ABOLISHING THE PHARMACIST'S VETO: AN ARGUMENT IN SUPPORT OF A WRONGFUL CONCEPTION CAUSE OF ACTION AGAINST PHARMACISTS WHO REFUSE TO PROVIDE EMERGENCY CONTRACEPTION

HEATHER A. WEISSER*

I. INTRODUCTION

On August 24, 2006, after years of scientific research and politically charged debate, the U.S. Food and Drug Administration ("FDA") approved an application for over-the-counter ("OTC") status for Plan B,[1] a type of emergency contraception ("EC") previously available only by prescription.[2] This FDA decision came more than two years after the agency's much criticized denial of Plan B's OTC application in 2004.[3] The

* Class of 2007, University of Southern California Gould School of Law; B.A. 2003, Mount Holyoke College. I would like to thank Professor Gregory Keating for his thoughtful observations and guidance, and the members of the Southern California Law Review for all of their hard work. I would also like to thank my family for their love and encouragement, and Brett Heiken for the balance he brings to my life with his unwavering love and support.

1. Letter from Steven Galson, M.D., M.P.H., Dir., Ctr. for Drug Evaluation & Research, to Joseph A. Carrado, M.Sc., R.Ph., Vice President, Clinical Regulatory Affairs, Duramed Research, Inc. 2 (Aug. 24, 2006), *available at* http://www.fda.gov/cder/foi/appletter/2006/021045s011ltr.pdf [hereinafter Plan B Approval Letter].

2. FDA, Plan B: Questions and Answers (Aug. 24, 2006, updated Dec. 14, 2006), *available at* http://www.fda.gov/cder/drug/infopage/planB/planBQandA20060824.htm [hereinafter FDA, Plan B: Questions and Answers].

3. *See* Letter from Steven Galson, M.D., M.P.H., Acting Dir., Ctr. for Drug Evaluation & Research, to Joseph A. Carrado, M.Sc., Ph.D., Senior Dir., Regulatory Affairs, Barr Research, Inc. 1 (May 6, 2004), *available at* http://www.fda.gov/cder/drug/infopage/planB/planB_NALetter.pdf.

In May 2004, in a decisionmaking process that the Government Accountability Office ("GAO") declared "unusual," the acting director for the FDA's Center for Drug Evaluation and Research

primary criticism of the 2004 denial was that it appeared reproductive politics were interfering in the FDA's usual scientific process.[4] Finally science won out, however, and in August 2006, the FDA announced that Plan B's application for OTC status would be approved for "consumers 18 years and older."[5] The drug will remain prescription-only for girls under eighteen years of age.[6]

While the FDA's approval of Plan B's OTC application will ease access to the drug for women eighteen and older, a significant and pervasive obstacle remains for women of all ages. Although a prescription will no longer be required for those women to obtain Plan B, the medication will be available only from behind a pharmacy counter, leaving the decision of whether to dispense the drug in the hands of the pharmacist on duty.[7] This obstacle may seem innocuous, but the reality is far different.

Doctors have been prescribing EC for decades,[8] but women seeking EC with a valid prescription often have been unable to get the medication

("CDER"), acting contrary to the recommendations of the joint advisory committee and two drug evaluation offices that reviewed the Plan B application, declined to approve the request for OTC status. U.S. GOV'T ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: FOOD AND DRUG ADMINISTRATION DECISION PROCESS TO DENY INITIAL APPLICATION FOR OVER-THE-COUNTER MARKETING OF EMERGENCY CONTRACEPTIVE DRUG PLAN B WAS UNUSUAL, GAO–06–109, at 5, 29 (2005), *available at* http://www.gao.gov/new.items/d06109.pdf. According to the GAO report that compared the traditional FDA decisionmaking process to that employed in the Plan B case, the irregularities of the process included participation by high level FDA officials, reports that the decision to reject the application came before the review was complete, and justifications for the rejection that were "novel and did not follow FDA's traditional practices." *Id.* at 5–6.

In the end, the directors of the drug evaluation offices that reviewed the application—the people normally responsible for signing a letter approving or rejecting a particular application—refused to sign the Plan B rejection letter. *Id.* Although the makers of Plan B filed a new OTC application with the FDA that attempted to address the concerns expressed by the CDER about the rejected application, the new application was placed on hold due to "unresolved regulatory and policy issues." Press Release, Lester M. Crawford, Comm'r FDA, FDA Takes Action on Plan B (Aug. 26, 2005), *available at* http://www.fda.gov/bbs/topics/NEWS/2005/NEW01223.html. *See* Letter from Lester M. Crawford, D.V.M., Ph.D., Comm'r, FDA, to Joseph A. Carrado, M.Sc., R.Ph., Senior Dir., Regulatory Affairs, Duramed Research, Inc. 1 (Aug. 26, 2005), *available at* http://www.fda.gov/cder/drug/infopage/planB/Plan_B_letter20050826.pdf.

4. *See 60 Minutes: The Debate over Plan B* (CBS television broadcast Nov. 27, 2005), *available at* http://www.cbsnews.com/stories/2005/11/22/60minutes/printable1068924.shtml.

5. Plan B Approval Letter, *supra* note 1.

6. Memorandum from Dr. Andrew C. Von Eschenbach, Acting Comm'r, FDA, to NDA 21-045, S-011 (Aug. 23, 2006), *available at* http://www.fda.gov/cder/drug/infopage/planB/avememo.pdf.

7. FDA, Plan B: Questions and Answers, *supra* note 2. The FDA has explained that Plan B will be kept behind the counter "in order to manage both prescription (17 years and under) and OTC (18 years and over) dispensing." *Id.*

8. *See* Charlotte Ellertson, *History and Efficacy of Emergency Contraception: Beyond Coca-Cola*, 28 FAM. PLAN. PERSP. 44 (1996), *available at* http://www.guttmacher.org/pubs/journals/2804496.pdf.

because pharmacists who conscientiously object to contraception or abortion refuse to fill the prescription or refer the woman to a willing pharmacist.[9] The problem is even more significant than that of traditional birth control refusals because EC is most effective when taken within seventy-two hours of unprotected sex or sex involving a contraceptive failure.[10] Additional complications arise for women in rural areas with only one pharmacy, and for low-income women who cannot afford to travel far to find a willing pharmacist.[11] Thus, the FDA decision will not cure the problem posed by pharmacist refusals because women of all ages will still be required to go to the pharmacy counter to obtain EC.

The National Women's Law Center has catalogued a number of pharmacist refusals that illustrate the burden that such refusals place on women seeking EC. For example, in Denton, Texas, a rape survivor went to a pharmacy to have her EC prescription filled, but was refused by three pharmacists due to their religious beliefs.[12] In Milwaukee, Wisconsin, a mother of six went to a pharmacy to have her EC prescription filled and the pharmacist scolded the woman in a crowded area, "shouting 'You're a murderer! I will not help you kill this baby. I will not have the blood on my hands.'"[13] The woman was too humiliated to attempt to have the prescription filled elsewhere and ended up becoming pregnant and having an abortion.[14] More recently, in Columbus, Ohio, a young mother went to her local Wal-Mart to obtain EC without a prescription and although the store did stock the OTC medication, she was told that no one on staff would give it to her.[15] These stories show not only that women were refused time-sensitive medication for which they had valid prescriptions, but also that the delay and trauma that can accompany such a refusal may

9. 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 3 (2007), *available at* http://www.nwlc.org/pdf/Don'tTakeNo2007.pdf.

10. *See* Population Council, *Emergency Contraception's Mode of Action Clarified*, POPULATION BRIEFS: REP. ON POPULATION CONTROL RES., May 2005, at 3, 3, *available at* http://www.popcouncil.org/pdfs/popbriefs/pbmay05.pdf.

11. *See* Susan Berke Fogel & Lourdes A. Rivera, *Saving* Roe *Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 729 (2004); Holly Teliska, Note, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 231 (2005).

12. NAT'L WOMEN'S LAW CTR., PHARMACY REFUSALS 101, at 2 (2006), *available at* http://www.nwlc.org/pdf/PharmacyRefusals101_09.14.06.pdf [hereinafter NWLC, PHARMACY REFUSALS 101].

13. *Id.*

14. *Id.*

15. *Id.*

result in an increased risk of pregnancy and abortion, and deter a woman from seeking EC in the future.

Despite the detrimental effects these refusals have on women, there is little evidence of women pursuing any recourse against the pharmacists who have harmed them, perhaps due to the embarrassment the women may feel. But the lack of action on the part of injured women might also be attributed to their confusion about what their rights actually are in the face of a pharmacist refusal and ignorance as to what potential remedies are available.

Filing a complaint with the state pharmacy board to institute an administrative proceeding is one avenue a woman can pursue if she believes a pharmacist refusal has violated a state law or regulation.[16] In one administrative proceeding, the Wisconsin Department of Regulation and Licensing brought an action against pharmacist Neil T. Noesen for refusing to refer a woman's regular birth control prescription to a willing pharmacist after refusing to fill the prescription himself.[17] An administrative law judge found that Noesen's failure to inform the managing pharmacist that he would not transfer oral contraceptive prescriptions and his failure to transfer the prescription constituted a "danger to the health, welfare, or safety of a patient," and concluded that he had "practiced in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist and which harmed or could have harmed a patient."[18] The Wisconsin State Pharmacy Examining Board affirmed the administrative law judge's proposed order recommending that Noesen be reprimanded, and required, as a condition of keeping his pharmacy license, to prepare a written plan specifying "the steps he [would] take to ensure that a patient's access to medication is not impeded by his declination(s)."[19] On appeal, a Barron County circuit judge upheld the pharmacy board's order of sanctions.[20] To clarify, Noesen was not disciplined for invoking a right of conscientious refusal, but rather for failing to then ensure the patient would still be able to access her medication.[21]

16. MORRISON & BORCHELT, *supra* note 9, at 6.

17. *In re* Noesen, Case No. LS-0310091-PHM, Findings of Fact, ¶¶ 25–32 (Wis. Pharmacy Examining Bd. Apr. 13, 2005) (final decision and order), *available at* http://drl.wi.gov/dept/decisions/docs/0405070.htm.

18. *Id.* at Conclusions of Law, ¶ 2.

19. *Id.* at Order, ¶ 2.

20. *Judge Backs Pharmacist Sanctions*, CAPITAL TIMES (Wis.), Feb. 8, 2006, at A5.

21. *In re* Noesen, at Findings of Fact, ¶¶ 25–32.

The *Noesen* case is notable, primarily, because it is the first of its kind.[22] But such a course of action has its limitations; pursuing an administrative proceeding through the state pharmacy board, which may result in a reprimand or other sanction levied against the offending pharmacist, does not compensate a woman directly for any damage she may have suffered as the result of an EC refusal.[23] Yet, women harmed by EC refusals may have another option for personal redress: suing the pharmacist directly in a private tort action for wrongful conception or wrongful pregnancy. This Note will argue that these causes of action should be extended to hold pharmacists liable when they deny women EC on the basis of nothing more than their own moral objections.

This Note will begin with the preliminary matter of identifying the conflict between competing religious, scientific, and medical definitions of emergency contraception and pregnancy in Part II. Part III will discuss enacted and proposed refusal clause statutes, and competing statutes that require pharmacists to dispense medication or refer patients to other pharmacies in spite of their conscientious objections to the use of such medication. Part IV will examine the standard of care to which pharmacists should be held, in light of professional, ethical, moral, and legal principles. Finally, Part V will construct an argument for a wrongful conception or wrongful pregnancy cause of action against a pharmacist whose refusal to dispense EC results in pregnancy.

II. PRELIMINARY MATTERS: WHAT IS EMERGENCY CONTRACEPTION AND HOW DOES IT WORK?

EC is a contraceptive device with high levels of the hormones found in daily oral contraceptive pills.[24] It is sold in prepackaged doses and each package has enough EC for a onetime use.[25] The doses must be taken within seventy-two hours after unprotected sex in order to be most effective at preventing pregnancy. If taken during that time frame, EC can reduce the likelihood of pregnancy by approximately eighty-one to ninety percent, but research shows that EC is more effective the sooner it is taken.[26]

22. *See* Teliska, *supra* note 11, at 230; Rob Stein, *Pharmacists' Rights at Front of New Debate; Because of Beliefs, Some Refuse to Fill Birth Control Prescriptions*, WASH. POST, Mar. 28, 2005, at A1.

23. *See* MORRISON & BORCHELT, *supra* note 9, at 6.

24. Ellertson, *supra* note 8, at 44–45; FDA, Plan B: Questions and Answers, *supra* note 2.

25. FDA, Plan B: Questions and Answers, *supra* note 2.

26. JENNIFER JOHNSEN, PLANNED PARENTHOOD FED'N OF AM., INC., FACT SHEET: THE DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION AND MEDICATION ABORTION 2 (2006), *available at* http://www.plannedparenthood.org/files/PPFA/fact-EC-mabortion.pdf [hereinafter PPF, DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION]; FDA, Plan B: Questions and Answers, *supra* note 2.

