> (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The average population density in the United States is approximately 79.6 persons per square mile. *Id.* South Dakota has a much lower population density of approximately 9.9 persons per square mile. U.S. CENSUS BUREAU, STATE AND COUNTY QUICKFACTS: SOUTH DAKOTA (2009), <http://quickfacts.census.gov/qfd/states/46000.html> (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

135. Mississippi has forty-three communities with only one independently owned pharmacy. RURAL POLICY RESEARCH INSTITUTE, MISSISSIPPI COMMUNITIES WITH ONLY ONE PHARMACY, INDEPENDENTLY OWNED (2007), <http://www.unmc.edu/ruprihealth/Pubs/statepharm/Mississippi.pdf>. Three of these communities are ones where the nearest retail pharmacy is located ten or more miles away. *Id.* South Dakota has thirty-nine communities with only one independently owned pharmacy. RURAL POLICY RESEARCH INSTITUTE, SOUTH DAKOTA COMMUNITIES WITH ONLY ONE PHARMACY, INDEPENDENTLY OWNED (2007), <http://www.unmc.edu/ruprihealth/Pubs/statepharm/South%20Dakota.pdf>. Thirty-three of these communities are located in areas ten or more miles away from another retail pharmacy. *Id.*

136. *See* Teliska, *supra* note 110, at 244–47 (noting that Mississippi and South Dakota have high percentages of low-income women of child bearing age in need of publicly funded contraceptive services).

137. *See id.* at 244 (observing in the context of Mississippi that low-income women in rural states have "fewer options when it comes to transportation and choice of pharmacies"). The author also notes that South Dakota's sparsely populated counties face "economic hardships that limit opportunities for travel and time needed to search for a friendly pharmacist." *Id.* at 246.

South Dakota's refusal laws compound the challenges for rural female populations.¹³⁸

The challenges to women in gaining access to contraceptives in Mississippi and South Dakota illustrate the types of problems faced by vulnerable women in rural areas.¹³⁹ Arkansas is another low-income, low-population state¹⁴⁰ with restrictive drug dispensation laws.¹⁴¹ Dozens of communities in Arkansas have only one independently-owned retail pharmacy, many of which are located ten miles or more from the next one.¹⁴² Even high population density states such as Florida,¹⁴³ which has no specific policy on conscientious drug refusals,¹⁴⁴ have pockets of rural areas served by only one pharmacy.¹⁴⁵ A policy addressing women's access to contraceptives would facilitate their health needs in these vulnerable communities where the law does not actively promote access to these drugs.

Finally, even the current comprehensive laws imposing duties to dispense contraceptives do not offer sufficient protection to women.

138. *See id.* at 243–44, 246 (concluding that Mississippi's and South Dakota's laws obstruct women's access to reproductive health care).

139. *See id.* at 245 (discussing access to contraceptives in rural South Dakota and stressing that "[i]n these smaller, more isolated communities, lawmakers have ignored the additional constraints on a woman's ability to find a friendly pharmacist").

140. Arkansas has a population density of approximately 51.3 persons per square mile, compared to the national population density of approximately 79.6 persons per square mile. U.S. CENSUS BUREAU, STATE AND COUNTY QUICKFACTS: ARKANSAS (2009), <http://quickfacts.census.gov/qfd/states/05000.html> (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

141. Arkansas is another one of the four states that allow drug dispensation refusals with no protection for women. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2.

142. The state has fifty-three communities with only one independently owned pharmacy. RURAL POLICY RESEARCH INSTITUTE, ARKANSAS COMMUNITIES WITH ONLY ONE PHARMACY, INDEPENDENTLY OWNED (2007), <http://www.unmc.edu/ruprihealth/Pubs/statepharm/Arkansas.pdf> (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The nearest pharmacy relative to twenty-three of these communities is more than ten miles away. *Id.*

143. Florida is relatively highly populated with a population density of approximately 296.4 persons per square mile versus the national average of approximately 79.6. U.S. CENSUS BUREAU, STATE AND COUNTY QUICKFACTS: FLORIDA (2009), <http://quickfacts.census.gov/qfd/states/12000.html> (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

144. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1.

145. Despite having major metropolitan areas like Orlando and Miami, Florida has twenty-one communities that only have one independently owned pharmacy. RURAL POLICY RESEARCH INSTITUTE, FLORIDA COMMUNITIES WITH ONLY ONE PHARMACY, INDEPENDENTLY OWNED (2007), <http://www.unmc.edu/ruprihealth/Pubs/statepharm/Florida.pdf> (on file with the Washington and Lee Journal of Civil Rights and Social Justice). People in nine of these communities must travel ten or more miles to the next nearest pharmacy. *Id.*

Ironically, though perhaps not surprisingly, these laws could fail to promote the provision of contraceptives in rural areas, where pharmacists may face a low demand for certain contraceptive products, such as Plan B.¹⁴⁶ They therefore may not stock it.¹⁴⁷ However, in states with strict duty-to-dispense rules, the threat of non-compliance could cause small, independent pharmacists to consider relocating, due to the financial and emotional costs of obeying the rule.¹⁴⁸ If a pharmacist relocates, then women in such areas are left with no convenient options for care.¹⁴⁹

146. See *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Comm. on Small Business*, 109th Cong. 9 (2005) [hereinafter *Small Pharmacy Hearings*] (testimony of J. Michael Patton, Illinois Pharmacists Association) (explaining that "one pharmacy told me they had two requests for [Plan B] in about 5 years"). This argument assumes, though, that women in these rural areas even would go to their local pharmacy to obtain Plan B in the first place. Obtaining such a medication risks embarrassment over questions regarding use of the medication and potential stigma of being turned down based on the pharmacist's objection to the medications. See Misty Cooper Watt, Comment, *Pharmacist Knows Best? Enacting Legislation in Oklahoma Prohibiting Pharmacists from Refusing to Provide Emergency Contraceptives*, 42 TULSA L. REV. 771, 786 (2007), which observes that a "woman may be thoroughly embarrassed due to questioning of how she is planning to use her medication and why she needs it . . . and may feel stigmatized or humiliated when she is turned away from the counter after being judged publicly by a pharmacist as wanting 'immoral' medication." *Id.* These risks are heightened in small communities. See Chris Newton, *Teen-Age Pregnancies Rise in Rural West Texas*, NEW ORLEANS TIMES PICAYUNE, July 19, 1998, at A32, available at 1998 WLNR 1204648 (quoting the executive director of the Austin chapter of Planned Parenthood, noting, in the context of teen pregnancies, that "[rural areas] may have to deal with more issues concerning people being embarrassed about buying contraceptives . . . [as t]here is less anonymity in a small town"). Fearing such risks, women in small communities may forgo going to their local pharmacies.

