CASE STUDY

WHOSE LIFE IS IT ANYWAY?

Becky Cox White
California State University, Chico

In June, 2005, Luke Vander Bleek, an Illinois pharmacist, filed a suit challenging the state requirement that pharmacists make Plan B (emergency contraception, also known as the “morning-after pill”) available “without delay” (MSNBC, 2005). Although Illinois law allows health care providers to refuse to participate in procedures they find morally objectionable, Illinois governor Rod Blagojevich ordered on April 1, 2005, that pharmacists must make Plan B available “without delay.”

Vander Bleek's decision, he reported, was grounded in his belief that emergency contraception (EC), by preventing implantation, is pregnancy termination. Even if it were not, Vander Bleek, a Roman Catholic, believes that full moral status begins at conception; thus, in his estimation, preventing implantation is morally equivalent to abortion. In short, he believes that participation in Plan B is morally impermissible (MSNBC, 2005).

Vander Bleek is not unique. Pharmacists throughout the U.S. are refusing to fill clients' legitimate prescriptions for emergency contraception. Appealing to so-called “conscience clauses” (initially invoked to excuse pharmacists from participating in physician-assisted suicide in Oregon (Ginty, 2005)), pharmacists have recently and regularly chosen to not dispense EC. So heated has been the discussion that this legislative year (2005) has seen thirteen states introduce legislation “which gives pharmacists the right to refuse to provide certain services based on a violation of personal beliefs or values” (Pharmacist Conscience Clauses, 2005, emphasis added; Charo, 2005). Four additional states have passed laws allowing (but not designating as a right) pharmacists’ exercise of conscientious objection; and three others introduced legislation requiring pharmacists to fill legitimate prescriptions (Pharmacist Conscience Clauses, 2005).
Proponents of pharmacists’ refusals appeal to the importance of autonomy and personal integrity. Autonomy, also known as self-determination, protects an individual’s freedom both to choose her own personal values and to determine which sorts of actions protect or violate those values. Protection of autonomy is a foundation of pluralistic societies — in the absence of a single set of values which all members of society share, the freedom of each citizen to live in terms of values she defines for herself is the foundational moral value; all other values take second place.

Persons often choose, autonomously, to join various communities of like-minded persons. So, for example, one joins a church, attends a university, or aligns himself with clubs whose members value the same things he values. Often such affiliations require that one forego certain conflicting values or eschew or engage in certain sorts of behavior. For example, students attending schools affiliated with religious communities may have mandatory chapel attendance. Such regulation is not, however, a violation of autonomy as long as persons freely and knowingly accept the rules of the group or institution when they join. Again, in a pluralistic society, such formal (and informal) associations are protected as free expressions of autonomy.

Once a person has embraced a set of values, the virtue of integrity requires that he live in accordance with them. In fact, because a person importantly is his values, requiring a person to act so as to contradict them strips him of his identity. To claim one values something, only to ignore it in one’s actions, is inconsistent. Integrity demands that people respect and protect their values on (nearly) every opportunity; failure to do so is — literally — morally unconscionable.

In sum, supporters of conscience clauses argue that the moral values of autonomy and integrity commit pharmacists who believe that moral considerability begins at conception to refusing to fill prescriptions for emergency contraceptives. Filling these prescriptions, however legal they may be, makes unwilling pharmacists participants in the destruction of a being who, by their values, commands protection. Pharmacists who believe that moral considerability begins at conception are morally obligated to refuse to participate in any activity that destroys a zygote (or embryo or fetus) or prevents its implantation. Were these pharmacists to fill EC prescriptions, they would abandon their values, integrity, and personal identity. Such values must not — indeed, cannot — be left at the door when the pharmacist enters his workplace.
Opponents of “conscience clauses” argue that those who invoke them violate the freedom, and often the consciences, of others. Pharmacists may morally justify their behavior in terms of acting in concert with their own personal values, but that same justification logically extends to others. Because autonomy protects an individual’s freedom to choose both her own personal values and to specify the actions that protect those values, a pluralistic society must respect and protect the values and beliefs of all persons who seek to define for themselves a good life. Thus, women who value reproductive freedom and privacy, or who do not value unwanted pregnancies, are justified in acting in concert with those personal values.

Reproductive values are among the most important a person holds. Given that decisions to reproduce have a profound and long-lasting impact on those making such choices, they should be among the most sacrosanct. Women (and men) typically have strong beliefs about what kind of families they want and when they want to have them — if, indeed, they want to have them at all. For example, a woman who wishes to finish her education and commit herself to a career may choose to delay child-bearing. A child born into her life too soon can thwart — or completely obliterate — options she takes to be self-defining. These values and beliefs would be irrelevant were the woman unable to act upon them. Thus, she must be free to control, without hindrance, her fertility and the timing of reproduction — whether the need for EC arises from sexual assault, rape, poor judgment, or contraceptive failure.

The noncompliant pharmacist foists his reproductive values on his clients, substituting his autonomy and integrity for those of his clients. Moreover — and for the same reasons noted above — a noncompliant pharmacist makes it difficult or impossible for a woman to act with integrity. A woman’s reproductive values must not — indeed, cannot — be overridden by a pharmacist who happens not to share them, because the values have equal moral status and because the woman and the pharmacist have equal moral claims that their autonomy and integrity be respected.