The first point of controversy regarding pharmacist refusals to dispense EC concerns the definition of pregnancy and the manner in which EC works to prevent pregnancy. The basic dispute is that the common religious definition says that pregnancy begins at the moment the egg becomes fertilized,[27] which some would call the "moment of conception."[28] But the accepted medical and scientific definition says that pregnancy does not begin until the fertilized ovum implants in the uterine lining.[29] Pharmacists who refuse to dispense EC often do so out of a religious belief that because EC may interfere with the implantation of a fertilized egg, EC is a type of abortion pill.[30] Yet according to the scientific and medical definition, EC in fact prevents pregnancy, and does not cause abortion.[31]

In a statement made after an FDA advisory committee approved Preven, another form of EC, in 1996, FDA spokesperson, Mary Pendergast, stated: "The scientific and medical definition of abortion is after implantation. . . . These birth control pills are used to prevent pregnancy, not to stop it. This is not abortion."[32] And, as stated on the FDA-approved label for Plan B, EC "can reduce your chance of pregnancy after unprotected sex," but "will not do anything to a fertilized egg already attached to the uterus."[33] Studies confirm that if a woman takes EC after the fertilized egg has attached to the uterus, the pregnancy will not be affected.[34]

Even under the religious definition, however, the evidence suggests that EC will not terminate a pregnancy. A report by the Population Council's International Committee for Contraception Research ("ICCR") has helped to clarify how EC works to prevent pregnancy. The research

27. B.A. Robinson, *Do Contraceptives Induce Abortions?*, RELIGIOUSTOLERANCE.ORG, Mar. 4, 2004, *at* http://www.religioustolerance.org/abo_cont.htm.

28. *See* Elizabeth Spahn & Barbara Andrade, *Mis-conceptions: The Moment of Conception in Religion, Science, and Law*, 32 U.S.F. L. REV. 261, 264–65 (1998) (explaining that although many refer to the moment of fertilization as "conception," the scientific literature defines conception as the implantation of the fertilized egg in the uterine lining, which is not a "moment," but a weeklong process).

29. *Id.*

30. *See* Stein, *supra* note 22, at A1.

31. *See* Aileen Pincus, *FDA Panel Endorses Morning After Pill*, CNN.COM, June 29, 1996, *at* http://www.cnn.com/HEALTH/9606/29/nfm/contraception.

32. *Id.*

33. Duramed Pharms., Inc., Carton Insert, Plan B (Levonorgestrel) Tablets, 0.75 mg, Emergency Contraception 2–3, *available at* http://www.fda.gov/cder/foi/label/2006/021045s011lbl.pdf.

34. *Id. See* Population Council, *supra* note 10, at 3; KAISER FAMILY FOUND., EMERGENCY CONTRACEPTION, FACT SHEET: WOMEN'S HEALTH POLICY FACTS 1 (2005), *available at* http://www.kff.org/womenshealth/upload/3344-03.pdf [hereinafter KFF, EMERGENCY CONTRACEPTION].

shows that despite earlier reports that Plan B's effectiveness might be attributed to its ability to prevent implantation of a fertilized ovum, Plan B works primarily by "interfering with ovulation, thus preventing fertilization, and not by disrupting events that occur after fertilization."[35] Such information lends support to the argument that EC is in no way an abortifacient, even according to the common religious definition of pregnancy as beginning at fertilization.[36] There are still some whose religious beliefs are opposed to both abortion and contraception of any kind,[37] but "[c]ontraceptive use in the United States is virtually universal among women of reproductive age: 98 percent of all women who [have] ever had intercourse [have] used at least one contraceptive method" to prevent unwanted pregnancy.[38]

III. ENACTED AND PROPOSED LAWS REGARDING PHARMACIST REFUSALS

The problem of pharmacist refusals to dispense EC is a matter not only of personal conscience but also of religious and reproductive politics.[39] Most states have laws, known as refusal clauses or conscience clauses, which allow some healthcare providers, especially doctors, to refuse to provide certain medical services to which those providers are morally opposed.[40] Common procedures covered by such laws are

35. Population Council, *supra* note 10, at 3.

36. It is also important to distinguish EC from Mifepristone, also known as the "abortion pill." Mifepristone can be taken up to fifty-six days after the first day of a pregnant woman's last menstrual period, and it works by blocking the hormones necessary to maintain a pregnancy. PPF, DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION, *supra* note 26, at 1–2. *See also* Heather M. Field, Note, *Increasing Access to Emergency Contraceptive Pills Through State Law Enabled Dependent Pharmacist Prescribers*, 11 UCLA WOMEN'S L.J. 141, 187–89 (2000) (discussing the classification of EC as a contraceptive, not an abortifacient).

37. Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703, 1713 (1999).

38. WILLIAM D. MOSHER ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS., CDC, ADVANCE DATA FROM VITAL AND HEALTH STATISTICS NO. 350, USE OF CONTRACEPTION AND USE OF FAMILY PLANNING SERVICES IN THE UNITED STATES: 1982–2002, at 1 (Dec. 10, 2004), *available at* http://images.ibsys.com/2005/0104/4047555.pdf.

39. *See* GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, STATE POLICIES IN BRIEF 1 (2007), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf [hereinafter GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES]. For discussions of the religious and reproductive politics involved in conscientious refusals to dispense EC, see, for example, Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993), Donald W. Herbe, Note, *The Right to Refuse: A Call for Adequate Protection of a Pharmacist's Right to Refuse Facilitation of Abortion and Emergency Contraception*, 17 J.L. & HEALTH 77 (2002–2003), and Teliska, *supra* note 11.

40. *See* GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, *supra* note 39; National Conference of State Legislatures, Pharmacist Conscience Clauses: Laws and Legislation (Oct. 2006), *at*

abortion, sterilization, and physician-assisted suicide.[41] As of March 2007, although forty-six states allowed healthcare providers to refuse to perform or participate in abortion, only thirteen states had refusal clauses that covered contraceptive services.[42] And even fewer states' refusal clauses explicitly extend similar rights to pharmacists asked to dispense EC.[43] Some refusal clauses clearly do not apply to pharmacists, while the application of others is unclear.[44] These state laws are significant in constructing an argument for a negligence cause of action against pharmacists because they provide evidence of the standard of care to which pharmacists are held in a particular state.

It is important to note that the legislation discussed in the following sections were in effect before the FDA decision to allow Plan B to be sold OTC to women eighteen and older. But because Plan B will continue to be sold from behind the pharmacy counter to women of all ages, this Note assumes that both the refusal clauses and statutes ensuring patient access to medication will continue to function in a similar fashion when applied to the efforts of women eighteen and older to obtain EC without a prescription.

A. PHARMACIST REFUSAL CLAUSES

According to the National Conference of State Legislatures, four states—Arkansas, Georgia, Mississippi, and South Dakota—have laws that explicitly allow pharmacists to refuse to dispense EC.[45] Three other states—Colorado, Florida, and Tennessee—have broadly worded refusal

http://www.ncsl.org/programs/health/conscienceclauses.htm [hereinafter NCSL, Pharmacist Conscience Clauses].

41. *See* GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, *supra* note 39, at 1; Wardle, *supra* note 39, at 178–81; White, *supra* note 37, at 1705–24.

42. *See* GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, *supra* note 39, at 1.

43. *See id.* at 1. *See also* Herbe, *supra* note 39, at 97–98.

44. GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, *supra* note 39, at 1.

45. NCSL, Pharmacist Conscience Clauses, *supra* note 40. See ARK. CODE ANN. § 20-16-304 (1987) (prohibiting private entities from preventing people from refusing to provide contraceptive services on the basis of "religious or conscientious objection"); GA. COMP. R. & REGS. 480-5-.03(n) (2001) (providing that, "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."); MISS. CODE ANN. §§ 41-41-203, 215(5) (1999) (providing that a "health-care provider" may decline to follow a patient's instructions for reasons of conscience, and defining a "health-care provider" as "an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business"); S.D. CODIFIED LAWS §§ 22-1-2(50A), 36-11-70 (1998) (preventing pharmacists from being required to dispense medication where there is reason to believe it would destroy an "unborn child," which is defined as "an individual organism of the species homo sapiens from fertilization until live birth").

clauses that might apply to pharmacists in this context.[46] Although the number of states with pharmacist refusal clauses is small compared to the number of states with refusal clauses for doctors in the abortion context, advocates on the state and federal level are working to change that. In 2006, at least twenty states introduced legislation to institute pharmacist refusal clauses.[47] While the bills did not all pass, 2007 presents a new opportunity for pharmacist refusal clause activists.[48]

B. LEGISLATION IN FAVOR OF PATIENT ACCESS TO HEALTHCARE

On the other side of the controversy, those in favor of patients' rights and healthcare access have been countering refusal clause activism with efforts of their own. For example, Illinois has a regulation that requires pharmacies to dispense all contraceptives when presented with a valid prescription.[49] Seven other states—California, Delaware, Massachusetts, Nevada, New York, North Carolina, and Oregon—require pharmacists either to dispense all medications or ensure that their patients can access medication in a timely manner.[50] Finally, Maine requires pharmacists to fill

46. *See* GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES, *supra* note 39, at 2. *See also* COLO. REV. STAT. § 25-6-102(4), (9) (2001) (stating that while healthcare providers may not generally interfere with a patient or physician's desire to use available contraceptive procedures, but allowing "private institution[s] . . . physician[s], . . . agent[s and] employee[s] of such institution[s] or physician[s]" to refuse to provide "contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection"); FLA. STAT. § 381.0051(3), (6) (2003) (permitting a "physician or other person" to refuse "to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons"); TENN. CODE ANN. § 68-34-104 (1971) (stating that "no private institution or physician, nor any agent or employee of such institution or physician" shall be prevented from refusing "contraceptive procedures, supplies, and information when such refusal is based upon religious" reasons).

47. NWLC, PHARMACY REFUSALS 101, *supra* note 12, at 3.

48. *See id*.; NCSL, Pharmacist Conscience Clauses, *supra* note 40.

49. *See* ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005). It is unclear, however, what protection this law might offer to women seeking the OTC form of EC.

50. *See* CAL. BUS. & PROF. CODE §§ 733, 4314, 4315 (2005) (stating that a pharmacist may refuse to dispense drugs for moral or religious reasons, but only if he or she has previously notified his employer and the employer can reasonably accommodate the pharmacist's objection; also requiring pharmacies to "establish protocols that ensure that the patient has timely access to the prescribed drug"; also allowing for enforcement of this provision through fines and letters); 639 Nev. Reg. Admin. Regs. reg. no. 036-06 (May 4, 2006), *available at* http://www.leg.state.nv.us/Register/2006Register/R036-06A.pdf (requiring pharmacists to fill all prescriptions unless they are unlawful, harmful to the patient's medical health, fraudulent, or not for a legitimate medical purpose). *See also* NCSL, Pharmacist Conscience Clauses, *supra* note 40 (providing descriptions of other states' laws). The Delaware, Massachusetts, New York, North Carolina, and Oregon rules are policies adopted by the state pharmacy boards. Those policies will be further discussed in Part III.C, *infra*.

valid prescriptions[51] and considers it unprofessional conduct for a pharmacist to refuse to do so.[52] At least some of these statutes will presumably continue to protect women eighteen and older who seek to obtain EC without a prescription from behind the pharmacy counter.

On the federal level, in April 2005, Senator Barbara Boxer introduced the Pharmacy Consumer Protection Act of 2005, which would require a pharmacy affiliated with Medicare or Medicaid to ensure that all valid prescriptions are filled without unnecessary delay or interference.[53] Similar bills were introduced by Senator Frank Lautenberg and Representative Carolyn Maloney.[54] These bills did not become law, but the increased attention that the pharmacist refusal debate is attracting may soon prompt Congress to act. These bills, like the California and Illinois policies, focus on the duty of pharmacies to ensure patient access to medication, as opposed to focusing on the ability of the pharmacist on duty to dispense or refuse to dispense a medication when a patient attempts to obtain it.

C. POLICIES OF THE STATE PHARMACY BOARDS AND THE AMERICAN PHARMACISTS ASSOCIATION

Legislatures are not the only policymaking bodies that have attacked the pharmacist refusal clause controversy. State pharmacy boards, which are responsible for licensing and otherwise regulating the profession,[55] have also adopted policies or interpretations of state law to address the recent pharmacist refusals.