147. See *Small Pharmacy Hearings*, *supra* note 146, at 9 (further noting that the pharmacy that had received two Plan B requests over five years chose not to inventory it).

148. See *id.* at 10 (testimony of J. Michael Patton, Illinois Pharmacists Association) (explaining that "some pharmacists are questioning the viability of maintaining their practice in the State of Illinois" due to the cost of compliance that "has become an emotional as well as an economic burden"). According to Mr. Patton, the acts of people testing pharmacists' compliance with the Illinois duty to dispense rule had heightened this risk. *Id.*

149. In the State of Illinois where the controversy giving rise to Mr. Patton's testimony took place, fifty-seven communities have only one independently owned retail pharmacy. RURAL POLICY RESEARCH INST., ILLINOIS COMMUNITIES WITH ONLY ONE PHARMACY, INDEPENDENTLY OWNED (2007), <http://www.unmc.edu/ruprihealth/Pubs/statepharm/Illinois.pdf> (on file with the Washington and Lee Journal of Civil Rights and Social Justice). Twenty-eight of these communities are in areas located more than ten miles from another retail pharmacy. *Id.* Closures of pharmacies in these areas would be problematic to women living in these areas. And such closures are not a hypothetical supposition. In protesting the Illinois duty to dispense rule, Mr. Vander Bleek had to close one of his pharmacies. *Morr-Fitz, Inc. v. Blagojevich*, 231 Ill.2d 474, 485 (2008).

*B. How a National Policy Solution Would Assist Pharmacists with
Conscientious Objections to Providing Contraceptives: Pharmacists'
Consciences Are at Stake*

States that either require pharmacists to dispense medicines, or impose a duty to refer, place pharmacists' consciences at risk. Emergency contraceptives pose a special case for pharmacists; they prevent pregnancy after unprotected intercourse by stopping ovulation.¹⁵⁰ Plan B also may prevent a fertilized egg from implanting in the uterus.¹⁵¹ For pharmacists who believe that life begins at conception, Plan B amounts to an abortifacient that takes a human life.¹⁵² The absolute duty to dispense medications imposed on pharmacists in Maine, Massachusetts, and Nevada therefore forces pharmacists who object to choose between their consciences and the law.¹⁵³ Even if the law does not specifically require the pharmacist to dispense a drug, he or she still may feel under siege in states that place a burden on pharmacists to provide a meaningful transfer to patients.¹⁵⁴ To these pharmacists, transferring a prescription is akin to abetting a crime.¹⁵⁵

Pharmacists' consciences are at stake even in states that do not have clear drug dispensation policies. As is true of women seeking the medications, the current set of state laws concerning pharmacists does not adequately recognize their interests, either. One problem is that the current laws are unclear. Just as thirty-two states do not particularly recognize the

150. Jennifer E. Spreng, *Pharmacists and the "Duty" to Dispense Emergency Contraceptives*, 23 ISSUES L. & MED. 215, 227 (2008).

151. *See id.* at 227–28 (noting that "Plan B could have several post-fertilization effects"). The author notes that controversy exists regarding the specifics of Plan B's post-fertilization effects, including the important fact that "it is difficult, if not impossible to measure Plan B's post-fertilization effect directly." *Id.* However, the Food and Drug Administration and Barr Pharmaceuticals, Plan B's maker, acknowledge the product's potential post-fertilization effect of preventing attachment of a fertilized egg to the uterus. *Id.* at 227.

152. *See, e.g., Morr-Fitz, Inc.*, 231 Ill. 2d at 474 (concerning a pharmacist who believes that Plan B is an abortifacient).

153. *See* NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2 (identifying Maine, Massachusetts, and Nevada as the three states that impose absolute duties on pharmacists to dispense medications).

154. Alabama, North Carolina, Oregon, and Texas require pharmacists to provide a meaningful transfer to patients seeking a drug to which they object. *Id.*

155. *See* Spreng, *supra* note 150, at 274 (acknowledging that "[a]s Karen Brauer, President of Pharmacists for Life explained it, referring a customer to a colleague who will sell Plan B 'is like saying 'I don't kill people myself but let me tell you about the guy down the street who does''").

women's interests at stake in medicine dispensation, they also do not have policies in place to deal with pharmacists who object to providing birth control.¹⁵⁶ It is true that their regulations impose an implicit duty to dispense contraceptives.¹⁵⁷ But whether the regulations actually impose this duty is unclear until a conscientious objector-pharmacist tests them. For example, in the incident discussed above a pharmacist in one of these states, Ohio, refused to give contraceptives to a customer.¹⁵⁸ Only the pharmacist's employer, Wal-Mart, looked into his actions to ensure his compliance with the retailer's store policy.¹⁵⁹ In contrast, in another non-official-policy state, Wisconsin,¹⁶⁰ a pharmacist refused to fill or to transfer a patient's birth control prescription.¹⁶¹ There, the Wisconsin Pharmacy Examining Board subjected the refusing pharmacist to a disciplinary hearing, finding that he had violated the usual standard of care.¹⁶² The pharmacist received limitations on his license and had to take six hours of continuing education in ethics for pharmacy practice.¹⁶³

Depending on a pharmacist's location and the corresponding state laws governing his or her actions, the pharmacist's conscience may feel under siege by the law. A national policy that recognizes this problem would allow pharmacists across the country to engage in their profession without risking their jobs.

