ARE PHARMACIST’S CONSCIENCE CLAUSES MORALLY AND PROFESSIONALLY JUSTIFIED?

A Thesis
submitted to the Faculty of the
Graduate School of Continuing Studies
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Master of Arts
in Liberal Studies

By

Robert H. Williams, B.S.

Washington, DC
November 26, 2008
ARE PHARMACIST’S CONSCIENCE CLAUSES MORALLY AND PROFESSIONALLY JUSTIFIED?

Robert H. Williams, B.S.

Thesis Advisor: Gladys B. White, PhD.

ABSTRACT

The health care profession has become embroiled in a controversy over autonomy. Patients, claiming the right to autonomy over their own bodies, want to obtain legal prescription medications. Pharmacists, claiming the autonomy to conform their professional duties according to their own personal moral or religious beliefs, evoke a “conscience clause,” and refuse to dispense the medication. The nature of these rights and the conflicts that have arisen between them will be examined in this thesis. The analysis will focus on pharmacist’s “conscience clauses,” and the refusal of pharmacists to dispense oral contraceptives. I will conduct an evaluation of the moral justification of pharmacist’s conscience clauses based on general theories of ethics and specific theories of medical ethics. Pharmacists generally base their refusal to dispense contraceptives on religious beliefs and their definition of when human life begins. These considerations will be examined in the context of the physiological functions of prescription contraceptives. I will review professional codes of
ethics, state legislation and court cases to assess any professional justifications for pharmacist conscience clauses. In conclusion, I will argue that pharmacist conscience clauses are neither morally nor professionally justified.

In general, the context for the patient and physician relationship in the United States has transitioned from paternalism (that is the general idea that doctor knows best) to enhanced patient autonomy. The evolution of patient autonomy will be discussed to provide a context for patient rights. I will argue that enhanced patient autonomy establishes standards for the medical profession that do not support pharmacist conscience clauses.

Provider rights have been established allowing physicians to opt out of performing services that violate their conscience. In advocating for conscience clauses, pharmacists accord themselves the same provider rights as physicians. I will establish that there is a substantial distinction between physicians and pharmacists who opt out of providing services. That distinction invalidates the use of physician conscience clauses to justify the establishment of similar clauses for pharmacists.
ACKNOWLEDGEMENTS

I would like to thank Gladys B. White Ph.D., for both inspiring this thesis and accepting the role of mentor to assist in taking the idea through to the completed project. One of my first two classes in the Georgetown Masters of Liberal Studies program was with Dr. White. She suggested that a paper I submitted for that class could be the foundation for a thesis. To that end I needed to grasp an understanding of duty based ethics as proposed by Immanuel Kant. In doing so I am very grateful to professors Terrence P. Reynolds, Ph.D., and John A. Reuscher, Ph.D., whose lectures gave life and meaning to the extraordinary, and sometimes dense, reading of Immanuel Kant.
TABLE OF CONTENTS

ABSTRACT ............................................................................................................. ii

ACKNOWLEDGEMENTS ...................................................................................... iv

CHAPTER 1. INTRODUCTION ............................................................................... 1

CHAPTER 2. THE EVOLUTION OF PATIENT AUTONOMY .................................. 6

CHAPTER 3. PROFESSIONAL CODES OF ETHICS .............................................. 11

CHAPTER 4. ORAL CONTRACEPTIVES ............................................................... 27

CHAPTER 5. THE CASE OF PHARMACIST NEIL NOESEN .............................. 40

CHAPTER 6. RELIGIOUS TRADITIONS REGARDING ORAL CONTRACEPTIVES ........................................................................................................ 50

CHAPTER 7. LEGISLATION IMPACTING CONSCIENCE CLAUSES ....................... 61

CHAPTER 8. DUTY BASED ETHICS .................................................................. 70

CHAPTER 9. CONCLUSION .................................................................................. 83

BIBLIOGRAPHY .................................................................................................. 95
CHAPTER 1. INTRODUCTION

The health care profession has become embroiled in a controversy over autonomy. Patients, claiming the right to autonomy over their own bodies, want to obtain legal prescription medications. Pharmacists, claiming the autonomy to conform their professional duties according to their own personal moral or religious beliefs, evoke a “conscience clause,” and refuse to dispense the medication. Various state legislatures have addressed this conflict by the enactment of conscience clauses that specifically establish the right of a pharmacist to refuse to fill a prescription based on their personal moral beliefs. This thesis will explore the question: “Are pharmacist conscience clauses morally and professionally justified?” What follows by way of introduction will set the parameters within which the thesis question will be explored and provide a brief history of conscience clauses in the medical profession. Each chapter will be introduced and its context for inclusion described. In this writing the terms “conscience clause” and “refusal clause” are used interchangeably.