1. State Pharmacy Board Refusal Clause Policies

The North Carolina Board of Pharmacy has a policy that requires pharmacists to ensure that EC prescriptions are filled in a "timely

51. 02-392-19 ME. CODE R. § 11 (Weil 2004) (citing ME. REV. STAT. ANN. tit. 32, § 13795(2) (2004)) (stating that a pharmacist may only refuse to fill a prescription where he is "unsatisfied as to [its] legitimacy or appropriateness" or the "validity of any photographic identification or the identity of any patient presenting a prescription or any person acting on behalf of the patient").

52. 02-392-30 ME. CODE R. § 1 (Weil 2004) (stating that unprofessional conduct includes "refusing to compound or dispense prescriptions that may ordinarily and reasonably be expected to be compounded or dispensed in a pharmacy by a pharmacist").

53. S. 778, 109th Cong. (2005).

54. Access to Legal Pharmaceuticals Act, S. 809, 109th Cong. (2005); Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005).

55. JODY FEDER, CONGRESSIONAL RESEARCH SERVICE, CRS REPORT NO. RS22293, FEDERAL AND STATE LAWS REGARDING PHARMACISTS WHO REFUSE TO DISPENSE CONTRACEPTIVES 2 (2005), *available at* http://digital.library.unt.edu/govdocs/crs/data/2005/upl-meta-crs-7544/RS22293_2005Oct07.pdf.

manner."[56] According to the policy, pharmacists are not to "impose their moral or ethical beliefs on the patients they serve," and must "take proactive measures so as not to obstruct a patient's right to obtain" a medication to which the pharmacists object.[57] Furthermore, the Board of Pharmacy says that "although pharmacists have a right to avoid moral or ethical conflict, they do not have a right to obstruct otherwise legitimate prescription dispensing or delivery solely on the basis of conscientious objection."[58] Speaking directly on the subject of EC, the Board of Pharmacy says that "if a pharmacist refuses to fill a prescription for emergency contraception then that pharmacist has an obligation to get the patient and the prescription to a pharmacist who will dispense that prescription in a timely manner."[59]

The Massachusetts Board of Registration in Pharmacy ("MBRP") has also adopted a policy that requires pharmacists to fill valid prescriptions in a timely manner.[60] A number of state provisions led to this MBRP interpretation of state law. First, the state's Code of Professional Conduct mandates that "[a] pharmacist shall not refuse to compound customary pharmaceutical preparations except upon extenuating circumstances."[61] And in 2003 James DeVita, president of the MBRP, clarified the state's position, telling Planned Parenthood League of Massachusetts that "a Massachusetts licensed pharmacist providing services in the Commonwealth is required to fill a prescription that has been determined by the pharmacist . . . to be a valid prescription."[62]

Finally, in 2006, MBRP ordered Wal-Mart to begin dispensing EC at its pharmacies, citing "a regulation requiring all pharmacies to dispense 'commonly prescribed medications in accordance with the usual needs of

56. *See* North Carolina Board of Pharmacy, Frequently Asked Questions for Pharmacists on Conscience Clause (Apr. 2005), *at* http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm [hereinafter NCBOP, FAQs]; North Carolina Board of Pharmacy, Conscience Concerns in Pharmacist Decisions (Apr. 2005), *at* http://www.ncbop.org/LawsRules/ConscienceClause.pdf. *See also* NAT'L WOMEN'S LAW CTR., PHARMACY REFUSALS: STATE LAWS, REGULATIONS AND POLICIES 1–2 (2006), *available at* http://www.nwlc.org/pdf/NWLCPharmacyRefusalsMapJuly2006.pdf [hereinafter NWLC, REFUSAL MAP]; David R. Work, *Refusing to Dispense Carries Legal Risks*, DRUG TOPICS, July 25, 2005, *available at* http://www.drugtopics.com/drugtopics/article/articleDetail.jsp?id=171440 (citing the North Carolina Board's position).

57. NCBOP, FAQs, *supra* note 56.

58. *Id.*

59. *Id.*

60. NWLC, REFUSAL MAP, *supra* note 56.

61. 247 MASS. CODE REGS. 9.01(16) (2005).

62. Planned Parenthood Affiliates of New Jersey, Refusal Laws by State and Refusal Incidents II (Feb. 15, 2006), *at* http://www.plannedparenthoodnj.org/library/detail.php?id=122.

the community.'"[63] The order came after three women filed a complaint against the pharmacy chain for turning the women away when they presented valid prescriptions for Plan B.[64] James De Vita explained that the "'usual needs of the community'" must be determined "'by the prescriptions that are presented.'"[65] This interpretation of the state regulation says that pharmacies have a duty to dispense certain drugs, and this duty exists regardless of whether individual pharmacist employees object to the use of such medication.

Pharmacy boards in New York and Oregon have also interpreted the professional duties of pharmacists to include the duty to ensure that a patient is able to access her medication "in a timely manner," without obstruction,[66] and the duty not to "interfere with a patient's lawfully and appropriately prescribed drug therapy."[67]

The Nevada State Board of Pharmacy, on the other hand, declined to enter the debate and instead said it would defer to the legislature's determination of the appropriate policy approach.[68] Yet even if a state pharmacy board does not adopt an explicit refusal clause policy, state pharmacy laws may be read to imply a duty to dispense all medications, as the *Noesen* case in Wisconsin illustrates.[69]

2. American Pharmacists Association Refusal Clause Policy

Also weighing in on the issue is the American Pharmacists Association ("APhA"), the national professional society of pharmacists, which adopted a balanced refusal clause policy statement in 1998.[70] The

63. Bruce Mohl, *State Orders Wal-Mart to Sell Morning-after Pill*, BOSTON GLOBE, Feb. 15, 2006. *See* 247 MASS. CODE REGS. 6.02(4) (2005).

64. *See* Complaint at 2, McCarty v. Wal-Mart Stores, Inc., No. 06-0422 (Mass. Dist. Ct. Feb. 1, 2006), *available at* http://walmartwatch.com/img/documents/complaint_plan_b.pdf.

65. Mohl, *supra* note 63.

66. Letter from Lawrence H. Mokhiber, Executive Secretary, Pharmacy Bd., N.Y. State Office of the Professions, to Supervising Pharmacists (Nov. 18, 2005), *available at* http://www.op.nysed.gov/pharmconscienceguideline.htm.

67. Oregon Board of Pharmacy, Position Statement: Considering Moral and Ethical Objections, *available at* http://www.pharmacy.state.or.us/Pharmacy/M_and_E_Objections_6-06.pdf (last visited Apr. 21, 2007).

68. Anjeanette Damon, *State Pharmacy Board Won't Make Conscience Rule*, RENO GAZETTE-JOURNAL, Dec. 9, 2005, at 1A.

69. FEDER, *supra* note 55, at 3–4. Recall that in the *Noesen* case, the pharmacy board, without adopting a specific refusal clause policy, found that Noesen had violated his duty to his patient by failing to refer her prescription. *See supra* text accompanying note 22.

70. *See* Memorandum from Adele H. Pietrantoni, Speaker, APhA House of Delegates & John A. Gans, Sec'y, APhA House of Delegates, to Delegates to the 2005 APhA House of Delegates (Aug. 9,

APhA policy, which applies to any situation in which a pharmacist might object to filling a prescription for religious or moral reasons,[71] states: "APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure [the] patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."[72] In the words of John A. Gans, Executive Vice President and CEO of APhA, the policy supports the ability of individual pharmacists to "step away from participating in activity to which they have personal objections—but not step in the way" of a patient's ability to obtain medication.[73] The APhA policy thus recognizes that the rights of pharmacists are not the only rights at stake in the refusal clause controversy and acknowledges the importance of caring for patients who rely on pharmacists to dispense vital medications.[74]

Taken together, the pharmacy board policies and disciplinary decisions, APhA's policy statement, and legislative proposals regarding pharmacist refusal clauses are informative guidelines for constructing a pharmacist standard of care for dispensing EC. But the distinctions among state policies and the continued practice of pharmacists refusing to refer patients show that a more detailed analysis is required to develop a consistent, principled, and ethical standard for pharmacist refusals. In the end, the standard that emerges will form the basis of any negligence cause of action against a pharmacist for impeding a woman's access to EC.

2005), *available at* http://www.aphanet.org/AM/Template.cfm?Section=Search&section=About_APhA1&template=/CM/ContentDisplay.cfm&ContentFileID=663 [hereinafter APhA, Memorandum].

71. *Freedom of Conscience for Small Pharmacies: Hearing on Freedom of Conscience for Small Pharmacies Before the H. Comm. on Small Business*, 109th Cong. 2 (2005) (statement of Linda Garrelts MacLean, R.Ph., C.D.E., American Pharmacists Association), *available at* http://www.aphanet.org/AM/Template.cfm?Section=Home&CONTENTID=3565&Template=/cm/CONTENTDisplay.cfm [hereinafter APhA, *Testimony*].

72. *Id.*

73. Press Release, APhA, John A. Gans, Executive Vice President and CEO, Pharmacists & Physicians: Not Just a Matter of Conscience (June 23, 2005), *available at* http://www.aphanet.org/AM/Template.cfm?Section=Search&section=June6&template=/CM/ContentDisplay.cfm&ContentFileID=686.

74. *See* APhA, *Testimony*, *supra* note 71. In the wake of the FDA's decision to allow OTC sales of Plan B, APhA released a statement in support of improved access to medication, and stated: "During the implementation phase of Plan B's change to OTC status, it will be important for employers to work with pharmacists to develop systems that support a pharmacist's ability to opt out of working with emergency contraception, while providing a timely alternative for consumers." Press Release, APhA, APhA Statement on FDA's Recent Approval of Plan B for OTC Status (Aug. 24, 2006), *available at* http://www.aphanet.org/AM/Template.cfm?Template=/CM/ContentDisplay.cfm&ContentID=6569.

IV. A PHARMACIST'S DUTY TO DISPENSE: THE ETHICAL, MORAL, AND LEGAL DIMENSIONS

Given the important role that pharmacists play in society in compounding and dispensing prescription medication, the standard of care to which they are held should be an exacting one. But as discussed above, few states recognize a pharmacist's duty to dispense. If a medication is available by prescription only, or, in the case of EC, is available only from behind the pharmacy counter, the monopolistic nature of the drug dispensing system requires the patient to rely on a pharmacist to dispense the medication. And the technical, scientific nature of pharmaceuticals forces the patient to trust the pharmacist's professionalism and skill and that the proper medication has been dispensed.[75] When a pharmacist impedes a patient's access to medication, the patient's trust is betrayed and she may not know where else to turn for her medication. Moreover, the pharmacy profession is guided by a code of ethics that may also be violated when a pharmacist refuses to dispense a patient's medication.[76]

A. ETHICAL AND PROFESSIONAL CONSIDERATIONS IN THE PRACTICE OF PHARMACY

1. Code of Ethics for Pharmacists

The practice of pharmacy is a patient-focused practice, as the Code of Ethics for Pharmacists, adopted by the APhA membership, makes clear.[77] The Code is a key to developing a standard of care for pharmacists because, as the preamble states, the principles embodied in the Code are meant to "state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society."[78] Although these ethical principles embodied in the Code are broadly worded, four of them in particular can be applied concretely to the pharmacist refusal clause debate.

75. *See* William L. Allen & David B. Brushwood, *Pharmaceutically Assisted Death and the Pharmacist's Right of Conscience*, 5 J. PHARMACY & L. 1, 2 (1996) (discussing the pharmacist's monopoly over the dispensing of prescription drugs and the pharmacist's "gatekeeper" role).

76. APhA, Code of Ethics for Pharmacists (Oct. 27, 1994), http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2809 [hereinafter APhA, Code of Ethics].

77. *Id.*

78. *Id.*

First, the Code states, "A pharmacist respects the covenantal relationship between the patient and pharmacist."[79] This principle means that a "pharmacist has moral obligations in response to the gift of trust received from society" and must promise to help patients "achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust."[80] The pharmacist-patient relationship is, according to these words, founded on a trust that exists between the pharmacist and the individual patient, and also extends to society as a whole. Helping a patient "achieve optimum benefit" from a time-sensitive drug like EC should mean getting the patient the EC as soon as possible, for optimum effectiveness in preventing unwanted pregnancy.[81]

Second, "A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner."[82] This means that a pharmacist must place "concern for the well-being of the patient at the center of professional practice."[83] Even if a pharmacist is morally opposed to the use of EC, treating the patient with care and compassion, and in a confidential manner, means that a pharmacist should not humiliate a woman publicly for attempting to obtain EC, as occurred in some of the stories discussed above.[84] Rather, a pharmacist should, in a private and respectful manner, ensure that a patient is able to access her medication through some means.