156. This number equals the total number of states, less those fourteen states with some policy facilitating women's access to drugs, and those four states with policies protecting drug refusals with no concomitant protection for women. *See* NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1.

157. *See* MORRISON & BORCHELT, *supra* note 56, at 4 (concluding that by "omitting religious, moral or personal beliefs from the enumerated reasons for refusals, most state pharmacy laws implicitly prohibit such refusals").

158. Crane, *supra* note 61, at A1. There, the pharmacist refused to provide Plan B to a couple after a "contraceptive mishap." *Id.*

159. *See id.* (noting that Wal-Mart allows any of its workers to refer customers to another pharmacist, pharmacy worker, or sales associate if he or she feels uncomfortable dispensing a product). Wal-Mart corporate spokesman stated that "Wal-Mart is investigating the Springfield incident." *Id.* In contrast, the Governor of Ohio, Ted Strickland, explained through spokesman Keith Dailey that that he "has no specific plans [regarding the incident] but 'does not believe (pharmacists) should be engaging in that kind of behavior.'" *Id.*

160. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 1.

161. *See* Mellick, *supra* note 113, at 412 (describing the story of pharmacist Neil T. Noesen who "refused to fill and to transfer a prescription for birth control because he did not want to commit a sin").

162. *Id.* at 428.

163. *Id.*

IV. Framework for a Policy Solution: Setting the Boundaries

The ideal public policy solution should further the respective interests of women and pharmacists. Currently, though, the law may favor either pharmacists or women at the expense of the other group.¹⁶⁴ The law, however, also may accommodate both groups' interests within the broad legal boundaries governing women's and pharmacists' interests. A public policy addressing access to contraceptives should accommodate both sides within the broad boundaries set by the law.¹⁶⁵

A. Access to Contraceptives Is Not a Positive Right

States do not have a constitutionally mandated obligation to legislate access to contraceptives. Generally, patients have no clear constitutional right to receive affirmative care.¹⁶⁶ This fact also means that they have no right to affirmative care from a particular health care provider.¹⁶⁷ The Supreme Court has specifically considered the issue of access to contraceptives.¹⁶⁸ In holding a state law forbidding the use of

164. See LYNCH, *supra* note 22, at 33 (discussing in the context of physicians that "[c]onscience clauses appear to be neither constitutionally mandated, not constitutionally prohibited, leaving state legislature ample room to strike a balance between the interests of both physicians and patients"). With regard to the interests of women who oppose strong protection for pharmacists, Lynch notes again in the general context of refusal protections that "[t]he bottom line is that despite arguments of conscience clause opponents who allege that refusers are violating patient rights to access, no such legal right exists." *Id.* at 41.

165. Similarly, Lynch explains that:

[T]he legal right's starting point often used by both sides of the current debate does not provide solid, consistent, reliable protection of either party. . . . An alternative analysis of legal duties clearly will not get us very far, since if there are no legal rights, there are no legal duties.

Id. at 42. This Note takes a similar approach, but it instead cites women's health interests and pharmacists' currently under-protected conscience interests in support of a nationwide policy aimed at promoting the interests of both parties. The purpose of the policy discussion presented in this Note is to best advance the interests of both parties within the bounds of the law, not to reach a conclusion on whether some alternative source of authority can and should guide a solution fit for women and pharmacists. In contrast, Lynch approaches the problem from the perspective of the moral obligations of medical professionals. *Id.*

166. *Id.* at 40.

167. *Id.*

168. See *Carey v. Population Serv., Int'l*, 431 U.S. 678 (1977) (holding that prohibition of the distribution of nonmedical contraceptives to persons over the age of sixteen, except through licensed pharmacists, is unconstitutional because it serves no compelling state interest); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding that a Massachusetts statute only allowing married couples to obtain contraceptives is unconstitutional under the equal

contraceptives unconstitutional, the Court explained in *Griswold v. Connecticut*,¹⁶⁹ that the law impermissibly violated a fundamental right to privacy encompassed in marriage.¹⁷⁰ Later, the Court solidified the right to contraceptive access in *Eisenstadt v. Baird*,¹⁷¹ by extending its holding in *Griswold* to all married or single people.¹⁷² The critical point is that the Supreme Court's line of cases on access to birth control considered state laws banning access to them.¹⁷³ In states lacking duty-to-dispense laws, pharmacists merely have the discretion to refuse to give contraceptives based on their conscientious objections.¹⁷⁴ Such pharmacist refusals do not implicate the state or, in turn, the Constitution.¹⁷⁵ As author Holly Fernandez Lynch observes, just as

protection clause of the Fourteenth Amendment); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (holding that a Connecticut law forbidding the use of contraceptives unconstitutionally intrudes upon the right of marital privacy); see also Cristina Arana Lumpkin, Comment, *Does a Pharmacist Have the Right to Refuse to Fill a Prescription for Birth Control?*, 60 U. MIAMI L. REV. 105, 108–11 (2005) (discussing the Court's holdings in *Griswold*, *Eisenstadt*, and *Carey*).

169. *Griswold v. Connecticut*, 381 U.S. 479 (1965) (plurality opinion).

170. *Griswold*, 381 U.S. at 485–86.

171. *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (plurality opinion).