Conscience clauses for medical providers came to the forefront after the U.S. Supreme Court issued the Roe vs. Wade decision. The Planned Parenthood Federation of America asserts as follows:
Refusal clauses limiting access to reproductive health care were initially established in the weeks following the January 1973 Roe v. Wade decision, which legalized abortion nationwide. In 1973, Congress passed the Church Amendment to allow health care providers to cite religious grounds in order to refuse to provide abortion or sterilization. Within five years, the majority of states adopted similar refusal clauses. Over time, refusal clauses have been extended to include assisted reproductive technologies, contraception and emergency contraception….¹

Initially conscience clauses focused on doctors and nurses who refused to participate in performing abortions. Reviewing current state legislation regarding refusal clauses, Planned Parenthood notes that: “Refusal clauses can cover …services including abortion, abortifacients, contraception, family planning services, and general reproductive health services.”² This thesis will focus specifically on the refusal of pharmacists to dispense prescription oral contraceptives.

Oral contraceptives are chosen as a focus for several reasons. There is a well documented case involving a pharmacist who refused to dispense oral


² Ibid.
contraceptives that was decided by the Wisconsin State Court of Appeals to
review. The pharmacist cited the beliefs of his religious teachings as grounds for
his refusal. This can be examined in the context of the varied religious teachings
regarding the use of oral contraceptives that have been in place since oral
contraceptives first became available by prescription in the early 1960s. In
addition, in examining oral contraceptives in the context of their intended purpose
and physiological impact, it will be established that there is no scientific basis for
objecting to their use.

Chapter 2 will focus on the evolution of patient autonomy from the
paternalistic model to the informed consumer or “enhanced autonomy” model.
Patient autonomy has become the new standard of care, and it will be argued that a
pharmacist’s refusal to fill a prescription violates that standard of care.

Chapter 3 will examine professional codes of ethics for doctors and
pharmacists. As currently written, these codes are based on a foundation of
principles that in effect reject paternalism and support enhanced patient autonomy.
The scope of practice and the distinction between physicians and pharmacists who
evoke conscience clauses will also be addressed. It will be argued that by refusing
to fill a prescription, pharmacists violate the major tenets of their own professional
codes of ethics. Although the American Pharmacists Association does offer a
caveat that allows a pharmacist to “step away” and not participate in filling a prescription that they morally object to, it will argued that this caveat is in essence a tacit admission that pharmacist conscience clauses violate their own codes of ethics.

Chapter 4 will discuss oral contraceptives, their general physiological functioning and the status of the embryo in terms of a definition of life at the point impacted by contraceptives.

Chapter 5 will discuss the case of Pharmacist Neil Noesen whose refusal to dispense oral contraceptives, based on his Roman Catholic faith, was ultimately adjudicated by the Wisconsin State Court of Appeals. This case delves into professional standards of competency.

Chapter 6 will examine religious traditions regarding oral contraception. These traditions were formulated in the 1960s at the onset of availability of prescription oral contraceptives. The lack of consensus among religious faiths about the use of oral contraceptives will be explored.

Chapter 7 will discuss current state legislation that impacts medical conscience clauses. A review of legislative action will provide examples where both the patient’s and provider’s rights to autonomy have been addressed.
Although in the minority, state action that has prohibited pharmacists from exercising a conscience clause will also be examined.

Chapter 8 will apply moral theory, specifically duty based ethics, as proposed by Immanuel Kant, to the concept of pharmacist’s conscience clauses.