Third, "A pharmacist respects the autonomy and dignity of each patient."[85] In strong, clear language, the Code states, "[A] pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health" and always "respects personal and cultural differences among patients."[86] To deny a woman access to EC based on one's personal religious or moral beliefs, and in disregard of the patient's own religious or moral beliefs, is in direct conflict with this principle. Respecting patient autonomy requires a pharmacist to respect a patient's desire to proceed with the course of drug therapy that she, perhaps in conjunction with her doctor, decides is in her best interest. It requires that a pharmacist refrain from taking away that patient's ability to follow through with the healthcare decision she has

79. *Id.*
80. *Id.*
81. *See* PPF, DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION, *supra* note 26.
82. APhA, Code of Ethics, *supra* note 76.
83. *Id.*
84. *See supra* notes 12–15.
85. APhA, Code of Ethics, *supra* note 76.
86. *Id.*

made because the pharmacist does not share her beliefs regarding the moral or religious propriety of that decision.

Finally, "A pharmacist acts with honesty and integrity in professional relationships."[87] The Code explains that this means a pharmacist must avoid "discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients."[88] This principle sets a high standard for the professional behavior of pharmacists and explicitly says that the best interests of the patient are primary. A pharmacist's refusal to help a patient obtain EC, although she, and in some cases, her doctor, have determined it is in her best interest to obtain that medication, does not meet the standard of professionalism required by this principle.

Pharmacists who agree to adhere to these ethical principles in the professional practice of pharmacy commit to treating all patients with respect, professionalism, care, and compassion, and such a commitment must extend to patients seeking EC to prevent an unwanted pregnancy. A pharmacist who violates these principles by impeding a woman's access to EC not only damages the pharmacist-patient relationship of trust, but also breaches a professional standard of ethical behavior by which the pharmacy profession has agreed to abide.

2. Professionalism in the Provision of Healthcare

Professionalism in the practice of pharmacy is closely related to the ethical principles just discussed, but it warrants a separate analysis in order to highlight the professional obligations that healthcare providers have regardless of their personal morals. While the notion of professional ethics is often confused with ideas about a professional's own moral and ethical beliefs, the impervious concept of professionalism in the provision of healthcare draws a line between a healthcare provider's personal beliefs and the dictates of the healthcare profession.

Pharmacists are professionals with obligations to patients who need to access their medication, employers who entrust the running of the pharmacy to them, doctors who expect the prescriptions they write to be honored, and fellow pharmacists who rely on their colleagues to do their job in a skilled and responsible manner. As one scholar, Adam Sonfield, has argued, pharmacists' refusals to dispense EC are inconsistent with the

87. *Id.*
88. *Id.*

professional obligations pharmacists have to these other parties and public policy must recognize this.[89]

According to Sonfield, there are basic values at stake in the refusal clause debate that apply to all members of the healthcare profession. Those values are: (1) "*beneficence*," which "requires the provider to act in the best interest of the patient and her welfare and is closely related to *nonmaleficence*, the basic obligation to do no harm"; (2) "*justice*," which "underlies the principle of nondiscrimination and the obligation of health care providers to work for the public good"; and (3) "*respect for autonomy*," which "leads to such principles as informed consent and confidentiality, as well as respect for the decisions of colleagues."[90] These values are threatened by pharmacist refusals to dispense a medication if the pharmacist acts on his or her personal beliefs without concern for the greater dictates of the healthcare profession.

Sonfield looks to the policy statements of various medical associations, such as the World Medical Association, American Medical Association, American Nurses Association, American Academy of Physician Assistants, American Academy of Pediatrics, Association of Women's Health, Obstetric and Neonatal Nurses, and the American Pharmacists Association, to point out that the various groups are consistent in their acceptance of the right of individual providers to refuse to perform services to which those providers object on moral or religious grounds.[91] But the groups also consistently recognize limits on the individual provider's right to refuse—providers are not permitted to abandon a patient or obstruct her access to the service she seeks.[92] Sonfield concludes that balancing of provider responsibilities and patient rights "leads to several clear obligations" that healthcare providers have toward their patients.[93] Those obligations, many of which trace the Code of Ethics just discussed, state: (1) "providers must impart full, accurate and unbiased information so patients can make informed decisions about their health care;" (2) "patients must always have access to services in emergency circumstances;" (3) "providers must not abandon patients but instead must refer them to another provider willing and ready to take over care;" and (4) "providers

89. Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP. ON PUB. POL'Y, Aug. 2005, at 7, 7, *available at* http://www.guttmacher.org/pubs/tgr/08/3/gr080307.pdf.

90. *Id.*

91. *Id.* at 7–8.

92. *Id.*

93. *Id.* at 7.

seeking to 'step away' must give adequate and timely notice to patients, employers and others who will be affected by their doing so."[94]

As these provisions make clear, medical professionals are often called upon to put aside personal beliefs in order to satisfy the demands of their professions, and pharmacists are no exception. Pharmacists have professional obligations toward their patients and, at times, will be called on, in the course of serving those patients, to do things that they may find personally objectionable. Meeting these obligations would require an objecting pharmacist presented with an EC request to put personal beliefs aside and to focus on the professional obligations that the pharmacist has toward the patient and ensure that she is able to access her EC from some source.

B. MORAL AGENCY OF THE PHARMACIST'S ROLE

Much of the debate over pharmacist refusal clauses boils down to whether the pharmacist is viewed as a mere "gatekeeper" who dispenses pills, or as a "drug therapy manager" whose action of filling a prescription and dispensing a medication has a moral component.[95] The extent to which moral agency is ascribed to the pharmacist's role affects the weight given to the pharmacist's personal moral or religious objections to the use of a particular medication. As some scholars have argued, "controversial use of medications, such as execution by lethal injection, abortion by pharmacotherapy, or pharmaceutically assisted death through prescription drugs, is a critical issue for pharmacists," and so their beliefs warrant respectful consideration.[96]

The question of moral agency is at the heart of the disparate treatment of refusal clauses for doctors and pharmacists. While few dispute the right of doctors to refuse to perform an abortion for religious or moral reasons, the case for pharmacist refusal clauses is less clear. Physically performing an abortion is, for some, conceptually far removed from the act of handing a patient a dose of pills that are either available OTC or have been prescribed for the patient by her doctor. But the potential moral dilemma that confronts a pharmacist asked to dispense a particular medication becomes more evident in the case of physician-assisted suicide, which some pharmacists might prefer to call "pharmaceutically assisted death."[97]

94. *Id.*
95. *See* Allen & Brushwood, *supra* note 75, at 1–2.
96. *Id.* at 1.
97. *See id.* at 1, 11–13.

Knowing that a patient is going to use a prescription medication to commit suicide, even in a state where it is legal, places a pharmacist in a potentially difficult situation if the pharmacist morally objects to suicide and wishes to refrain from facilitating it.[98]

The argument in favor of recognizing a moral component to the pharmacist's role in the assisted suicide context is that pharmacists have responsibilities beyond simply dispensing a medication correctly. They must also engage in "drug therapy monitoring functions" to ensure that prescriptions are screened for potential problems, to counsel patients regarding their medications, and to keep records of patient medical information to assure that patients are fully informed about their medications and able to use them properly.[99] These increased responsibilities to the patient, according to this argument, transform the pharmacist from medication dispenser to active counselor and monitor. Some would also argue that this more active role entitles the pharmacist's moral agency to greater consideration in drug policymaking than it has gotten in the past.[100] Advocates of pharmacist refusal clauses would extend this argument to the EC context as well and say that pharmacists who believe contraception is wrong should not be forced to facilitate its use.[101]

Given the FDA's decision to make Plan B available without a prescription for women eighteen and older, a pharmacist's moral agency is arguably lesser when the pharmacist is asked to dispense EC OTC than when a woman under eighteen presents a prescription for EC. This is because the FDA decision to make EC available OTC was based, in part, on the conclusion that the drug is safe enough to be taken by women without the supervision of a prescribing doctor.[102] In fact, the FDA has stated that the reason that all forms of EC are still kept behind the counter is so that pharmacists can manage the prescription-only version, and so pharmacy staff can check identification for women eighteen and older who seek the OTC version.[103] Thus the pharmacist no longer needs to engage in the type of drug therapy monitoring with the OTC EC that would accompany a prescription-only drug. Such a theoretical distinction, however, is difficult to justify to proponents of pharmacist refusal clauses and to objecting pharmacists.

98. *See id.* at 11–13.
99. *Id.* at 2–5.
100. *Id.* at 4–9.
101. *See* Herbe, *supra* note 39, at 77–89, 102.
102. *See* Plan B Approval Letter, *supra* note 1.
103. *See id.*; FDA, Plan B: Questions and Answers, *supra* note 2.

C. A PATIENT'S RIGHT TO HEALTHCARE ACCESS AND THE PHARMACIST'S VETO

Admittedly, pharmacists are more than mere pill dispensers in most circumstances.[104] But allowing the pharmacist's personal moral or religious beliefs to dictate whether a patient can access her medication implicates the ethical considerations of the patient-focused pharmacy practice already discussed,[105] and begs the question why the pharmacist's personal convictions should outweigh those of the patient, whether she has chosen to obtain an OTC medication, or has discussed a prescription-only medication with her doctor, obtained a valid prescription, and wishes to use it. This section will first discuss the implications of the doctor-patient relationship for patients under eighteen who need to obtain a prescription in order to access EC. The section will then proceed to discuss a patient's right to healthcare access more broadly.

1. The Doctor-Patient Relationship and Patients Under Eighteen

One way to distinguish the physician's role in patient care from the pharmacist's role is to say that "the physician initiates a treatment plan," while the "pharmacist implements aspects of [the] treatment plan."[106] According to this characterization, a pharmacist's refusal to fill a validly prescribed prescription interferes with the treatment plan developed by the patient and her doctor, and disappoints the patient's expectation that the treatment plan is in her best interests and will be followed.[107] Disappointment of patient expectations is a result that is inconsistent with APhA's patient-centered Code of Ethics and APhA's refusal clause policy, and reaches beyond the pharmacist-patient relationship to interfere with the professional determination of the physician who, in consultation with the patient, devised a treatment plan to promote that patient's best interests.[108]

In fact, the impact that a pharmacist refusal has on the doctor-patient decision to pursue a particular course of drug therapy prompted the American Medical Association ("AMA") to adopt a resolution of its own

104. Significantly, now that EC is available OTC for women eighteen and older, pharmacists are, at least in some cases, mere dispensers of prepackaged doses of EC.

105. *See supra* Part IV.A.1.

106. Kelsey C. Brodsho, Recent Development, *Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses*, 7 MINN. J. L. SCI. & TECH. 327, 328 (2005).

107. *Id.* at 329.

108. *See id.* at 329–31.

regarding pharmacist refusal clauses in June 2005.[109] According to the AMA resolution, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," the AMA supports legislation that would require pharmacists to fill or refer all legally valid prescriptions, and, "in the absence of all other remedies," legislation that would allow physicians to dispense prescription medications to their own patients if no willing pharmacist could be found within a thirty mile radius.[110]

Pharmacists would likely object to such an intrusion on their monopoly over dispensing prescription drugs,[111] but the lengths to which the AMA resolution goes is a consequence of that very monopoly that pharmacists have—when a patient is turned away by a pharmacist invoking a conscientious objection to the medication she seeks, that patient has nowhere else to go but to another pharmacist. The AMA resolution was passed in response to "a stampede of pharmacists who say they cannot in good conscience dispense certain medications," and who "compound their refusal to fill prescriptions by not returning the unfilled prescriptions to patients, thereby stymieing efforts to turn to other pharmacists."[112] The AMA supports the right of pharmacists to refer prescriptions they morally oppose, but the practical situation confronting doctors is that their patients are being denied their prescribed medications by, in effect, a pharmacist's veto.

2. A Patient's Right to Healthcare Access

Although a sweeping right to healthcare has never been found in the U.S. Constitution,[113] the Supreme Court has consistently acknowledged that an individual has the right to make private decisions regarding

109. Resolution, American Medical Association, Preserving Patients' Ability to Have Legally Valid Prescriptions Filled (June 20, 2005), *at* http://www.nrharural.org/advocacy/pdf/AMAResolution.pdf [hereinafter AMA, Resolution]. *See also* MICHAEL B. SIMON & STEVE STACK, DELEGATE REPORT, AMERICAN MEDICAL ASSOCIATION, YOUNG PHYSICIANS SECTION, AMA–YPS DELEGATE'S REPORT (June 2005), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/17/a2005delegatesreport.pdf; Peggy Peck, *AMA: Physicians Charge Pharmacists with Interference in Medical Care*, MEDPAGE TODAY, June 20, 2005, *at* http://www.medpagetoday.com/tbindex.cfm?tbid=1215&topicid=88; APhA, Memorandum, *supra* note 70.

110. AMA, Resolution, *supra* note 109.

111. *See* Gans, *supra* note 73 (responding to the AMA Resolution, Gans clarified that the APhA recognizes the right of pharmacists to refuse to dispense a prescription on the basis of conscience, but also supports the creation of systems to ensure patient access to validly prescribed medication).