Another version of integrity is applicable to this dilemma: the virtue of professional integrity. When one enters a profession, one commits to the values and behaviors that define the profession in question. These values and behaviors are typically specified in professional codes of ethics. In the case of pharmacists, professional integrity requires filling patients’ legitimate prescriptions. According to the American Pharmaceutical Association (APhA), “APhA advocates and will facilitate pharmacists’
participation in the continuum of patient care. The continuum of care is
caracterized by the interdisciplinary care provided a patient through a
series of organized, connected events or activities independent of time or
practice site in order to optimize desired therapeutic outcomes” (APhA,
2004(b), emphasis added). This obligation is amplified in the APhA “Code
of Ethics for Pharmacists” (APhA, 2005, emphases added):

I. A pharmacist respects the covenental relationship
between the patient and pharmacist.
Considering the patient-pharmacist relationship as a covenant
means that a pharmacist has moral obligations in response to
the gift of trust received from society. In return for this gift, a
pharmacist promises to help individuals achieve optimum benefit from their
medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in
a caring, compassionate, and confidential manner.
A pharmacist places concern for the well-being of the patient at the center of
professional practice. In doing so, a pharmacist considers needs stated by
the patient as well as those defined by health science. A pharmacist
is dedicated to protecting the dignity of the patient. [. . . .]

III. A pharmacist respects the autonomy and dignity
of each patient.
A pharmacist promotes the right of self-determination and recognizes
individual self-worth by encouraging patients to participate in decisions
about their health. [. . . .] In all cases, a pharmacist respects personal
and cultural differences among patients. [. . . .]

VII. A pharmacist serves individual, community, and
societal needs.
The primary obligation of a pharmacist is to individual patients.

Nor is the APhA in principle opposed to EC: A special continuing
education report on EC states, “At its 2000 Annual Meeting, the . . .
APhA adopted a policy supporting the voluntary involvement of pharmacists, . . . in emergency contraception programs that include patient
evaluation, patient education, and direct provision of emergency contraceptives medications,” and “The efficacy of emergency contraception is
greatest when treatment is initiated soon after unprotected intercourse; . .
. . .” In sum, APhA’s educational efforts directed at its members rebut the claim
that EC is equivalent to abortion and advise prompt “direct provision”
of EC (APhA, 2000).
Interestingly, some pharmacists (including Vander Bleek) are appealing to a flawed belief: that pregnancy begins at fertilization. According to biologists, the American College of Obstetrics and Gynecology, and the American Pharmaceutical Association, pregnancy begins with uterine implantation. Thus EC prevents pregnancy; it does not terminate it. Moreover, the APhA agrees: the 2000 report also specifies, “Because emergency contraceptives act before implantation and cannot disrupt an established pregnancy, they are not considered to be abortifacients” (emphasis added). And no reason supports respecting positions based on inaccurate information or idiosyncratic definitions.

Of course, pharmacists who believe (Note: belief is different from knowing) that moral worth begins at conception are not tainted by this factual error. The APhAs 1998 “Pharmacist Conscience Clause” recognizes, “. . . the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patients’ access to legally prescribed therapy without compromising the pharmacist’s conscientious right of refusal” (APhA, 2004(a), emphasis added). Note, however, that this right is to be located within systems that “ensure patients’ access;” it does not recognize an unfettered right, the result of which is an unmedicated patient.

Would-be compromisers suggest that pharmacists may refuse to fill prescriptions, but must refer clients to another pharmacist/pharmacy. However, such referrals are themselves often contested on moral grounds. Supporters of conscientious refusal argue that if one believes killing is wrong, one should not enable it in any fashion. Those who refer patients with EC prescriptions to colleagues are (the argument goes) still morally complicit in the death of an innocent person.

Opponents of conscientious refusal also object to referrals: because they simply may be impossible (e.g., small towns with only one pharmacist), they effectively obstruct a woman’s autonomous choice. Even where possible, referrals may delay a woman’s access to EC, thereby diminishing its efficacy. This risk is not insignificant: Plan B — which is 95% effective in preventing pregnancy if taken within 24 hours of sex — drops to an 85% rate of efficacy if taken between 25-48 hours after sexual intercourse; and a 59% efficacy rate when ingested between 49-72 hours post-sex. It is ineffective after 72 hours (World Health Organization, 1998, 428-433; Litt, 2005, 98-99). Women whose access to EC is delayed or denied may have to sustain an unwanted pregnancy or undergo an unwanted abortion.
Finally, a very brief worry about justice: In historically patriarchal societies, disparate gender-based reproductive capacities and assignment of responsibilities for child rearing have long resulted in oppression of women. Each year 3.5 million unintended pregnancies occur in the U.S. (Raine, 2005). Men who unwittingly father children whom they do not wish to raise can — and too often do — walk away from their parenting responsibilities. Women who are unwittingly and unwillingly impregnated have no such freedom. The law designates the birth mother as the child’s parent, and confers on her parental responsibilities. Justice — understood as equal opportunity — demands that women who do not desire to parent must have other choices; forced pregnancy is not only unjust, but also violates a woman’s autonomy, right to privacy, and personal integrity.

Currently two medical options are available to women who are unwillingly at risk of having a child: prevent the pregnancy or terminate it once it is established. EC, in virtue of not taking a life (whether or not one deems it to have moral status), seems morally preferable. Until and unless “sperm donors” become responsible parents, unwanted pregnancies/children burden women inequitably and unfairly.

From a moral point of view, should pharmacists be allowed to opt out of filling prescriptions for emergency contraception?

REFERENCES