In conclusion, Chapter 9 will answer the question: “Are pharmacist conscience clauses morally and professionally justified?”
CHAPTER 2. THE EVOLUTION OF PATIENT AUTONOMY

In the historical paternalistic relationship, the physicians are the primary decision makers and their values and opinions have priority over those of the patient. Paternalism has its roots in the cultural traditions of the United States. Robert Young, star and creator of the 1950s television show “Father Knows Best,” which was at the time “…one of a slew of middle class family sitcoms in which moms were moms, kids were kids and fathers knew best,”\(^1\) portrayed the typical paternalistic male head of household. Perhaps this seems innocuous in the pre-feminist era of the 1950s; however, another television show starring Young that aired from 1969 to 1976 presented the traditional role of a paternalist medical professional. That show, Marcus Welby M.D., a drama about doctors, “…may have been more appropriately called ‘Dr. Knows Best’.”\(^2\) In keeping with a doctrine of beneficence, the character of Dr. Welby approached his patients with a

---


\(^2\) Ibid.
holistic view of caring for their whole person.\textsuperscript{3} In many ways the character of Dr. Welby exemplified “…the long tradition of medical paternalism (or parentalism), which considered the duty of physicians to decide what was best because the patient lacked medical knowledge….”\textsuperscript{4} The show dealt with controversial issues of the day and sparked controversies of its own, particularly “…complaints by the rising woman’s movement that Marcus Welby’s control over the lives of his patients (many of whom were women) represented the worst aspects of male physician’ paternalistic attitudes.”\textsuperscript{5} The paternalistic attitude of doctors is “…based on asymmetric knowledge and power…in which the dependence of patients on professionals [is] generally accepted.”\textsuperscript{6} In its “worst aspect” it is described below:

Paternalism does not account for the patient’s preferences or values that are part and parcel of her good or best interests. 
Paternalism makes the medical good of the patient the only good


\textsuperscript{5} Joseph Turow, “Marcus Welby, M.D.”

and subverts other goods to that good. Paternalism violates the patient’s autonomy in the name of the patient’s best interests while ignoring or overriding some of the most vital of those interests.7

When this paternalistic role is accepted, there is no need for “conscience clauses” because the physician knows what is best, and more importantly, is seen as being totally in charge of decision making. Today, however, an increase in patient autonomy has fostered changes in the patient-physician relationship. Writing on the topic of the shift from physician paternalism to patient autonomy, Timothy E. Quill, MD and Howard Brody, MD, PhD, note: “Medical care in the United States has rapidly moved away from a paternalistic approach to patients and toward an emphasis on patient autonomy….Twenty-five years ago, most major medical decisions were left exclusively in the hands of physicians.” 8 Quill and Brody argue for an “enhanced autonomy” relationship “which encourages patients and physicians to actively exchange ideas, explicitly negotiate differences, and share their power and influence to serve the patients best


interests.” The transition from a primarily paternalistic relationship between physicians and patients has been influenced by cultural changes in how patients perceive themselves and increased availability of medical information, especially through the internet. The internet provides a wide range of resources, from medical information web sites such as WebMD, to numerous journals which allow free access to articles, such as the Journal of the American Medical Association. Typing “flu” into your internet search engine should result in about 48,300,000 responses, including from reputable web sites such as the Center for Disease Control and the Mayo Clinic. The abundance of easily available knowledge is power, and Quill and Brody comment that: “The consumer movement has taught patients to be more assertive, to question physicians’ recommendations, and to demand interventions that might otherwise be withheld.”

The onset of direct marketing to consumers by the pharmaceutical industry has also impacted how patients view their role in receiving medical care. In an editorial for the Archives of Family Medicine, Forest Lang, MD and James H. 

---

9 Ibid.
10 Ibid.
Quillen note that “…consumers’ rights and direct marketing to consumers have all become mainstream….Most physicians recognize that direct-to-consumer advertisements encourage patients to take a more active role in their care.”

These factors have all contributed to an era where an expectation of some degree of patient autonomy has become the norm and health care choices are looked upon as those being made by an informed consumer, in conjunction with their physician. As will be discussed in detail in Chapter Three, the Pharmacists Code of Ethics acknowledges patient autonomy stating directly that: “A pharmacist respects the autonomy and dignity of each patient,” and “promotes the right of self-determination….“

The recognition of patient autonomy has become the new standard of care within the medical field and accordingly, is supported by the tenets of the professional codes of ethics for doctors and pharmacists, which will be examined in the next chapter.