112. Peck, *supra* note 109.

113. *See* Maher v. Roe, 432 U.S. 464, 469 (1977).

"whether to bear and beget a child."[114] The Court has also recognized that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[115] While there is no recognized positive right to treatment, patients do have an interest in their personal healthcare decisions. Patient access to EC, it follows, cannot be surrendered to a pharmacist's veto with complete disregard for the patient's personal decision to seek the medication to prevent an unwanted pregnancy.[116] Some have argued that the patient's interest in obtaining EC should undoubtedly be subordinated to the pharmacist's religious beliefs because religion is a fundamental right and so-called "healthcare on demand" is not.[117] Religion does have a favored status in our society, as the First Amendment's Free Exercise and Establishment clauses make clear,[118] but when a pharmacist refuses to dispense a medication on personal religious grounds, another individual's personal religious beliefs are simultaneously being challenged—those of the patient.

A constitutional argument in favor of the unlimited right of pharmacists to conscientiously refuse to fill prescriptions would also suggest that a state law requiring pharmacists to fill all valid prescriptions would be unconstitutional as a violation of the Free Exercise Clause, but this argument is flawed in light of the Supreme Court's most recent religious accommodation decisions. In *Employment Division v. Smith*,[119] the Supreme Court held that while the Establishment Clause may permit nondiscriminatory religious accommodations, the Free Exercise Clause

114. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 859 (1992). *See also* Roe v. Wade, 410 U.S. 113, 169–70 (1973) (Stewart, J., concurring) (arguing that the constitutional right to decide whether to "bear or beget a child" necessarily includes the right to terminate a pregnancy); Griswold v. Connecticut, 381 U.S. 479, 485–86 (1965) (creating a constitutional right to privacy that includes the right for married couples to use contraceptives).

115. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990). In a footnote, however, the *Cruzan* Court noted that while a competent person has a Fourteenth Amendment liberty interest in refusing unwanted medical treatment, this interest is not a constitutionally protected right within the right to privacy. *See id.* at 279 n.7.

116. For a more in-depth discussion of the conflict between religious healthcare providers' beliefs and patients' rights, see White, *supra* note 37. *See also* Fogel & Rivera, *supra* note 11, at 748 (recommending that policymakers adopt a series of rules ensuring that patients' decisions about healthcare be honored, even when healthcare professionals have moral objections).

117. Molly McDonough, *Rx for Controversy*, 4 NO. 23 A.B.A. J. E-REPORT 3 (2005) (quoting Frances Manion, senior counsel at the American Center for Law and Justice, who represents pharmacists challenging the Illinois order to fill valid birth control prescriptions, as saying "I hope even today that we value an individual's freedom of conscience more than we value the instant convenience of the customer coming in for a particular service").

118. U.S. CONST. amend. I.

119. Employment Div. v. Smith, 494 U.S. 872 (1990).

does not require them.[120] The Court stated, "We have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate."[121] As long as a law requiring pharmacists to fill all prescriptions is generally applicable and neutral regarding religion, it is not barred by the Free Exercise Clause.[122] Therefore, the argument that the fundamental rights embodied in the two religion clauses automatically trump the patient's interest in healthcare access is overly simplistic.

In addition, the adjudication of religious accommodation claims under Title VII of the Civil Rights Act of 1964,[123] which prohibits employers from discriminating against employees on the basis of religion, demonstrates the limited scope of protection afforded religious exercise in the workplace. Under Title VII, an employee can establish a prima facie case of religious discrimination against an employer by showing that the employee has a "bona fide religious belief that conflicted with an employment requirement, that [the employee] informed [the] employer of this belief and that [the employee] was discharged for failing to comply with the conflicting employment requirement."[124] Once the employee has made out a prima facie case, the employer has the burden to show it could not make "reasonable accommodations" for the employee without "undue hardship."[125]

The undue hardship test is often fatal to an employee's case[126] because the Supreme Court has interpreted the undue hardship language to include any accommodation that has "more than a de minimis cost" to the employer.[127] In the context of pharmacist refusals to dispense EC, the undue hardship test might be met if the employer pharmacy argues, for example, that the plaintiff pharmacist must fill all prescriptions because

120. *Id.* at 890.

121. *Id.* at 878–79.

122. *Id.* at 879–80.

123. 42 U.S.C. § 2000e-2(a)(1) (2000).

124. Brener v. Diagnostic Ctr. Hosp., 671 F.2d 141, 144 (5th Cir. 1982) (citing Brown v. Gen. Motors Corp., 601 F.2d 956, 959 (8th Cir. 1979) and Anderson v. Gen. Dynamics Convair Aerospace Div., 589 F.2d 397, 400–01 (9th Cir. 1978)). *See* §§ 2000e(j), 2000e-2(a)(1).

125. Trans World Airlines, Inc. v. Hardison, 432 U.S. 63, 66 (1977). *See* § 2000e(j).

126. *See, e.g.*, *Hardison*, 432 U.S. at 84–85 (finding that requiring TWA to give Hardison Saturdays off would be an undue hardship on the employer); *Brener*, 671 F.2d at 146–47 (finding that Brener's suggestions that his employer accommodate him by hiring a substitute pharmacist would be more than a de minimis cost, having a substitute pharmacist resulted in decreased efficiency and risk to patients, and operating without Brener harmed the operation of the pharmacy, and so such suggestions were not reasonable accommodations that would cause no undue hardship on the employer).

127. *Hardison*, 432 U.S. at 84.

hiring another pharmacist to fill prescriptions to which the plaintiff pharmacist conscientiously objects would be too costly.[128] Thus, federal statutory and constitutional law allows employers to require employees to perform some functions that may infringe on their free exercise of religion when certain circumstances are satisfied.

Furthermore, given that pharmacy law is primarily a product of state law, additional elements of state constitutional and common law must be considered in conjunction with the federal constitutional analysis. For example, sixteen state constitutions provide stronger protection for reproductive freedom than the federal constitution.[129] Some states have also passed their own Equal Rights Amendments, which provide heightened protection against sex discrimination.[130] Finally, some states have adopted laws or regulations to prohibit sex discrimination in the practice of pharmacy.[131] These additional protections for patients afforded by the states demonstrate that the states value female patients' equal access to prescription medication, and offer additional support for a system of redress for women harmed by pharmacist refusals.

Moreover, the interests on each side of the equation cannot be balanced simply on the weight of their status under the U.S. Constitution. The woman who is refused EC is threatened with the stark reality of an increased risk of unwanted pregnancy, the potential heart-wrenching decision of whether to seek an abortion if that pregnancy occurs, and the potential long-term consequence of going through with the pregnancy and raising the child into adulthood. These weighty consequences of potential unplanned pregnancy, abortion, or parenthood seem of much greater consequence than the moral discomfort a pharmacist might feel if forced to hand over a dosage of pills to which the pharmacist personally objects.

128. *See* Herbe, *supra* note 39, at 94–95.

129. NARAL PRO-CHOICE AMERICA, WHO DECIDES? THE STATUS OF WOMEN'S REPRODUCTIVE RIGHTS IN THE UNITED STATES 27 (15th ed. 2006), *available at* http://www.prochoiceamerica.org/assets/files/who_decides_2006.pdf. The sixteen states are Arkansas, Arizona, California, Connecticut, Florida, Illinois, Indiana, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Tennessee, Vermont, and West Virginia. *Id.*

130. MORRISON & BORCHELT, *supra* note 9, at 7 n.56. *See* League of Women Voters of the Fairfax Area Education Fund, Ratification Status in the States and State ERA's (Mar. 2004), *at* http://www.lwv-fairfax.org/pdf_folder/era_ratifications.pdf.

131. MORRISON & BORCHELT, *supra* note 9, at 7. *See, e.g.*, IOWA ADMIN. CODE r. 657-8.11(6) (2006) ("Discrimination. It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.").

D. THE PHARMACIST'S LEGAL DUTIES AND LIABILITIES

Generally the scope of potential civil liability of pharmacists is limited to the activity of filling prescriptions, but the scope of liability expands as the role of the pharmacist in patient care broadens.[132] Pharmacists may be held civilly liable for a breach of warranty or "negligence amounting to professional malpractice," but pharmacists are generally not liable for mere judgment errors.[133] Still, they are "held to a very high standard of care" and are "bound to exercise ordinary care of a high character in filling prescriptions."[134] Given the potentially dangerous nature of prescription drugs and the relative inability of laypeople to both distinguish between drugs, and to judge whether a prescription has been properly filled, the "ordinary" degree of care to be exercised by pharmacists means "the highest practicable degree of prudence, thoughtfulness, and vigilance, and the most exact and reliable safeguards consistent with the reasonable conduct of the business."[135] Ordinarily, a pharmacist has no duty to question the judgment of a physician who prescribed a medication, or to warn customers about potentially harmful side effects; a pharmacist must simply exercise ordinary care and fill the prescription according to the physician's instructions.[136]

There are two situations in which a pharmacist may be found civilly liable that are particularly relevant to the topic of this Note. First, a pharmacist may be found liable for "willful refusal to deliver to plaintiff [her] prescription for medicine after having refused to fill it."[137] In *White v. McComb City Drug Co.*, a pharmacist in Mississippi refused to fill a sick patient's prescription, and then refused to return the prescription to the patient to have it filled elsewhere, claiming that the patient owed the pharmacist money.[138] The trial court granted the defendant pharmacist's demurrer, but the state's highest court reversed, stating "[i]f this be not a tort, both willful and oppressive, it would be difficult to conceive of one" and concluded that the patient would be entitled to damages if the jury found in his favor.[139] Second, a pharmacist may be found liable for

132. Allen & Brushwood, *supra* note 75, at 4–5.
133. 28 C.J.S. *Drugs and Narcotics* § 48 (2005).
134. *Id.* § 53.
135. AM. L. PROD. LIAB. 3d § 10:55 (2005).
136. *Id.*
137. 28 C.J.S. *Drugs and Narcotics* § 48 (2005) (citing White v. McComb City Drug Co., 38 So. 739 (Miss. 1905)).
138. *White*, 38 So. at 740.
139. *Id.* at 740.

"negligently dispensing a drug other than that prescribed."[140] In *Troppi v. Scarf*, a pharmacist was deemed negligent when he filled a woman's oral birth control prescription with mild tranquilizers and she subsequently became pregnant.[141] The case will be discussed in detail in Part V.B.

Objecting pharmacists who refuse to return an EC prescription to a patient or who otherwise impede a patient's ability to access her medication elsewhere in a timely manner may be civilly liable to the woman if injury results from that refusal or delay. Part V argues that pharmacists should be held liable for harm done to women in this manner and that the proper action to bring against the offending pharmacist is a wrongful conception or wrongful pregnancy claim.

V. COURTS SHOULD ALLOW WOMEN TO SUE OBJECTING PHARMACISTS IN TORT FOR WRONGFUL CONCEPTION OR WRONGFUL PREGNANCY

A pharmacist's refusal to dispense EC or refer a patient to a friendly pharmacist has the potential to cause great harm to a woman attempting to prevent an unwanted pregnancy. Yet, there are few avenues of recourse through which a woman can seek redress for the harm she suffers if she is refused EC and subsequently becomes pregnant. While various states wrestle with the problem of developing an appropriate policy on pharmacist refusal clauses, tort law may provide a woman with the redress she deserves for being denied her time-sensitive medication by a pharmacist's veto.

A. DEFINING WRONGFUL CONCEPTION AND WRONGFUL PREGNANCY

The torts of wrongful conception and wrongful pregnancy are in a category of birth-related torts—along with the torts of wrongful birth and, where it is recognized, wrongful life—that follow general negligence principles,[142] but which are assigned their own category due to the particular policy difficulties that accompany a tort when the injury alleged

140. 28 C.J.S. *Drugs and Narcotics* § 53 (2005) (citing Stebbins v. Concord Wrigley Drugs, Inc., 416 N.W.2d 381 (Mich. Ct. App. 1987)).

141. Troppi v. Scarf, 187 N.W.2d 511 (Mich. Ct. App. 1971), *disapproved on other grounds by* Bushman v. Burns Clinic Med. Ctr., 268 N.W.2d 683 (Mich. Ct. App. 1978).