172. See *Eisenstadt*, 405 U.S. at 453, which explains that:

[If] under *Griswold* the distribution of contraceptives to married persons cannot be prohibited, a ban on distribution to unmarried persons would be equally impermissible. It is true that in *Griswold* the right of privacy in question inhered in the marital relationship. Yet the marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup. If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

173. The Court, in *Griswold*, reviewed a law that forbade a person from using any drug or other device for preventing conception. *Griswold*, 381 U.S. at 480. The Massachusetts law in question in *Eisenstadt* provided a "maximum five-year term of imprisonment for 'whoever . . . gives away . . . any drug, medicine, instrument or article whatever for the prevention of conception[.],' " only allowing an exception for married persons. *Eisenstadt*, 405 U.S. at 441.

174. See LYNCH, *supra* note 22, at 41 (observing that "health-care professionals have a great deal of open space in which to exercise their own consciences even if they have no express legal right to do so").

175. See *The Civil Rights Cases*, 109 U.S. 3, 12–13 (1883), which explains that under the Fourteenth Amendment:

[I]nvasion of individual rights is not the subject-matter of the amendment . . . [U]ntil some state law has been passed, or some state action through its offers or agents has been taken, adverse to the rights of citizens sought to be protected by the Fourteenth Amendment, no legislation of the United States under said amendment, nor any proceeding under such legislation, can be called into

consumers of ordinary goods such as orange juice have no recourse at law when a private party legally restricts access through a store closure, for example, women have no recourse under the Court's line of cases when pharmacists choose not to dispense contraceptives, notwithstanding the Court's recognition of women's fundamental rights to them.¹⁷⁶

The current state laws regarding pharmacist refusal simply do not implicate the Constitution's aid in facilitating women's access to contraceptives. Public policy makers should approach the challenge of facilitating women's access to contraceptives with recognition of the health and social interests served by these products.¹⁷⁷

B. The Government Has Wide Latitude in Implementing Laws or Regulations Either for or Against Pharmacists' Consciences

One factor in favor of pharmacists is that states and the federal government have the discretion to enact sweeping conscience protections,¹⁷⁸ such as those in Mississippi.¹⁷⁹ For example, in *Chrisman v.*

activity, for the prohibitions of the amendment are against State laws and acts done under State authority.

See also Lumpkin, *supra* note 168, at 115 ("A patient who attempts to raise a constitutional challenge against a pharmacist who refuses to fill a prescription for oral contraceptives faces another hurdle: The pharmacist's refusal does not constitute state action, so the patient has no private cause of action to assert against the pharmacist.").

176. LYNCH, *supra* note 22, at 40. Lynch recognizes that the Supreme Court's first case establishing a right to contraceptives, *Griswold*, establishes no positive right to contraceptives, just a "negative right against state laws prohibiting their use or sale." *Id.* She further explains that:

[I]f we understand positive rights [as opposed to negative ones like the right to contraception, which means to be free from government interference] to impose correlating duties or responsibilities on others to ensure that those rights can be exercised, then claiming a positive right to all that is legal cannot work. For example, it is legal for you to purchase your favorite orange juice, but if the company that manufactures that juice goes out of business or your local grocer no longer sells the product, you have not been denied any right, for no one owes you any obligation to provide that particular orange juice. Legality on its own simply does not mandate universal availability.

Id. at 39–40.

177. *See id.* at 33 (concluding in the context on the limits of conscience clauses that the real questions are when should a health professional have to yield to patient concerns and how should such concerns be addressed).

178. *See id.* at 27 (stressing that conscience protection statutes "are hardly amenable to legal attack").

Sisters of St. Joseph of Peace,¹⁸⁰ the United States Court of Appeals for the Ninth Circuit considered a lawsuit challenging the constitutionality of the federal Church Amendment.¹⁸¹ The appellant challenged the Church Amendment provision that prohibited public officials and authorities, as a condition of receipt of federal funds, from imposing requirements on health care institutions, such as making their facilities available for abortions or sterilizations as a violation of the First Amendment Establishment Clause.¹⁸² The court held that the appellant's argument lacked merit because she failed to prove that the state took action affirmatively preferring one religion over another.¹⁸³ Similarly, the broad pharmacist conscience statutes of today feature language like the following:

No private institution [like a pharmacy] or physician, nor any agent or employee [like a pharmacist] 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 objection.¹⁸⁴

Like the language of the Church Amendment at issue in *Chrisman*, the language of this statute does not support the inference that the state chose to prefer one religion over another.¹⁸⁵

On the other hand, states and the federal government do not necessarily have to enact sweeping protections in favor of pharmacists. Legislators or executive officials can choose to impose dispensation requirements¹⁸⁶ such as the ones imposed in Maine.¹⁸⁷ Such requirements

179. See NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2. Mississippi is one of the states that allows all health care providers and institutions to refuse to dispense any drug.

180. *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308, 311 (9th Cir. 1974).

181. 42 U.S.C. § 300a-7(b) (2000).

182. *Chrisman*, 506 F.2d at 311.

183. See *id.* (explaining that the plaintiff "fail[ed] to distinguish between action taken to preserve the 'government's neutrality in the face of religious differences' and action which affirmatively prefers one religion over another" (citation omitted)).

184. ARK. CODE ANN. § 20-16-304(5) (West 2009).

185. And more importantly, the language of the statute also does not implicate the state action requirement necessary to invoke the Establishment Clause. See Spreng, *supra* note 150 (explaining how pharmacist refusals, even though permitted by state law, do not constitute action implicating the power of the state).

186. See LYNCH, *supra* note 22, at 33 (explaining that "[c]onscience clauses appear to be neither constitutionally mandated, nor constitutionally prohibited, leaving state legislatures with ample room to strike a balance between the interests of both physicians [or pharmacists] and patients").