CHAPTER 3. PROFESSIONAL CODES OF ETHICS

The “Principles of Medical Ethics” as adopted by the American Medical Association’s House of Delegates on June 17, 2001, states in its preamble as follows:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.¹

The initial focus is on “the benefit of the patient,” and there is a hierarchy of responsibility delineated with the patient “first and foremost,” followed by society, other health professionals, and responsibility of the physician “to self.”

These opening statements are supportive of the concept of patient autonomy. An American Medical Association policy statement outlining the fundamental elements of the patient-physician relationship elaborates further on principles supporting the concept of an “enhanced autonomy” relationship:

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between

physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they… work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients’ advocate and by fostering these rights: (1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action…. (2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.2

Giving the patient “the right to make decisions regarding health care” supports patient autonomy and is counter to the strictly paternalistic concept that the doctor is solely in charge of decisions regarding the patient’s health care.

The World Medical Association also addresses patient autonomy. In its preamble to the “Declaration on the Rights of the Patient,” both patient autonomy and a physician’s right to be guided by their conscience are addressed in the statement: “While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to

guarantee patient autonomy and justice.”³ This statement condones the concept of a physician making decisions based “according to his/her conscience,” but tempers that with the admonition regarding the “best interests of the patient” and prescribes that a “guarantee” of “patient autonomy and justice” is equal to any considerations stemming from the physician’s conscience. This policy statement appears to mitigate the arbitrary nature of paternalism with a focus on patient rights, but not at the expense of a physician’s conscience. Principles elaborated in the World Medical Association’s Declaration on the Rights of the Patient under the heading “Right to self-determination” reinforce patient autonomy declaring as follows:

- The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the

³ “World Medical Association Declaration on the Rights of the Patient,” The World Medical Association, Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981, and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995, and editorially revised at the 171st Council Session, Santiago, Chile, October 2005., http://www.wma.net/e/policy/l4.htm Accessed 10/18/2008. (Note: The over 80 member nations of the World Medical Association include The United States, United Kingdom, Canada, France, Germany, Spain, Cuba, the Vatican State and Zimbabwe.)
implications of withholding consent. The patient has the right to refuse to participate in research or the teaching of medicine.⁴ This statement is a prescription for enhanced patient autonomy stressing the patient’s right to choose and the physician’s responsibility to provide information. Both the American Medical Association and the World Medical Association support patient autonomy and promote medical ethics that supersede the concept of paternalism. These organizations also respect physicians’ right to autonomy of personal conscience and the American Medical Association gives clear guidance on how a physician can exercise that right.

The American Medical Association Principles of Ethics give explicit license to a physician to exercise a conscience clause and not provide services that the physician finds objectionable. The code states that: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”⁵ This statement is unequivocal, except for the caveat regarding emergencies, in empowering the physician to refuse to participate in serving

⁴ Ibid.
⁵ “Principles of medical ethics,” American Medical Association.
patients whose desired treatment the physician finds objectionable to their conscience. In exercising the option to “be free to choose whom to serve,” the very nature of the role of a physician gives them the ability to exercise this freedom to choose with minimal or even no impact on a patient’s autonomy. The choice of specialty by a physician gives them total control over the clients they see. A very simple example illustrates this point. If a physician does not want to treat children, they can specialize in geriatrics rather than pediatrics. Even in a more complex example specialization can avoid conflicts with conscience. An obstetrician/gynecologist whose conscience objects to abortion is free to limit their practice to prenatal care and birthing. They can still carry out the essential functions of a physician within the limits they have placed on their choice of specialty. The American Board of Obstetrics and Gynecology lists the following subspecialties:

Board-certified obstetrician-gynecologists may become further specialized in the areas of: maternal-fetal medicine (care of high-risk pregnancy), gynecologic oncology (care of women with cancers of the reproductive system), reproductive endocrinology and infertility (care of women who have hormonal or infertility problems), and female pelvic medicine and reconstructive surgery.
(care of urinary tract dysfunction and disorders stemming from loss of support of pelvic structures). 6