142. *See* Ann M. v. Pac. Plaza Shopping Ctr., 863 P.2d 207, 211 (Cal. 1993) ("An action in negligence requires a showing that the defendant owed the plaintiff a legal duty, that the defendant breached the duty, and that the breach was a proximate or legal cause of injuries suffered by the plaintiff." (citing United States Liab. Ins. Co. v. Haidinger-Hayes, Inc., 463 P.2d 770, 774 (Cal. 1970))); RESTATEMENT (SECOND) OF TORTS § 281 (1965).

is a pregnancy or the birth of a child.[143] Wrongful conception and wrongful pregnancy are distinct causes of action, usually brought by a parent against a doctor or pharmacist for "tortiously failing to prevent the birth of a *healthy*, but unwanted, child."[144] Wrongful conception refers to negligence that occurs prior to conception, such as a negligently performed sterilization or a negligently filled oral contraceptive prescription, which involves the actual mechanics of conception.[145] In other words, the patient plaintiff's complaint is that "but for a professional's negligence with respect to the mechanics of contraception, an unwanted conception would not have taken place."[146] Wrongful pregnancy refers to negligence not causally related to conception, such as a negligently performed abortion or a negligent failure to detect a pregnancy in time to have a safe and legal abortion that results in an unwanted pregnancy.[147]

Some would characterize wrongful conception as a subset of wrongful pregnancy because, in certain circumstances, a negligent act that gives rise to a wrongful conception action will also support an action for wrongful pregnancy.[148] For example, a negligently performed sterilization, which occurs prior to conception and involves the mechanics of conception, might be blamed for the conception of an unplanned child, as well as the subsequent pregnancy.[149] On the other hand, a negligently performed abortion can support only a wrongful pregnancy action and not a wrongful conception action because the negligence occurred after conception and involved only the continuation of pregnancy.[150] In establishing a potential negligence cause of action against a pharmacist whose refusal to dispense

143. *See* 62A AM. JUR. 2D *Prenatal Injuries* § 64 (2005). Wrongful pregnancy, as opposed to wrongful life, may be more easily accepted by a court because, as one court explained, a wrongful pregnancy cause of action limits

> the scope of the injury to the very real expenses, and obvious difficulties attending the unexpected pregnancy of a woman.
>
> Limitation of the cause of action in such a manner is valid since to do otherwise, would be to invite unduly speculative and ethically questionable assessments of such matters as the emotional affect of a birth on siblings as well as parents, and the emotional as well as pecuniary costs of raising an unplanned and, perhaps, an unwanted child in varying family environments.

Bushman, 268 N.W.2d at 686 (quoting Coleman v. Garrison, 327 A.2d 757, 761 (Del. Super. Ct. 1974)).

144. W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 55, at 372 (5th ed. 1984).

145. Mark Strasser, *Misconceptions and Wrongful Births: A Call for a Principled Jurisprudence*, 31 ARIZ. ST. L.J. 161, 162–63 (1999).

146. *Id.* at 163.

147. *Id.* at 163–64.

148. *Id.* at 163.

149. *Id.*

150. *Id.* at 164.

EC or refer the patient to a pharmacy willing to dispense EC results in a pregnancy, both causes of action would apply because EC prevents conception, and thus pregnancy.[151] Throughout this Note, I will refer to both causes of action, although the elements of the torts—the elements of negligence[152]—are essentially identical.

B. RECOGNITION OF A WRONGFUL CONCEPTION CAUSE OF ACTION AGAINST A NEGLIGENT PHARMACIST IN *TROPPI V. SCARF*

The first court to recognize a wrongful conception cause of action against a pharmacist for negligently filling a birth control prescription was the Michigan Court of Appeals in the much-cited case, *Troppi v. Scarf*.[153] Dorothy Troppi, a mother of seven, suffered a miscarriage while pregnant with her eighth child. She and her husband "decided to limit the size of their family" and obtained a prescription for Norinyl, an oral contraceptive, from their doctor.[154] When Mrs. Troppi went to the pharmacy to fill her prescription, the pharmacist negligently gave her Nardil, a mild tranquilizer, in place of her birth control.[155] Mrs. Troppi took the pills daily, believing them to be birth control, but subsequently become pregnant and gave birth to her eighth child.[156]

Mr. and Mrs. Troppi sued the pharmacist, Frank Scarf, for negligently causing Mrs. Troppi to conceive, and the trial court granted summary judgment against the plaintiffs for failure to state a claim for which relief can be granted.[157] But the Michigan Court of Appeals, after a review of traditional tort principles, reversed the summary judgment ruling, declaring, "We have here a negligent, wrongful act by the defendant, which act directly and proximately caused injury to the plaintiffs."[158] The court explained,

> Contraception has been held to be within a constitutionally protected 'zone of privacy' that surrounds the marital relationship. The State may not infringe upon the rights of husband and wife to use contraceptives to limit the size of their family. Since the State may not infringe upon this

151. *See* discussion *supra* Part II.

152. *See* Ann M. v. Pac. Plaza Shopping Ctr., 863 P.2d 207, 211 (Cal. 1993).

153. Troppi v. Scarf, 187 N.W.2d 511, 514 (Mich. Ct. App. 1971), *disapproved on other grounds by* Bushman v. Burns Clinic Med. Ctr., 268 N.W.2d 683 (Mich. Ct. App. 1978) ("[A]s yet, no appellate court has passed upon the liability of a pharmacist for negligently dispensing oral contraceptives.").

154. *Id.* at 512.

155. *Id.*

156. *Id.* at 512–13.

157. *Id.* at 512.

158. *Id.* at 514.

> right, it may not constitutionally denigrate the right by completely denying protection provided as a matter of course to like rights.[159]

Finally, the court concluded, "there is no valid reason why the trier of fact should not be free to assess damages as it would in any other negligence case."[160] As the next sections demonstrate, the same is true in the case of a pharmacist's negligent refusal to ensure a patient's access to EC when she presents a valid prescription or presents valid identification to show that she is at least eighteen years of age and needs no prescription to purchase EC.

C. NEGLIGENCE PRINCIPLES

Simply defined, "negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."[161] As the court in *Troppi v. Scarf* made clear, pharmacists can be held liable for wrongful conception under traditional negligence principles when the pharmacist fills a birth control prescription with another type of drug.[162] Determining whether a pharmacist's refusal to dispense EC should also support a negligence cause of action is the focus of this section.

1. Damages

Before there can be any recovery against a defendant pharmacist for negligence, some actual harm must be shown to have befallen the plaintiff patient.[163] In *Brownfield v. Daniel Freeman Marina Hospital*,[164] a rape victim sued the Catholic hospital that treated her for failure to give her EC when requested, or to inform her that if she wanted EC she should seek it within seventy-two hours of the rape in order for the drug to be most effective.[165] The California Court of Appeal found the rape victim failed to state a cause of action because she did not show damages[166]—she did not become pregnant after the rape despite failing to obtain EC within seventy-two hours.[167] Yet the court stated that a rape victim *could* state a cause of action against a Catholic hospital for failure to provide information about

159. *Id.* at 517 (citing Griswold v. Connecticut, 381 U.S. 479, 485 (1965)).
160. *Id.* at 516.
161. RESTATEMENT (SECOND) OF TORTS § 282 (1965).
162. *Troppi*, 187 N.W.2d at 513.
163. KEETON ET AL., *supra* note 144, § 30, at 165.
164. Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240 (Ct. App. 1989).
165. *Id.* at 242.
166. *Id.* at 245.
167. *Id.* at 242.

EC by alleging: that "a skilled practitioner of good standing would have provided her with information" about EC in similar circumstances, that she would have used such information to seek EC, and that damages "proximately resulted from the failure to provide her with information concerning this treatment option."[168]

In the context of pharmacist refusals to dispense EC, similar damage principles logically must apply, and the patient should be required to show she has suffered harm due to the pharmacist refusal—she must become pregnant. In a wrongful conception or wrongful pregnancy cause of action, unwanted pregnancy is an essential element, and the plaintiff may recover damages for expenses related to the continued pregnancy or, in some jurisdictions, the cost of an abortion.[169] Most jurisdictions, however, require the pregnancy to result in the birth of a child in order for the parents to assert this cause of action and recover damages.[170]

2. Duty and Breach of Duty

The success of a wrongful conception or wrongful pregnancy cause of action depends on the conclusion that a pharmacist has a duty to honor valid EC requests by dispensing the drug or referring the patient to a friendly pharmacist, and that a pharmacist's refusal to do so is a breach of that duty. Satisfaction of this element involves finding a "duty, or obligation, recognized by the law, requiring the person to conform to a certain standard of conduct, for the protection of others against unreasonable risks."[171] In a medical malpractice case against a physician, a duty is often established when the doctor-patient relationship is formed.[172]

Similarly, a pharmacist's duty to the patient may arise when the patient presents the prescription to be filled or presents proof of her age to obtain the medication OTC, establishing the pharmacist-patient relationship. But determining the extent of a pharmacist's duty to the

168. *Id.* at 245.

169. *See* KEETON ET AL., *supra* note 144, § 55, at 372. *See also* Beardsley v. Wierdsma, 650 P.2d 288, 292 (Wyo. 1982) (stating damages under a wrongful conception cause of action may include expenses and damages for "medical expenses associated with the unsuccessful [sterilization] . . . medical and hospital expenses for the birth of the unplanned child, . . . wages necessarily lost by the woman because of pregnancy and childbirth or because of an abortion, . . . pain and suffering of the mother in connection with pregnancy, and . . . cost of abortion, together with pain and suffering of the women who elected to have their pregnancies terminated"). Further discussion of the elements of damage in such cases is beyond the scope of this Note.

170. *See* 62A AM. JUR. 2D *Prenatal Injuries* §§ 53, 65 (2005).

171. KEETON ET AL., *supra* note 144, § 30, at 164.

172. *See* Dehn v. Edgecombe, 834 A.2d 146, 158–59 (Md. Ct. Spec. App. 2003).

patient and whether the duty has been breached when a pharmacist refuses to honor or refer the EC request necessitates an examination of the proper standard of care to which pharmacists should be held in this context. While most courts agree that "[a] pharmacist is held to a very high standard of care in filling prescriptions,"[173] it is not clear how far a pharmacist's duty extends when that pharmacist conscientiously objects to the medication the patient requests. It is also unclear whether a pharmacist's duty extends to medication sold without a prescription from behind the pharmacy counter.

In order to determine whether a pharmacist breached his or her duty to a patient and behaved negligently, a court must measure the pharmacist's behavior in that case against the appropriate standard of conduct.[174] Courts refer to many factors in defining whether particular behavior is a breach. For example, they may look for guidance in legislative rules or industry standards and customs.[175] Such factors will be helpful in determining the standard of conduct to which pharmacists should be held in dealing with patients who request EC. But this will not be a straightforward analysis, especially in light of the controversy of the validity and scope of refusal clauses as they apply to pharmacists who refuse to dispense contraceptives on moral or religious grounds.

When a healthcare provider objects on religious grounds to providing treatment that a patient requests, the duty and breach determination may also involve balancing the interests of the patient against the objections of the healthcare provider. The *Brownfield* court, for example, was faced with a hospital that objected to providing EC on religious grounds. In explaining the origin of the duty of a Catholic hospital to inform a rape victim about EC, the court said that the duty "arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment,'"[176] and that "[m]eaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an

173. Troppi v. Scarf, 187 N.W.2d 511, 513 (Mich. Ct. App. 1971), *disapproved on other grounds by* Bushman v. Burns Clinic Med. Ctr., 268 N.W.2d 683 (Mich. Ct. App. 1978). *See also* 28 C.J.S. *Drugs and Narcotics* §§ 48, 53 (1996 & Supp. 2005) (discussing druggists' liability, noting in particular that the pharmacist is held to a very high standard of care in filling prescriptions); Timothy E. Travers, Annotation, *Druggist's Civil Liability for Injuries Sustained as Result of Negligence in Incorrectly Filling Drug Prescriptions*, 3 A.L.R. 4th 270 (1981 & Supp. 2004) (discussing druggists' liability for their particular acts in dealing with prescriptions).

174. *See* KEETON ET AL., *supra* note 144, § 30, at 164.

175. *See* MARSHALL S. SHAPO, PRINCIPLES OF TORT LAW ¶ 19.03 (2d ed. 2003).

176. Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 245 (Ct. App. 1989) (quoting Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972)).

intelligent decision with regard to the options available."[177] Here, where no refusal clause was available to the hospital, the court stated that the rape victim's "right to control her treatment must prevail over respondent's moral and religious convictions."[178] Furthermore, as this Note will explain, pharmacists should have a duty to honor or refer valid EC requests—even when a refusal clause is invoked.

a. Legislative Rules

As already discussed in Part III, states have various rules regarding whether a pharmacist is required to fill or refer all valid prescriptions presented at the pharmacy or whether the pharmacist may refuse to dispense medications on the basis of a moral or religious objection to the purpose of the medication. States that have laws creating a duty to fill all valid prescriptions have established a statutory duty of care, and the violation of such a statute would be a clear breach of duty to the patient. On the other hand, states with statutory refusal clauses may have established that pharmacists have no such duty, and thus no liability to a patient for failing to fill or refer a prescription. Finally, three states have found that regardless of the extent of an individual pharmacist's duty toward his or her patients in dispensing medications, a pharmacy has a duty to ensure patient access to prescribed medications.[179]

Due to the complexity and variety among these state laws, this Note will focus primarily on industry policies in arriving at what this Note argues should be a universal standard of care for pharmacists presented with EC requests. But this Note further argues that statutory refusal clauses that allow pharmacists to refuse to honor or refer EC requests without liability go too far in subordinating an individual patient's very personal and private choice about whether to have a child to a pharmacist's personal objection to the use of contraception.

b. Industry Standards and Customs

Establishing that pharmacists have a duty to honor or refer EC requests requires revisiting the Code of Ethics for Pharmacists and the APhA conscience clause policy, both of which are industry-created guidelines that provide evidence of the proper standard of care and professionalism that the pharmacy profession demands of its pharmacists and promises to the public it serves. The preamble to the Code of Ethics

177. *Id.* (citing *Cobbs*, 502 P.2d at 9–10).

178. *Id.* at 244.

179. The three states are California, Illinois, and Massachusetts. *See supra* notes 49–50, 63–65, and accompanying text.

asserts, "This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society."[180] This assertion shows that the industry intends the Code to be a public statement of how pharmacists should act and how patients can expect to be served by their pharmacists.

Other provisions of the profession's Code make further promises to patients. The Code states that the pharmacist-patient relationship is a *covenantal* relationship that is to be respected,[181] suggesting that the industry believes pharmacists do have a duty toward their patients once the pharmacist-patient relationship is established. The Code further promises that the pharmacist will treat the patient with compassion and professionalism, respect the patient's dignity and autonomy, and promote the patient's best interests.[182] These promises show that the industry expects a high degree of care from its pharmacists in their treatment of patients, and that the industry considers the best interests of its patients to be a primary professional concern that should be given priority over the pharmacists' personal interests.

While the Code of Ethics is not a formal contract, it was adopted by APhA and all APhA members and is intended to guide the profession in its treatment of patients. Even if such a high standard of conduct would not otherwise be required, these ethical principles are persuasive evidence of the proper standard of conduct because they are public promises that the industry itself has voluntarily made and promises that individual pharmacists have agreed to abide by.

Turning to another relevant industry statement, the APhA conscience clause policy specifically prohibits a pharmacist from turning his or her back on a patient seeking a medication for a purpose that the pharmacist might object to on moral or religious grounds.[183] Recognizing the patient-centered nature of the practice, the policy aims to strike a balance between the right of conscience of a particular pharmacist and the patient's right to obtain her medication.[184] A pharmacist who refuses to refer an EC prescription or return the prescription to the patient violates the APhA

180. APhA, Code of Ethics, *supra* note 76.
181. *See id.*
182. *See id.*
183. APhA, *Testimony*, *supra* note 71.
184. *Id.*

policy by impeding the patient's access to her medication. Inherent in this policy is the recognition of a duty that the pharmacist must "not step in the way" of a patient's attempt to access her medication.[185] Refusing to refer or return a prescription that the pharmacist will not fill should be considered a breach of that duty. Similarly, by refusing to refer an OTC request for EC to a willing pharmacist or to otherwise ensure that a woman is able to access the medication, a pharmacist is effectively turning his or her back on a patient in violation of the duty imposed by the APhA policy.

Both the Code of Ethics for Pharmacists and the APhA conscience clause policy were applied by the administrative law judge in the *Noesen* case to determine whether Noesen had a duty to the patient whose birth control prescription he refused to fill, and whether he breached that duty by refusing to refer or return her prescription.[186] The judge in that case said that the Code was "informative as to the standard of practice to be considered." The judge then concluded that Noesen's "conduct in refusing to transfer [the patient]'s prescription or to provide her with information about how she could obtain her prescription, [was] inconsistent with the principles of a patient-focused practice set forth in the Code of Ethics for Pharmacists," as he had "failed to balance his covenantal duties to his patients with the exercise of his conscience."[187] He also failed to adhere to the APhA conscience clause policy when he refused to refer the patient's prescription or advise her what steps she could take to have it filled elsewhere, thereby stepping in the way of her ability to obtain her medication.[188]

In the *Noesen* case, the pharmacist invoked his claimed right to conscientiously refuse to fill a prescription despite the fact that there was no statutory refusal clause applicable to pharmacists, yet the state pharmacy board did not argue with his right to do so.[189] The case is not unique in this respect[190]—pharmacists who object to contraception and other drugs frequently refuse to fill prescriptions when they have no law to back up their so-called right to refuse, and the APhA conscience clause policy appears to support that.[191] But, absent statutory authority, a pharmacist's

185. Press Release, John A. Gans, *supra* note 73.

186. *In re* Noesen, Case No. LS-0310091-PHM, Analysis of the Evidence (Wis. Pharmacy Examining Bd. Apr. 13, 2005) (final decision and order), *available at* http://drl.wi.gov/dept/decisions/docs/0405070.htm.

187. *Id.*

188. *See id.*

189. *See id.*

190. Stein, *supra* note 22, at A1.

191. *See* Peck, *supra* note 109.

right to refuse to refer a patient to a source from which she can obtain her medication is much more limited than the pharmacist's right to refuse to fill a prescription.

As in the *Noesen* case, when a pharmacist refuses to fulfill the public role that he or she has promised to fulfill, without the protection of a statutory refusal clause, evaluating the pharmacist's conduct in light of an appropriate standard of care will help determine whether a duty to the patient existed and was breached. Given the widespread adoption of the APhA Code of Ethics and the established common law rule that pharmacists are held to an exacting standard of care in filling prescriptions,[192] the duty and breach elements of a wrongful conception cause of action can be satisfied in cases where a pharmacist refuses to fill or refer a prescription and no statutory pharmacist refusal clause can be invoked.

The question is not whether the pharmacist has the right to refrain from filling the prescription, which the APhA conscience clause policy permits, but whether that pharmacist can further impede the patient's access to her medication by refusing to refer the prescription or advise the patient of an alternative means to obtain that medication. And recall the case of *White v. McComb City Drug Co.*, discussed in Part IV.D, in which the Mississippi Supreme Court stated that a pharmacist could be held liable for willfully refusing to return to the patient a prescription that the pharmacist refused to fill.[193] These industry policies and court decisions show that courts will recognize a pharmacist's duty to, at a minimum, refer a prescription to which the pharmacist personally objects. Such policies should apply to OTC requests for EC because selling the medication only from behind the pharmacy counter effects the same barrier to access when a woman is faced with a pharmacist unwilling to dispense it.

In some circumstances, however, if a referral is not possible in the face of severe time constraints or practical limitations on a patient's ability to travel to a friendly pharmacist within the seventy-two hour window, or if the system in place fails to result in the patient's receipt of the medication in a timely manner, then the objecting pharmacist's failure to dispense the medication should be deemed a breach of duty as well—even if a valid refusal clause was invoked.[194] Although the standard of care for a

192. *See* Travers, *supra* note 173.

193. White v. McComb City Drug Co., 38 So. 739, 740 (Miss. 1905).

194. It is important to note that the existing refusal clauses described in Part III do not specifically discuss the ability of a pharmacist to refuse to refer a patient's prescription. *See supra* note 45 and accompanying text.

pharmacist may be established by statute,[195] a sweeping refusal clause that allows a pharmacist to veto the treatment plan that the patient wishes to follow goes too far in protecting a pharmacist's personal beliefs at the expense of a patient's health. Recognition of this reality is inherent in the refusal clause policies adopted by APhA and the California legislature, which allow a pharmacist to conscientiously object to dispensing a medication only if the patient is still able to obtain it in a timely manner.[196]

Pharmacists have a virtual monopoly over dispensing prescription drugs, and the ability to dispense EC remains confined to pharmacy counters despite the drug's partial OTC status. Allowing pharmacists to stand in the way of a patient's access to EC violates the industry's own policies and, in the case of women under age eighteen, permits a pharmacist to disregard the course of treatment that the patient and her physician have determined is in her best interests. This intrusion into the doctor-patient relationship is simultaneously a breach of the covenantal pharmacist-patient relationship, and a violation of the patient's own right of conscience and right to make autonomous healthcare decisions. The violation is no less serious when the woman seeking EC is eighteen or older.

A refusal clause that gives a pharmacist an absolute power to refuse to honor or refer a patient's EC request goes beyond accommodating religion to give primary protection to the pharmacist's conscience at the expense of the patient who has no other means of obtaining her time-sensitive medication. The gravity of the threat to patient care is evident in the AMA resolution supporting legislation to allow physicians to dispense prescription drugs if no willing pharmacist can be found within a thirty mile radius.[197] A patient seeking to obtain EC should not be placed in the desperate position of having her private decision regarding whether to have a child vetoed by a pharmacist who disapproves of contraception.

To summarize, pharmacists are held to a high standard in filling prescriptions, and are in a covenantal relationship with the patients they have pledged to serve. The duty pharmacists have toward these patients, which is evident in the APhA Code of Ethics and refusal clause policy, requires the pharmacist to ensure a patient's access to her medication—even when the pharmacist is morally or religiously opposed to the purpose of that medication. If the pharmacist is able to refer the patient or return the

195. KEETON ET AL., *supra* note 144, § 36, at 220.

196. For a discussion of these policies, see *supra* Sections III.B–C.

197. AMA, Resolution, *supra* note 109.

prescription to the patient so that she can take it elsewhere, then the pharmacist must do so. But if the patient has no other means of accessing her medication, then the pharmacist's refusal to assist her should constitute a breach of duty, regardless of whether a valid refusal clause was invoked by that pharmacist. According to the balancing analysis of the *Brownfield* court, the patient's "right to control her treatment must prevail over [the pharmacist's] moral and religious convictions."[198] The patient-centered nature of the pharmacy profession, the professional obligations pharmacists have toward their patients, and the monopoly pharmacists have in dispensing EC demands such a conclusion.

3. Causation: Cause in Fact and Proximate Cause

When it is established that a pharmacist has a duty to honor or refer a valid EC request and that the pharmacist breached that duty, the next prong of the wrongful conception analysis asks whether the failure to obtain EC was the cause in fact and the proximate, or legal, cause of the patient's unwanted pregnancy.[199] In professional malpractice cases, courts generally require such causation to be determined by expert testimony unless the matter at issue is considered to be within the common knowledge of an ordinary person.[200] The cause in fact element is satisfied if, but for the defendant's act or omission, the plaintiff would not have suffered the harm.[201] In the context of EC, the specific question is whether, but for the pharmacist's refusal to honor or refer the patient's EC request, she would have suffered the unwanted pregnancy.

Application of this test asks the fact-finder "to compare what did occur with what would have occurred if hypothetical, contrary-to-fact conditions had existed."[202] Putting aside the fact that causation must be determined on a case by case basis, statistics show that while eighty-five percent of sexually active women who use no contraceptive method over the course of a year will become pregnant within that year,[203] a dosage of EC, if taken within seventy-two hours, can reduce a woman's risk of

198. Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 244 (Ct. App. 1989).

199. *See* Troppi v. Scarf, 187 N.W.2d 511, 513 (Mich. Ct. App. 1971), *disapproved on other grounds by* Bushman v. Burns Clinic Med. Ctr., 268 N.W.2d 683 (Mich. Ct. App. 1978).

200. SHAPO, *supra* note 175, ¶ 48.01.

201. KEETON ET AL., *supra* note 144, §§ 41, 56, at 265–66, 373–82.

202. *Id.* § 41 at 265.

203. Schiffert Health Ctr., Patient Information: Contraceptive Methods Failure Rates, (Sept. 2004), *at* http://www.healthcenter.vt.edu/Resources/shc-online-docs/information-sheets/slide-contra-fail-rate-04-2003.pdf.

pregnancy by up to ninety percent.[204] According to these numbers, a plaintiff patient should be able to establish cause in fact easily if she can show that but for the pharmacist's refusal to honor or refer her EC request in a timely manner, she would have taken the EC as directed and *probably* would not have conceived.