187. NAT'L WOMEN'S LAW CTR., *supra* note 15, at 2. Maine is one of the states that

likely would pass muster under the First Amendment Free Exercise Clause.¹⁸⁸ Under the Free Exercise Clause, an individual must comply with a law that infringes on religious activity, so long as the law is religiously neutral and generally applicable.¹⁸⁹ If the law targets a particular religion, then a compelling government interest must support it, and it must be narrowly tailored to serve that interest.¹⁹⁰ The duty-to-dispense statutes against pharmacists employ language such as, "A pharmacist may refuse to fill a prescription or dispense a drug only as permitted by 32 M.R.S.A. § 13795(2) [allowing refusals for reasons such as failure to present a valid prescription, but not for reasons of conscience]."¹⁹¹ This language is applicable to all pharmacists in all circumstances, no matter their religion, so forcing a pharmacist to dispense medications under the statute likely would pass muster under the Free Exercise Clause.

Still, duty-to-dispense rules are not immune from challenge on First Amendment grounds.¹⁹² A lawsuit in the State of Washington challenging

require pharmacists to dispense all medicines. *Id.*

188. See LYNCH, *supra* note 22, at 32, which points out that:

[C]ourts have generally been less sympathetic to religious freedom claims made by those engaged in voluntary commercial activity, such as the practice of medicine, as opposed to directly religious activity, since the religious person could have theoretically made different professional choices that would not burden his or her beliefs at all.

189. See *Employment Div. v. Smith*, 494 U.S. 874, 879, 890 (1990) (upholding a neutral, generally applicable Oregon state law forbidding the ingestion of peyote as applied to two men who ingested peyote for religious reasons, noting that the Oregon Employment Division properly denied unemployment benefits from these men because doing so did not burden their free exercise rights). See also *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520 (1993) (concerning the ritual slaughter of animals). The rule must be neutral by not targeting a particular religion, *id.* at 532, and it must be generally applicable, *id.* at 542.

190. See *Church of Lukumi Babalu Aye*, 508 U.S. at 546 (explaining that "[a] law burdening religious practice that is not neutral or not of general application must undergo the most rigorous of scrutiny").

191. 02-392 ME. CODE R. ch. 19, § 11 (West 2009) (citing ME. REV. STAT. ANN. tit. 32, § 13795 (West 2008)).

192. See LYNCH, *supra* note 22, at 30 (discussing a lawsuit currently challenging the validity of Washington's rule requiring pharmacies to dispense lawfully prescribed drugs). Another lawsuit is also underway in the State of Illinois challenging its regulations: *Morr-Fitz, Inc. v. Blagojevich*, 231 Ill. 2d 474 (2008). However, the merits of that lawsuit are undeterminable at this time because the Supreme Court of Illinois only has overruled the trial court's dismissal of the pharmacist and pharmacies' complaint based on procedural grounds for failure to show standing, ripeness, and failure to exhaust administrative remedies. *Id.* at 474, 490–95.

the validity¹⁹³ of its regulation requiring pharmacies to dispense contraceptives.¹⁹⁴ In that lawsuit, the plaintiffs obtained a preliminary injunction, allowing pharmacies to refuse to dispense the emergency contraceptive Plan B if they immediately refer the patient to another source of Plan B.¹⁹⁵ The court found that the regulations impermissibly targeted religious refusers, based on the evolution of the regulations in response to religious refusals and on an apparent motivation to target religious practices.¹⁹⁶ The court also found that the government had not demonstrated its interests in increasing access to Plan B or preventing gender discrimination as sufficiently compelling interests to support the regulation.¹⁹⁷ The court's ruling is certainly questionable,¹⁹⁸ in light of the neutral language of the regulation at issue.¹⁹⁹

The district court's conclusions were rejected on appeal to the United States Court of Appeals for the Ninth Circuit. The history of the regulation's drafting revealed "a patchwork quilt of concerns, ideas, and motivations," and the Ninth Circuit rejected the argument that religious

193. See *supra* note 82 and accompanying text (discussing the specifics of Washington's regulation requiring pharmacies to dispense medications).

194. See *Stormans, Inc. v. Selecky (Stormans I)*, 524 F. Supp. 2d 1245 (W.D. Wash. 2007) (ruling on the plaintiff pharmacists' and pharmacy's motion for preliminary injunction).

195. *Id.* at 1266.

196. See *id.* at 1259–63 (discussing the neutrality and general applicability of the regulation at issue).

197. As to the interest in the access to medications, the court explained that "[t]he evidence provided by the parties, including the intervenors [additional people concerned about access to Plan B and HIV medications], convinces the Court that the interest promoted by the regulations have more to do with convenience and heartfelt feelings than with actual access to certain medications." *Id.* at 1263. With respect to the interest in preventing gender discrimination, the court explained "[n]or is preventing discrimination on the basis of gender, within the context of this case, a compelling state interest The plaintiffs' objection to Plan B is not about gender, it is about the sanctity of life as defined by their religious teachings." *Id.* at 1263–64.

198. See LYNCH, *supra* note 22, at 31, which comments that:

Although the regulations apply to all pharmacists and pharmacies in the state, and to all types of prescriptions, the fact that they were explicitly prompted by religious refusals to dispensing 'Plan B' emergency contraceptives led the court to conclude, somewhat questionably, that policymakers acted with the direct intent to burden free exercise rights.

199. See WASH. ADMIN. CODE §§ 246-869-010(1), (3) (stating that pharmacies must either provide the drug or a "therapeutically equivalent drug . . . in a timely manner consistent with reasonable expectations for filling the prescription" or provide a "timely alternative for appropriate therapy which, consistent with customary pharmacy practice, may include obtaining the drug or device").

animus motivated the rule's promulgation.²⁰⁰ Instead, the court found the rule generally applicable.²⁰¹ The Ninth Circuit emphasized that the regulation at issue applied broadly because it imposed on "all pharmacies . . . a 'duty to deliver' all medications 'in a timely manner.'"²⁰² Accordingly, the court found that the lower court applied an overly stringent review standard and remanded the case for a finding on whether the regulation satisfied the rational basis standard.²⁰³ The rational basis standard uses a low bar, and a law passes the standard if "any reasonably conceivable state of facts . . . could provide a rational basis for [it]."²⁰⁴ Given the significant women's health issues implicated by access to emergency contraceptives and, more generally, the significant health issues implicated by access to all prescription medications, courts likely would uphold generally applicable laws such as Washington's under rational basis review.