The specialist in gynecologic oncology or female pelvic medicine and reconstructive surgery is unlikely to have their conscience tested by being asked to perform an abortion in their normal scope of practice. Even so, for any obstetrician/gynecologist, unless they actually specialized in terminating or preventing pregnancies, contraception or abortions would never encompass the entire scope of practice of their profession or specialty. Physicians invoking the conscience clause have many options and do not negate the primary function of their profession or specialty by opting out of one procedure. Patient autonomy is guaranteed by the simple function of the marketplace; there are multiple physicians to choose from within specialties, so the patient can “shop around” to find a physician who will meet their needs. However, there is the potential that a physician may withhold information regarding potential treatments that they find morally objectionable, thereby negating patient autonomy and establishing the

physician once again in an ascendant, paternalistic, role over the patient. Research indicates that this has happened recently.

In a study of how physicians view their responsibilities when their own moral convictions conflict with their patients’ requests for legal medical treatments, Farr A. Curlin, MD, et. al., found that “…most physicians believe it is ethically permissible for the doctor to describe that objection to the patient (63%) and that the doctor is obligated to present all options (86%) and to refer the patient to someone who does not object to the requested procedure (71%).” The study involved a survey of physicians and covered several issues including: “administering terminal sedation to dying patients, providing abortion for failed contraception, and prescribing birth control to adolescents without parental approval,” where a physician might object to providing treatment based on moral or religious reasons. The results indicate that most physicians honor honesty in communications with their patients and do not believe it is right to lie or withhold

---


8Ibid.
information. However, there were physicians who disagreed with the majority opinions of those studied. Curlin et. al., note the potential consequences of those who disagree with the majority when stating the following:

If physicians’ ideas translate into their practices, then 14% of patients---more than 40 million Americans---may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients---or nearly 100 million Americans---may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments.  

As the authors note regarding patients: “They should know that many physicians do not believe they are obligated to disclose information about or provide referrals for legal yet controversial treatments.” Study results also reveal that there are physicians in their consultations with patients who would withhold information regarding “treatments they consider objectionable.” In effect, by omission, the physician withholding information is evoking a conscience clause, albeit covertly. If the purposeful failure to mention available treatments is akin to a lie, then a

---

9Ibid.
10Ibid.
physician who makes such an omission would breech basic standards of ethical
communication on two counts, lying and withholding information. The physician
withholding information would also fail to “be honest in all circumstances,”\textsuperscript{11} in
violation of the professional ethics of the American Medical Association. The
withholding of information by the physician impacts patient autonomy by denying
the patient all available options to choose from. This reflects a return to
paternalism, where the physician’s special knowledge is withheld from the patient
because “doctor knows best.”

The preponderance of the principles of medical ethics as adopted by the
American Medical Association and the World Medical Association support
patient autonomy and do not reinforce paternalism. Physicians can exercise their
choice of specialty to define whom to treat and avoid conflicts of conscience
while still fulfilling the essential duties of their scope of practice. Even so the
study cited above indicates that some physicians will still choose the dictates of
their own conscience over the needs, wants and rights of the patient, in conflict
with the proposed ethics of their own profession.

\textsuperscript{11} “Principles of Medical Ethics”, American Medical Association.
The professional ethics of pharmacists are even more stringent in upholding patient autonomy. The ethics of pharmacists are central to this thesis, key elements from the Code of Ethics for Pharmacists as found on the American Pharmacists Association’s web-site follow:

Pharmacists are health professionals who assist individuals in making the best use of medications. I. A pharmacist respects the covenantal 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. IV. A pharmacist acts with honesty and integrity in professional relationships: A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair
professional judgment, and actions that compromise dedication to the best interests of patients.\textsuperscript{12}

