Becky Cox White presents the case of Luke Vander Bleek — a pharmacist who refuses to dispense emergency contraception (EC). After reviewing the arguments of proponents and opponents of conscience clauses, she concludes that pharmacists have a moral obligation to dispense EC. She bolsters this claim by arguing that dispensing is required by professional integrity and that conscience clauses perpetuate injustice against women.

White’s analysis of the case is individualistic. She treats the case simply as a conflict between a pharmacist and a patient. At this level, she does not adequately consider the importance of career choices. She also fails to provide a plausible causal or normative account to support her assertion that noncompliant pharmacists foist their values on their patients. The case, however, should not be analyzed at the interpersonal, but rather at the systems level. The central issue is the relative monopoly created by state licensure and the resulting limitation of access. The power differential between health professionals and patients engenders obligations which are contingent on local circumstances. Within a systems analysis that emphasizes access, over-the-counter availability of EC represents a morally acceptable resolution to this conflict.

White frames the argument in terms of a conflict between the autonomy and integrity of pharmacists and of their patients. She resolves this conflict in favor of patients arguing for the importance of reproductive values and against pharmacists imposing their values on patients. White prioritizes reproductive values because of their “profound and long-lasting impact.” While not demeaning the import of reproductive values, I argue that White does not sufficiently consider the effects of maintaining professional integrity. If required to dispense EC, Vander Bleek might leave the practice of pharmacy. He might require retraining.
to be employable and might, nonetheless, not be able to reestablish his prior standard of living. Depending on his views of cooperation, his conscience might prevent him from selling his pharmacies to individuals or corporations willing to dispense EC. Alternatively, he might continue to practice but experience migraine headaches or gastrointestinal upset and/or professional blunting or burnout as a result of moral distress.

Such actions may also have significant consequences for Vander Bleek’s family, employees, and customers. Both career and reproductive decisions may have profound and long-lasting effects that are difficult to predict and/or commensurate.

White should clarify her claims that “the noncompliant pharmacist foists his reproductive values on his clients” and that “[women] must be free to control, without hindrance, [their] fertility and the timing of reproduction.” While not being able to obtain EC at a particular pharmacy limits patients’ options, pharmacists who refuse to dispense EC do not force their patients to act in a particular way. What degree of coercion does foisting one’s values on another entail? Conversely, do opponents of conscience clauses foist their values on dissenting pharmacists? White should specify whether reproductive freedom is a negative or positive right and its correlative responsibilities. In terms of this case, there are multiple barriers to access to EC in addition to conscientious objection. These barriers include limited access to physicians or other health care providers, especially at night or on weekends; cost; and pharmacies not stocking the medication. If women have a right to reproductive freedom, do pharmacies have an obligation to stock EC? Does this obligation persist if the sale of EC is not profitable? Reproductive freedom may be a negative right to noninterference, but White has not shown it to be a positive right with corresponding responsibilities.

White asserts that professional integrity requires pharmacists to dispense EC. She states that, “When one enters a profession, one commits to the values and behaviors that define the profession in question.” She cites the American Pharmaceutical Association’s (APhA’s) publications including its “Code of Ethics for Pharmacists” to argue that pharmacists’ professional integrity requires filling patients’ legitimate prescriptions. While I disagree with White’s characterization of the APhA’s position, identifying a professional norm only establishes a \textit{prima facie} obligation. One must consider whether the professional norm is ethically justifiable. In addition, professional identification does not encompass all of the practitioners’ being and professionals may object to certain practices
based on independent moral beliefs. Their status as professionals, rather than automatons, legitimates their objections.\(^7\)

White’s consideration of professionalism is an important move beyond her initial individualistic framing of the case. The pharmacist’s refusal needs to be contextualized within the healthcare delivery system(s). Within this broader frame, the central issue is not reproductive values, coercion, or professional values, but rather the relative monopoly granted to professions by the state through licensure and the resulting limitations of access.\(^8\) Pharmacists appear to foist their views on patients because other individuals and groups are prevented from dispensing EC. Pharmacists have a moral obligation to mitigate this power differential but this obligation is contingent on local circumstances. For example, it is unreasonable to require a pharmacist to dispense EC against his/her conscience, if a patient can have her prescription filled by a willing pharmacist across the street. A fundamental criterion for requiring pharmacists to dispense EC is that it would significantly delay a woman using it.

The central issue in this case, which White fails to identify adequately, is the development of systems to ensure access. Possible systems include advance prescription (women filling prescriptions prior to actually needing them), pharmacist provision (pharmacists dispensing medication under protocols without a physician’s prescription), and over-the-counter (OTC) availability. EC is available OTC in many other countries, including Canada and the United Kingdom.\(^9\) This is a potentially morally acceptable compromise because stockers and cashiers are not professionals and stocking shelves or ringing up sales does not entail immoral cooperation.

Domestically, the manufacturer of one form of EC, Plan B, applied to the Food and Drug Administration (FDA) to make it available OTC. In spite of approval by the responsible advisory committees, the FDA issued a “Not Approvable” letter contending that there was inadequate evidence that young adolescents could safely use EC without professional supervision. The manufacturer subsequently requested approval for OTC sales of Plan B to women 16 years old and older and prescription sale for those under 16. The FDA responded by initiating a public comment period. Critics have argued that the FDA’s decision was based on considerations, other than safety and efficacy, beyond its purview — considerations such as whether the OTC availability of EC would lead to changes in sexual behavior opponents of OTC sales consider undesirable.\(^10\)
The issue of access to EC and conscientious objection is, therefore, more complex than White suggests. It should not be constructed simply as a conflict between two individuals which can be resolved by identifying a single overriding value. The debate involves values which may be equally compelling and consequences which may be similarly difficult to predict. Refusing to fill a prescription does not entail the imposition of pharmacists’ beliefs on patients. Pharmacists’ actions, however, occur within social practices which create power differentials and corresponding moral obligations. A mutually acceptable resolution of this conflict could come as a result of system changes to increase women’s access to EC.

NOTES

1 This paper was accepted for publication prior to the Food and Drug Administration’s August 24, 2006, approval of limited over-the-counter sale of Plan B. (See “FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older, Prescription Remains Required for Those 17 and Under.” Retrieved July 30, 2007, from http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html).


6 White states, “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.” Although the APhA’s Special Report, Emergency Contraception: The Pharmacist’s Role, states, “Because emergency contraceptives act before implantation and cannot disrupt an established pregnancy, they are not considered to be abortifacients (3),” the United States Conference of Catholic Bishops utilizes a different definition of abortion. According to the Conference’s definition, “Every procedure whose sole immediate effect is the termination of preg-
nancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo ("Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition." Washington, DC: United States Conference of Catholic Bishops, 2001. Retrieved August 16, 2006, from http://www.nccbuscc.org/bishops/directives.shtml)," EC may cause an abortion. The status of the early embryo is the fundamental moral issue which cannot be resolved by stipulating a definition of abortion. Furthermore, the Roman Catholic Church considers contraception to be immoral and some pharmacists have also refused to dispense oral contraceptive pills (Jones, "Druggists Refuse to Give Out Pill.").

With respect to the latter claim regarding “prompt ‘direct provision’ of EC,” APhA supports pharmacists prescribing emergency contraception directly to women under collaborative practice agreements. “Direct provision” in this context means without having to see another health care provider. APhA supports both voluntary participation in such agreements and conscience clauses. The APhA does not consider the pharmacist’s conscientious right of refusal to be contingent on the establishment of systems to ensure patients’ access to legally prescribed therapy.