Other support exists favoring such conscience-based rules.²⁰⁵ The New York State Court of Appeals recently upheld a law "requiring all who choose to provide insurance coverage for prescription drugs to also provide coverage for contraceptives, unless the employer's organizational purpose is to spread religious beliefs, it primarily employs persons sharing those beliefs, and it qualifies as a nonprofit organization."²⁰⁶ Many religious groups did not qualify for the exception.²⁰⁷ Still, the court emphasized that the law was facially neutral and had a primary purpose of improving women's health.²⁰⁸ The fact that the religious groups who objected to the law were not required to provide prescription drug coverage at all greatly influenced the court.²⁰⁹ The court's holding reveals that courts are

200. *Stormans, Inc. v. Selecky (Stormans II)*, 586 F.3d 1109, 1133 (9th Cir. 2009).

201. *Id.* at 1137.

202. *Id.* at 1134.

203. *Id.* at 1137–38.

204. *Heller v. Doe*, 509 U.S. 312, 320 (1993) (quoting *FCC v. Beach Commc'n., Inc.*, 508 U.S. 307, 313 (1993)).

205. *See LYNCH, supra* note 22, at 31 (emphasizing that the Washington case does not support the proposition that service requirements on health professionals are not inherently impermissible).

206. *See id.* (discussing *Catholic Charities of the Diocese of Albany v. Serio*, 7 N.Y.3d 510 (2006)).

207. *Id.*

208. *Id.*

209. *See id.* (explaining the "court also relied heavily on the fact that the plaintiffs were not required to provide prescription drug coverage at all, so they were not actually required to violate their religious beliefs").

generally less amenable to religious freedom claims made by people voluntarily engaged in commercial professions.²¹⁰

Public policymakers have wide latitude in choosing whether to enact statutes facilitating access to contraceptives or protection of pharmacists' conscientious objection.²¹¹ Legally, it is not necessary for legislators to advance either group's interests. However, both groups have important personal interests at stake, which public policymakers should not ignore. Therefore, the balance of women and pharmacists' interests in potential public policy solutions should control the solutions' analyses.

C. A National Solution Is Feasible

A national solution is legally feasible. Congress could pass a law under the authority of the Commerce Clause of the Constitution.²¹² The nationwide sale of Plan B is certainly an activity that is carried on across state lines, and easing the ability of women to obtain these drugs would advance a commercial interest.²¹³ Or, Congress or an administrative agency, such as the Department of Health and Human Services, could pass a law or a regulation, respectively, conditioning the receipt of federal funds on compliance with a rule advancing the interests described in this Note.²¹⁴ Such an approach would parallel the federal Church Amendment, which has used Congress's financing powers to impose conscience protections for health care providers objecting to the provision of abortions or

210. *See id.* at 32 (explaining the great importance of recognizing that "the courts have generally been less sympathetic to religious freedom claims made by those engaged in voluntary commercial activity, since the religious person could have theoretically made different professional choices that would not burden his or her beliefs at all").

211. *See supra* note 165 and accompanying text (introducing Lynch's criticism of the legal rights approach in analyzing conscience clauses in the broader context of conflicts of conscience between medical doctors and patients). As discussed in the footnotes in support of Part III, Lynch's observations in this context support the idea that it is inappropriate to assume that a legal rights approach provides a solid foundation for analyzing the conflict between women and pharmacists.

212. *See Lumpkin, supra* note 168, at 127 (arguing that Congress could override state conscience clauses by promulgating a federal law requiring pharmacists to fill valid, legal prescriptions regardless of their individual objections).

213. *See id.* (urging that this kind of statute would be valid under the Commerce Clause because contraceptives are distributed nationally through interstate commerce).

214. *See infra* Part IV (discussing the federal conscience regulation).

sterilizations.²¹⁵ Adoption of either method would create a national policy addressing the interests of both women and pharmacists.

IV. Proposed National-Level Policy Solutions

A. Proposed Federal Conscience Regulation

A public policy solution such as the federal "conscience regulation"²¹⁶ proposed by the outgoing Bush administration represents an approach that would strongly support pharmacists' interests. On December 19, 2008, the Bush administration issued a regulation designed to promote the protection of health care providers' consciences.²¹⁷ Though it came into effect on January 20, 2009,²¹⁸ that same day newly-inaugurated President Barack Obama ordered a freeze on all pending regulations from the previous administration.²¹⁹ On February 27, 2009, the Department of Health and Human Services served notice that it intended to rescind the regulation.²²⁰ Nonetheless, this regulation could provide a possible public policy solution for the future.²²¹

The regulation requires recipients of federal health care funding, such as states through programs such as Medicaid, not to discriminate against

215. See discussion *supra* Part III.B (explaining how the Church Amendment validly imposes protections for medical professionals who object to abortions and sterilizations, as a condition of receipt of federal funding).

216. See David Stout, *Move Toward Undoing Rule on Abortion*, N.Y. TIMES, Feb. 28, 2009, at A16 [hereinafter Stout, *Undoing Rule on Abortion*], available at 2009 WLNR 3900611 ("[C]onsiderable emotion surrounds the issue [of the regulation], as illustrated by the shorthand used to describe the rule. Supporters called it the 'provider conscience regulation,' while the Planned Parenthood Federation of America disdained it as a 'midnight regulation.'").

217. 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. 78,071 (Dec. 19, 2008) [hereinafter Conscience Regulation].

218. *Id.* at 78,072.

219. See David Stout, *Obama Takes Oath, and Nation in Crisis Embraces the Moment*, N.Y. TIMES, Jan. 21, 2009, at A1 [hereinafter Stout, *Obama Takes Oath*], available at 2009 WLNR 1150642 (noting that President Obama "ordered all pending Bush regulations frozen for a legal and policy review").