Several statements from the pharmacists’ code of ethics categorically support the concept of patient autonomy. In respecting the “autonomy and dignity” of the patient the pharmacist “promotes the right of self-determination.” Patients are to be encouraged “to participate in decisions about their health.” The ethics statement also recognizes that the relationship between the pharmacist and patient is a “covenant” that is a “gift from society.” It is noteworthy that in return for this “gift” the pharmacist is “to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.” A pharmacist is also charged with the obligation to respect “personal and cultural differences among patients” and to avoid “discriminatory practices.” The rights of the patient to dignity and autonomy are clearly delineated in the pharmacist code of ethics. The “right to self determination” is a right that empowers an autonomous patient; it is a prescription for freedom of choice for the patient in regard to their medication needs. There is no parallel statement in the

pharmacists’ code of ethics to the statement in the physicians’ code of ethics that would allow a pharmacist to “be free to choose whom to serve.” The code of ethics promulgated for pharmacists does not seem to allow autonomy for an individual pharmacist to exercise personal moral choice in regard to what prescription medications to dispense.

Invoking a conscience clause to refuse to dispense prescription medications denies a patient their autonomy, their “right to self determination,” and certainly discriminates against those whose moral beliefs are not shared by the pharmacist. In recognition of the conflict with the code of ethics that is created when a pharmacist refuses to dispense medication evoking a conscience clause, the American Pharmacists Association has also adopted a policy allowing for the right of “conscientious refusal” by a pharmacist. The policy allowing conscience clauses for pharmacists is separate from the formal pharmacist code of ethics. In her testimony before the Small Business Committee, United States House of Representatives, Linda Garrelts MacLean, RPh, CDE, explained the “Pharmacist Conscience Clause” as follows:

…the policy applies to any situation where a pharmacist objects to dispensing a medication for personal (religious or moral) reasons….APhA’s policy supports the ability of a pharmacist to opt out of dispensing a prescription or providing a service for personal reasons and also supports the establishment of systems so
that the patient’s access to appropriate health care is not disrupted. In sum, our policy supports a pharmacist ‘stepping away’ from participating but not ‘stepping in the way’ of the patient accessing the therapy.\textsuperscript{13}

The “Pharmacist Conscience Clause” and the autonomy it grants to pharmacists conflicts with the mandate in the “Code of Ethics for Pharmacists” to promote “the right of self-determination” of the consumer. The very act of a pharmacist to refuse to dispense prescription medication is a violation of the primary role of a pharmacist and clearly in conflict with their scope of practice.

A beginning definition of a pharmacist’s scope of practice is stated in the American Pharmacists Association code of ethics: “pharmacists are health professionals who assist individuals in making the best use of medications.”\textsuperscript{14} The World Medical Association offers a policy statement that expands the definition of scope of practice and suggests parameters for the relationship between physicians and pharmacists. Regarding the physician/pharmacist relationship the policy states the following:


\textsuperscript{14} “Code of Ethics for Pharmacists,” American Pharmacists Association.
Physicians and pharmacists have complementary and supportive responsibilities in achieving the goal of providing optimal medicinal therapy. This requires communication, respect, trust and mutual recognition of each other's professional competence. When counseling patients, the physician may focus on the goal of therapy, the risks and benefits and side effects. The pharmacist on the other hand may focus on correct usage, treatment adherence, dosage, precautions and storage information.¹⁵

The physician’s role is defined in part as having the responsibility for “diagnosing diseases on the basis of the physician’s education and specialized skills…” and “assessing the need for medicinal therapy and prescribing the relevant medicines…”¹⁶ The pharmacist’s role as defined by the World Medical Association includes the following:

Providing information to patients, which may include the name of the medicine, its purpose, potential interactions and side effects as well as correct usage and storage… reviewing prescription orders to identify interactions, allergic reactions, contra-indications and


¹⁶ Ibid.
therapeutic duplications. Concerns should be discussed with the prescriber (physician).\textsuperscript{17}

In short, the physician diagnoses and prescribes while the pharmacist dispenses, advises, and reviews the safety of the prescription. It is clearly stated that if the pharmacist has “concerns” they should be discussed with the prescribing physician. The scope of practice of the pharmacist does not include diagnosis; the primary role of the pharmacist is to dispense prescribed medication, and if there are “contraindications,” those are to be discussed with the prescribing physician. Protecting the patient’s safety by reviewing possible negative interactions with other prescriptions the patient has received requires the pharmacist to utilize their scientific, clinical based knowledge. Mark R. Wicclair notes that “A pharmacist who objects to dispensing a pharmaceutical for conscience-based reasons is exercising \textit{moral judgment}, not her clinical expertise.”\textsuperscript{18} Exercising “moral judgment” to withhold a prescription is not within the pharmacist’s scope of practice as defined in professional terms. The act of invoking a conscience clause