Finding that a pharmacist's breach of duty was one cause in fact of a patient's unwanted pregnancy does not end the causation analysis, however. The next step is to satisfy the related element of proximate cause, or legal cause, which asks whether the harm suffered by the plaintiff is within the scope of defendant's liability resulting from the breach of duty.[205] Factors that a court will consider include the foreseeability of the resulting harm, whether the harm was too indirect or remote from the defendant's conduct to justify imposing liability, and whether there was an intervening event that "broke the chain of causation between the negligence and the injury."[206] In one wrongful pregnancy action against a physician for performing an allegedly negligent sterilization, the court, referring to proximate cause as "'that which, in the natural and continuous sequence, unbroken by other causes, produces an event, and without which the event would not have occurred,'"[207] stated that expert testimony "couched in terms of reasonable medical probabilities and certainties" was all that was required to prove such causation.[208]

Relying on the foreseeability factor, the court in *Troppi v. Scarf* easily found the proximate cause element satisfied, stating, "[T]he possibility that [the patient] might become pregnant was certainly a foreseeable consequence of the defendant's failure to fill a prescription for birth control pills; we therefore, could not say that it was not a proximate cause of the birth of the child."[209] A patient plaintiff should have an equally easy time proving that a pharmacist—an expert who deals almost exclusively with prescription drugs and other medications—should foresee that an unwanted pregnancy could be the direct consequence, in the natural and unbroken chain of events, of a refusal to honor or refer a request for a time-sensitive contraceptive. In fact, this is likely the pharmacist's intended consequence. The resulting pregnancy is not a remote or indirect consequence of failure

204. PPF, DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION, *supra* note 26.

205. KEETON ET AL., *supra* note 144, § 42, at 272–73.

206. SHAPO, *supra* note 175, ¶ 55.01.

207. *See* Wasdin v. Mager, 619 S.E.2d 384, 386 (Ga. Ct. App. 2006) (quoting Zwiren v. Thompson, 578 S.E.2d 862, 865 (Ga. 2003)).

208. *Id.* at 386–87.

209. Troppi v. Scarf, 187 N.W.2d 511, 513 (Mich. Ct. App. 1971), *disapproved on other grounds by* Bushman v. Burns Clinic Med. Ctr., 268 N.W.2d 683 (Mich. Ct. App. 1978).

to obtain EC, which would have halted the ovulation process to prevent that pregnancy. And an expert's testimony that it is a "reasonable medical probabilit[y]" that the pharmacist's conduct was the proximate cause of the patient's injury, as opposed to the certain and sole cause of her pregnancy, is sufficient to satisfy this element.[210]

4. Contributory Negligence and Mitigation of Damages

Although a full discussion of the elements of damages in wrongful conception and wrongful pregnancy cases is beyond the scope of this Note, a brief analysis of the related principles of contributory negligence and mitigation of damages is helpful to a complete analysis of the wrongful conception and wrongful pregnancy causes of action as applied to pharmacists who refuse to honor or refer EC requests. As mentioned above, the successful plaintiff in a wrongful conception or wrongful pregnancy suit is generally able to recover only costs associated with her pregnancy (or abortion), and not the subsequent costs of childrearing.[211] But a defendant pharmacist may attempt to invoke the doctrines of contributory negligence and mitigation of damages to limit the patient's recovery. In the context of EC, however, the refusing pharmacist should not have the benefit of such doctrines in most cases.

In any tort case, the defendant may attempt to establish an affirmative defense, such as contributory negligence, to limit his or her liability. Contributory negligence is "conduct on the part of the plaintiff which falls below the standard to which [she] should conform for [her] own protection," and the test is an objective one.[212] If a plaintiff is contributorily negligent, some jurisdictions would deem that a complete bar to her recovery.[213] Many states, however, adhere to the theory of comparative negligence, whereby the finder of fact will apportion the blame between the defendant and plaintiff, and plaintiff's negligence will limit, but not bar, her recovery.[214] Contributory negligence would certainly be available as an affirmative defense to a defendant pharmacist who refused to fill a plaintiff patient's ordinary birth control prescription and was subsequently sued for wrongful pregnancy or wrongful conception; the

210. *See Mager*, 619 S.E.2d at 386–87.

211. *See* KEETON ET AL., *supra* note 144, § 55, at 372. *See also* Beardsley v. Wierdsma, 650 P.2d 288, 292 (Wyo. 1982) (holding that expenses after childbirth would be too speculative, remote from the negligent actions, burdensome on the defendant, and subject to fraud).

212. RESTATEMENT (SECOND) OF TORTS §§ 463–64 (1965).

213. SHAPO, *supra* note 175, ¶ 31.01.

214. *Id.*

patient was negligent in proceeding to have unprotected sexual intercourse. But in the case of EC, which is a postcoital contraceptive, as long as the patient makes a reasonable attempt to obtain the EC within the seventy-two hour time window and the pharmacist refusal impedes that effort, the patient has not been negligent and the defense should fail.

For instance, a pharmacist might argue that the woman should have used another form of precoital birth control, such as a traditional daily oral contraceptive pill or an intrauterine device, rather than depending on EC to avoid an unwanted pregnancy. Such an argument should fail, however, given that there is a range of safe, legal, and effective birth control methods, and the patient should be able to choose the method that is appropriate for her. Each case must turn on its own facts, but imagine a case where a couple experienced a contraceptive failure; it seems the woman should not be deemed negligent for choosing to use a condom rather than a daily oral contraceptive.

Some may also argue that the plaintiff patient has the duty to mitigate damages by seeking alternate means to avoid the pregnancy, such as by having an abortion. But courts have generally rejected the notion that a woman faced with an unwanted pregnancy due to another's negligence should have her recovery limited for making the very private choice to carry that pregnancy to term and not seek an abortion.[215] As one court noted, imposing such a choice on a plaintiff patient would "impermissibly infringe upon Constitutional rights to privacy in these matters. . . . We observe, however, that where a plaintiff exercises her Constitutional right to terminate the pregnancy, recovery of the cost of the abortion, in lieu of that of the delivery, is a proper element of damages."[216]

A pharmacist may in some cases argue that the patient should have mitigated her damages by going elsewhere for her medication, but such an argument should fail if the patient has made a reasonable attempt to mitigate damages. For example, if the pharmacist refused to refer or return an EC prescription to a patient under eighteen, thereby taking away her only means of accessing the medication elsewhere, the pharmacist's argument should fail. If, on the other hand, the pharmacist simply refuses to dispense the medication, causing the patient to hunt it down elsewhere, the extent to which the pharmacist's action delayed or inhibited the patient's access to her drug would have to be determined in each case. EC is most effective the earlier it is taken, but it is effective for up to seventy-two

215. Smith v. Gore, 728 S.W.2d 738, 751–52 (Tenn. 1987).
216. *Id.* at 752.

hours following unprotected sex or a contraceptive failure.[217] Thus, even if a patient was able to travel to another pharmacy to obtain the medication, the delay could have caused the drug to be less effective at preventing pregnancy. This would clearly be the case if the patient diligently attempted to obtain the medication up to the end of those seventy-two hours and was still unable to find a pharmacist willing to dispense it.

D. TORT POLICY JUSTIFICATIONS

Finally, courts attempting to determine whether a defendant has behaved negligently and should be held liable may also look to policy arguments about the goals of tort law, such as "a moral conviction that the law should aim to reduce the kinds of risks that arise from conduct like the defendant's," or a belief that the "purpose of law is to achieve an economically efficient level of accidents."[218] In fact, the common policy justifications of tort law, such as "corrective justice," "deterrence," and "economic efficiency" further support a wrongful conception or wrongful pregnancy cause of action against pharmacists who refuse to honor or refer EC requests.[219]

Corrective justice refers to the theory that the goal of tort law is to achieve a just balance between the individual parties to a case.[220] The theory considers notions of "justice, fairness and morality," as opposed to broader system-wide considerations,[221] and attempts to compensate an innocent plaintiff for the harm she suffered due to a defendant's wrongful or negligent conduct. Holding a pharmacist liable to an individual plaintiff who suffers an unwanted pregnancy as the result of the pharmacist's negligent refusal to honor or refer the patient's EC request would balance the harm suffered by the patient against the wrongful conduct of the pharmacist by compensating the patient for the costs associated with the pregnancy. Some would object to requiring a pharmacist to compensate a patient for her pregnancy when the pharmacist's refusal to facilitate the patient's receipt of the medication was based on a moral or religious objection to the purpose of the medication. But if the pharmacist has a duty to return or refer the prescription, and to refer an OTC request to a friendly

217. *See* PPF, DIFFERENCE BETWEEN EMERGENCY CONTRACEPTION, *supra* note 26 and accompanying text.

218. SHAPO, *supra* note 175, ¶ 19.02, at 83.

219. *See id.* ¶ 1.04.

220. *See id.*

221. *See id.*

pharmacist, then the pharmacist's conduct has in fact been wrongful toward this particular patient.

Furthermore, of the two parties, the pharmacist is in the best position to avoid the harm that befell the plaintiff. Pharmacists who refuse to honor or refer EC requests must make that information public and must establish systems, as the APhA conscience clause policy states, to ensure a patient's access to her medication. A pharmacist's failure to adhere to this minimum standard of care, if it results in harm to a patient, is not faultless, despite the moral or religious motivations of the conduct.

Instrumental policy goals, such as deterrence and economic efficiency, help guide courts to look at a dispute from a broad societal perspective. Invoking a deterrence goal in deciding to hold a defendant liable in negligence, for example, is an attempt to use tort law to prevent similar harms from occurring in the future, whether the harms are committed by this defendant or someone entirely removed from the present case.[222] And successful deterrence can work to further the related goal of economic efficiency as well. In the EC context, if women sue their pharmacists in negligence for their wrongful EC refusals, then that could in fact have the effect of deterring pharmacists from continuing to impede EC access in the future. Individual pharmacists and their employers might be more likely to devise systems that will ensure their patients are able to access medication in a timely fashion, even when an objecting pharmacist is on duty. This outcome is an economically efficient resolution for these kinds of cases.

The immense costs of unwanted pregnancies are suffered not only by the individuals involved but also by society. Researchers have found the costs of unintended pregnancy include: Medicaid and other public healthcare expenses, the social, political, and economic costs of abortion, public assistance for the children of unintended pregnancies,[223] the costs of having children reared by one parent,[224] the costs of pregnant women receiving inadequate pre- and postnatal care, and the costs of low birth

222. *See id.*

223. *See* Carol J. Rowland Hogue, *Missing the Boat on Pregnancy Prevention*, ISSUES SCI. & TECH., Summer 1997, *available at* http://www.issues.org/13.4/hogue.htm ("More than one-third of public spending for Aid to Families with Dependent Children ("AFDC"), Medicaid, and food supplement programs goes to support children who were unintended at conception.").

224. *See id.* ("Almost three-fourths of births to single women began as unintended conceptions," and that potential harms to single-parent children include developmental problems and "an increased chance of failing to achieve their full potential because of neglect, abuse, or economic and social deprivation.").

weight babies.[225] The benefit of preventing unwanted pregnancies through EC use, on the other hand, will save society and individual patients much in the long run.[226] It is estimated that EC use could be credited with forty-three percent of the decrease in abortions from 1994 to 2000, preventing 51,000 pregnancies that would have ended in abortions in the year 2000 alone.[227] Further reducing the number of unwanted pregnancies and abortions is a desirable societal goal, and EC has the potential to further that goal in an economically efficient way.

VI. CONCLUSION

The problem of pharmacist refusals to dispense EC has received much recent attention in the media and in legislatures across the country. But the problem has rarely found its way to the courtroom for resolution. Women harmed by EC refusals should be able to turn to the courts for redress of their harms. When a pharmacist refuses to dispense EC or refer the patient seeking the drug to a pharmacist willing to dispense it, that pharmacist has abandoned his or her professional role and violated a duty toward that patient. And the blow of the pharmacist's refusal is further strengthened by the weight of the pharmacy profession's monopoly in dispensing such medication; this effectively transforms the EC refusal into a pharmacist's veto. The potential harms that can result from such a refusal include unwanted pregnancy, abortion, and unplanned parenthood. A woman should, at a minimum, be able to recover the costs of that harm by pursuing a wrongful conception or wrongful pregnancy cause of action against the pharmacist who harmed her.

225. *See id.* ("[T]he mother in an unwanted pregnancy is less likely to receive adequate prenatal care and more likely to expose the fetus to smoking and alcohol," often resulting in a low birth weight. "The risk that such a child will die before a first birthday is also greater. It is estimated that the elimination of unwanted conceptions would result in a 7 percent reduction in the low-birthweight rate among African American infants and a 4 percent reduction among white infants . . . .").

226. A study done in 2003 by the Office of the State Comptroller of New York State estimated that wider EC use could save the state $452.3 million annually by preventing 122,161 unwanted pregnancies and 82,315 abortions each year. OFFICE OF THE STATE COMPTROLLER, EMERGENCY CONTRACEPTION IN NEW YORK STATE: FEWER UNINTENDED PREGNANCIES AND LOWER HEALTH CARE COSTS 27 (2003), *available at* http://www.osc.state.ny.us/press/releases/nov03/emergencycontraceptionreport.pdf.

227. Rachel K. Jones, Jacqueline E. Darroch & Stanley K. Henshaw, *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34 PERSP. ON SEXUAL AND REPROD. HEALTH 294, 300 (2002), *available at* http://www.guttmacher.org/pubs/journals/3429402.pdf.