220. See Stout, *Undoing Rule on Abortion*, *supra* note 216.

221. Given the Department's intent to rescind the regulation, at a bare minimum, the regulation will be modified significantly in the near future. See *id.* (pointing out that "[w]hen the administration publishes official notice of its intent, probably next week, a 30-day period for public comment will begin, after which the regulation can be repealed or modified").

individual health care providers for refusing to provide abortion procedures if doing so violates the provider's religious beliefs or moral convictions.²²² The regulation fails to specify any definition for the term "abortion," implying that the term's controversial nature defies definition but that it nonetheless could still enforce the regulation.²²³ Such a reference presumably includes Plan B, which some pharmacists believe functions as an abortifacient.²²⁴ Groups opposing the regulation, such as the National Family Planning and Reproductive Health Association, expressed this fear over the regulation, even contending that the term "abortion" could encompass regular birth control contraceptives, as well.²²⁵ Even if the regulations did not, another provision still would stymie states from requiring pharmacists to dispense medications against their consciences in circumstances implicating federal health programs, such as requiring a pharmacist to dispense contraceptives to a Medicaid recipient.²²⁶

Such a conscience-focused solution to regulation approximates the state regulations that strongly favor pharmacists and furthers objecting pharmacists' interests. However, merely providing such refusals leaves little protection for women.²²⁷ Some commentators have proposed alternative solutions to remedy such problems.

222. Conscience Regulation, 73 Fed. Reg. at 78,097–98.

223. *See id.* at 78,077 (explaining that the "Department declines to add a definition of abortion to the rule. . . . [S]uch questions over the nature of abortion and the ending of a life are highly controversial and strongly debated. The Department believes it can enforce the federal health care protection laws without an abortion definition").

224. *See* *Morr-Fitz, Inc. v. Blagojevich*, 231 Ill. 2d 474, 474 (2008) (explaining Mr. Vander Bleek's understanding of Plan B).

225. *See* Complaint of Plaintiff, National Family Planning & Reproductive Health Association, Inc. and Fair Haven Community Health Clinic, Inc. v. Michael O. Leavitt, Secretary of the United States Department of Health and Human Services ¶ 47, https://www.aclu.org/pdfs/reproductiverights/nfprhavleavitt_complaint.pdf ("This definition [of abortion] could encompass some of the most widely used methods for *preventing* pregnancy, such as birth control pills, emergency contraception, and IUDs because these methods occasionally work by interfering with implantation of a fertilized egg in the lining of the uterus.").

226. *See* Conscience Regulation, 73 Fed. Reg. at 78,098 (disallowing state actions from requiring "any individual to perform or assist in the performance of any part of a health service program or research activity funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions").

227. *See* LYNCH, *supra* note 22, at 33 (urging in the general context of refusal clauses that "current conscience clause policy strikes the wrong balance—in fact it offers hardly any balance at all, allowing physicians to refuse in too many situations without exception and without concern for the patient's ability to access medical services").

B. Commentator Proposals

Commentator proposals have focused on two solutions that could ameliorate the concerns of women and pharmacists. One solution involves notice. Commentators propose providing notice to women about pharmacists' stance toward certain controversial products, such as emergency contraceptives.²²⁸ This could involve placing a sign at a pharmacy, so that women seeking Plan B, for instance, would know to avoid pharmacists who are unwilling to dispense the product.²²⁹ The other major proposal offered by commentators is "transfer-or-refer."²³⁰ These commentators point to state professionalism standards that would support such a compromise. Under this solution, a pharmacist could avoid the unpleasant circumstance of dispensing a contraceptive, yet the woman seeking the medication still could obtain it from somewhere else, based on the pharmacist's recommendation.²³¹

Neither solution fully solves the problem. Notice proposals merely requiring a sign at pharmacies only partly solve the problem of seeking access. A sign at a pharmacy does not stop first-time customers from visiting that location, nor does it necessarily tell them where to go if that pharmacy does not meet their medical needs. As for the transfer-and-refer solution, pharmacists still face the admittedly unpleasant task of aiding an ultimate outcome that is contrary to their beliefs.²³²

V. Potential Policy Solution

This Note's policy proposal builds upon the ideas proposed by others in order to better serve the interests of both women seeking contraceptives and conscientiously objecting pharmacists. A better way to advance women's and pharmacists' interests would co-opt the strongest features of the currently offered public policy solutions to create a comprehensive set of measures that would validate women's and pharmacists' interests. Federal public policymakers should create a national database of

228. See, e.g., Spreng, *supra* note 150, at 275. ("A prophylactic means of eliminating customer reliance entirely is to make clear from the beginning of the pharmacist's relationship with the customer what the pharmacist will and will not sell.")

229. *Id.* at 275.

230. *Id.* at 274.

231. *Id.*

232. See *id.* (explaining how some pharmacists object even to referrals for contraceptives).

pharmacists.²³³ The database would collect information yearly from all pharmacists regarding what products they would sell. This format would avoid potentially controversial questions involving the pharmacists' personal beliefs. Assembling this data, the federal government then should distribute the notices to pharmacies and to health care providers, such as physicians.²³⁴ The government also should publish this information on the internet and in public health clinics. Such measures would ensure a broad distribution. Moreover, the government should make the notices geographically specific, so they inform women about the range of pharmacies available nearby to them. Through maximizing the amount of information available to women and channeling it through several different avenues, this public policy solution would do much to absolve the current clash between women and pharmacists by directing women away from objecting pharmacists.²³⁵ Accordingly, the comprehensive notice policy aims to

233. Of course, this proposal would be less effective if some pharmacists fail to comply with the survey. If the national policy makes receipt of federal funds contingent on compliance, though, states presumably would find a way to comply with the policy, such as through their licensing boards. See, e.g., *supra* note 88 and accompanying text (identifying state laws enabling pharmacy boards to regulate the pharmacy business in their respective jurisdictions). See Suzanne Davis & Paul Lansing, *When Two Fundamental Rights Collide at the Pharmacy: The Struggle to Balance the Consumer's Right to Access Contraception and the Pharmacist's Right of Conscience*, 12 DEPAUL J. HEALTH CARE L. 67, 104 (2009) (advocating the creation of databases by state pharmacy boards and dissemination of information similar to the approach proposed by the author). The problem with Davis and Lansing's solution is that it fails to recognize the need for uniform requirements in all states, even those with ostensibly stronger protections for women's access to contraceptives. As advocated by this Note, a women's access to emergency contraceptives and the protections afforded to pharmacists who object to providing them should not vary according to the state in which they reside.