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{17} Ibid.
\end{itemize}
\end{footnotesize}
as grounds to refuse to dispense medications places the pharmacist’s personal conscience not only ahead of the patient’s needs, but also usurps the authority of those whose scope of practice is specifically charged with determining what medications should be prescribed. Wicclair notes that “when dispensing medications to individuals, it is not within the scope of professional responsibility of pharmacists…to determine whether drug X generally is medically indicated or the standard of care for condition Y. Such determinations are the primary responsibility of researchers, clinicians, regulatory agencies, and so forth.”

The pharmacist who refuses to dispense properly prescribed medications based on a conscience clause is failing to perform essential functions of their profession. Arguably, filling prescriptions is not only a primary function of a pharmacist, but also an exclusive function of pharmacists. Pharmacists, by virtue of their license, are “granted a monopoly to dispense medications that require prescriptions….” The refusal also negates the pharmacist’s essential function to make appraisals of the appropriateness of medications on a scientific, clinical

---

19 Ibid.

20 Ibid.
basis, and abdicates the responsibility to confer with the prescribing physician regarding the appropriateness of the prescription. These functions make up a majority of the most essential functions of a pharmacist. There is no corresponding parallel to the physician who exercises the right to opt out of providing certain services. The physician’s scope of practice is much broader than the pharmacists’, and the opting out of one procedure by a physician does not create a parallel disruption to their essential functions as does that of the pharmacist refusing to fill a prescription. This reflects the substantial distinction between the roles of physicians and pharmacists in terms of how invoking a conscience clause impacts their professional scope of practice. There is minimal effect on the entirety of a physician’s scope of practice when they opt out of one procedure. A pharmacist who opts out of dispensing prescription medication is abdicating the essential function of the primary role of their scope of practice.
CHAPTER 4. ORAL CONTRACEPTIVES

Oral contraceptives have been available by prescription within the Untied States for over 48 years. As prescription medication, oral contraceptives are regulated by the U.S. Food and Drug Administration. Suzanne White Junod, Ph.D., a historian for the Food and Drug Administration, notes that while “the first oral contraceptive was submitted first for regulatory approval in 1957 for treatment for menstrual disorders and infertility…it was not until 1960 that the same drug was submitted to FDA for approval specifically as an oral contraceptive.”\(^1\) Although the 1957 approval by the Food and Drug Administration was “specifically limited to the treatment of gynecologic disorders,” Louise Tyrer, M.D., observed that at the time “everyone in the pharmaceutical industry knew that these drugs could be used for contraceptive purposes….”\(^2\) Tyrer reports that there was a “reluctance” to applying for


approval specifically for contraception use based on several factors.\(^3\) These factors were cost, requiring a healthy woman to “take a drug every day for 21 days,” “concerns about religious disapproval,” and “potential side effects, including the long term effect of suppressing ovulation.”\(^4\) Although there were initial negative side effects of oral contraceptive use, changes in the formulation of oral contraceptives have occurred that have resulted in mitigating the negative effects. Speaking to the safety of contraceptives Tyrer states the following:

> In the 40 year history of the pill, both the content and dose of its steroid components have changed significantly….A review of the epidemiology of oral contraceptives and cardiovascular disease has concluded that the fear of cardiovascular disease among current users of today’s pills is unwarranted….Better selection of users coupled with safer formulations have made the “risks” associated with pill use far less than those associated with long term pregnancy…continued evolution of pill content and hormone dose has resulted in a greatly improved and safer contraceptive.\(^5\)

In addition to the current safety of oral contraceptive use, Tyrer notes that there are “a broad range of noncontraceptive health benefits associated with the pill.”\(^6\)

\(^3\) Ibid.

\(^4\) Ibid.

\(^5\) Ibid.