234. Admittedly, one can assume that some physicians may object to providing contraceptives. However, these physicians probably would not be giving out contraceptive prescriptions in the first place. Therefore, the physicians that would be giving out contraceptive prescriptions would give out the notices, too.

235. See Spreng, *supra* note 150, at 275 n.490 (observing that "[o]ne of the intriguing developments in the academic literature is that those sympathizing with both the buyer and seller in the Plan B squabble lean toward compromises that rely on letting the market work, which implies, of course, full information"). The problem with the authorities discussed in the literature, though, is that their proposals do not seem to move beyond postings at the pharmacy door, which would not go as far as the proposal in this Note goes in promoting full information to contraceptive consumers. *Id.* Of course, problems still remain for women living in remote areas. One novel solution proposed in the medical context is to have an institution regulate health care access. LYNCH, *supra* note 22, at 110–11. This proposal's broad potential for promoting notice to women would obviate the need to broadly regulate pharmacists.

prevent conflicts between women and pharmacists by stopping them in the first instance.

The national solution also should address the major weakness in a purely notice-based policy. The problem with a notice-only solution is that women in rural areas still may face significant challenges in obtaining emergency contraceptives. Information about nearby pharmacies would alert women that the nearest pharmacy that sells emergency contraceptives is far away but also would do nothing to resolve the challenges they may have in obtaining emergency contraceptives. Using the information gathered regarding the availability of emergency contraceptives, state pharmacy boards should identify areas that suffer from an acute lack of pharmacists willing to dispense emergency contraceptives.²³⁶

After identifying such areas, the boards should ensure that non-objecting pharmacists are available to women who request emergency contraceptives. With the ever-increasing ease of electronic communication, state licensing boards should establish communication infrastructures in underserved areas that directly connect patients with pharmacists who are willing to distribute emergency contraceptives.²³⁷ These systems could take the form of telephone hotlines staffed by local health care professionals, or automated online systems, such as kiosks. With such set-ups in place, off-site pharmacists would only need to verify the patient's identification to confirm that the patient meets the age requirement, which is feasible in light of today's video and scanner technology. Such a solution is especially realistic given the federal government's efforts to facilitate the verification of state

236. See LYNCH, *supra* note 22, at 110–11 (arguing in the medical context that state licensing boards should take responsibility for assuring access to controversial health care procedures). Some isolated areas may experience a shortage in pharmacists from a true lack of patient demand, so it is unreasonable to expect states to support pharmacists' employment in those areas. See *id.* at 190 (illustrating this concept by discussing a scenario in which demand in a rural area may be too low to support a full-time abortion provider). This recognition does not preclude pharmacy boards from adopting other measures to facilitate women's access to emergency contraceptives.

237. See *id.* at 185–86 (promoting the use of electronic communication via "telemedicine" to bridge the physical distances separating patients and health care providers). Lynch points out that at this point in time, consultative services like those involved in the provision of emergency contraceptives are especially appropriate contexts for the use of telemedicine. See *id.* at 186 (noting that for telemedicine to work beyond consultative services and to address physical medical procedures, robotics technology must advance).

identification materials.²³⁸ Similarly, pharmacy boards should allow young women with prescriptions for emergency contraceptives to use these machines as well. After a remote pharmacist verifies a woman's identification or prescription, she should be permitted to purchase the medication, completely removing an objecting pharmacist from any role in providing access to this medication. A government solution connecting women in isolated areas with off-site pharmacists facilitates access to Plan B and avoids violating the conscientious objections of pharmacists who oppose dispensing the medication.

VI. Conclusion

This Note opened by contrasting the situations of two states with sharply differing approaches to handling the clash between women and pharmacists with conscientious objections against emergency contraceptives. One state gave strong protections to the women seeking contraceptives, to the detriment of pharmacists, whereas the other gave strong protections to pharmacists, to the detriment of women. Neither outcome is desirable because both women and pharmacists have valuable interests at stake in this debate. The current mishmash of state attitudes toward pharmaceutical access creates a situation in which women and pharmacists potentially face sharply contrasting outcomes, depending upon where they live. A national level policy solution is feasible and would promote the interests of women and pharmacists, such that the rights of neither would be contingent on where a woman or pharmacist lives. The law does not mandate any particular outcome, so the policy can and should aim to promote both groups' interests. A variety of proposals have been offered for a general policy solution, one by the federal government, and others by commentators, but none fully ameliorates the potential for conflict between women seeking contraceptives and pharmacists. The proposal offered by this Note intends to improve on those policies by advocating the dissemination of information to the fullest extent possible by the government in order to prevent such clashes at the first instance. When full information cannot overcome barriers to access, the government should step in and ensure that women still have access to these medications. Such

238. See Press Release, U.S. Dep't. of Homeland Sec., Real Progress on Real ID (Dec. 13, 2007), <http://www.dhs.gov/journal/leadership/2007/12/real-progress-on-real-id.html> (discussing efforts to create a national electronic network to verify state IDs) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

a comprehensive policy should help resolve much of the conflict arising between conscientiously objecting pharmacists and women seeking emergency contraceptives.