\(^6\) Ibid.
A very broad range of health benefits of oral contraceptive use not related to birth control is outlined as follows:

COCS, [combined oral contraceptives], indisputably have beneficial effects on menorrhagia, dysmenorrhoea, ovulatory pain, acne and hirsutism…they have preventative effects of varying magnitude on salpingitis, endometriosis and myomas. They lower the risk of endometrial, ovarian, and possibly colon cancer. An increase in bone mass is observed when COCs are used during perimenopause. The Pill may reduce the risk of ovarian cysts, rheumatoid arthritis and benign breast disease, and may protect against atherosclerosis.7

One of the noncontraceptive health benefits of oral contraception outlined is its use in the treatment of acne vulgaris. Writing in the Journal of the American Academy of Dermatology, Jason E. Frangos, BA, Christina N. Alavian, MD, and Alexa B. Kimball, MD, MPH, observe that “it has been ten years since…oral contraceptives…first obtained approval by the Food and Drug Administration for the use in the treatment of acne.”8 They also report that “several randomized controlled trials have corroborated their [oral contraceptives] efficiency and safety


for this growing indication in women of child-bearing age.”

Because oral contraceptives “have been shown to be safe and effective for the treatment of acne…” the authors support current revisions to prescribing guidelines that “…have stated clearly that a pelvic exam and Pap smear are no longer required for the initiation of hormonal contraception….” They argue that the “onerous logistical efforts involved in obtaining a preliminary pelvic examination and Papanicolaou (Pap) smear…” have contributed to the reluctance of dermatologists to add oral contraceptives to “their mainstream acne arsenal.”

Essentially they are arguing that an impediment to receiving oral contraceptive treatment for acne should be removed. This is supported by the statement of James J. Leyden that: “The treatment of acne starts with the recognition that it is a disease that can have profoundly adverse psychosocial effects and that therapy is

9 Ibid.
10 Ibid.
11 Ibid.
12 Ibid.
13 Ibid.
warranted.”  

Oral contraceptives are a safe and effective treatment for acne and one can easily perceive that the “profoundly adverse psychosocial” impacts of acne can be exacerbated by the obstacles presented in receiving treatment due to the pelvic exam requirement or the possible refusal of a pharmacist to fill a valid prescription.

In addition to treatment for acne, Annette Fuentes also cites several other benefits not linked to birth control that can be received from taking oral contraceptives. She reports as follows:

The pill lowers the risk of pelvic inflammatory disease…by improving the mucus barrier against bacteria…causes lighter menstrual flow and eliminates irregular bleeding, which can contribute to anemia, another problem for teenagers. Oral contraceptives are also linked to reduced risk of ovarian, endometrial and uterine cancers.  

The case supporting the efficacy of oral contraceptives in preventing ovarian cancer is strong. An editorial in the Lancet summarizes a full report of a study

---


regarding oral contraceptives and prevention of ovarian cancer in the same issue.

The editorial states the following:

   In today’s Lancet, Valerie Beal and colleagues provide a definitive analysis of the association between oral contraceptives and ovarian cancer. Although the findings are not unexpected, this study is impressive and compelling. It pools worldwide data from 45 epidemiological studies and shows beyond doubt that ovarian cancers can be prevented by the long-term use of different generations of oral contraceptives. Moreover, this substantial protection begins quickly, and increases with increasing duration of use.16

A similar review of research reported in Perspectives on Sexual and Reproductive Health asserted that “oral contraceptive use has a well-established association with a reduced incidence of ovarian cancer” and research indicated that “the risk of ovarian cancer was reduced by up to 80% among pill users, depending on the oral contraceptive formula.”17 Treatment of gynecologic disorders, acne and prevention of ovarian cancer are all valid reasons for a physician to prescribe oral contraceptives. In these cases, since the women taking oral contraceptives may


not be sexually active, the question of how oral contraceptives facilitate birth control is moot. In the absence of sexual activity, there is no moral reason to deny these women access to oral contraceptives.

When there is sexual activity, how contraceptives facilitate birth control can be the basis for a moral objection to the use of oral contraceptives. Part of the objection relies on a definition of human life beginning at the time of conception, and granting the conceptus the full moral standing of an individual person. It will be agreed that conception is the beginning of human life, but the moral standing of the conceptus will be examined. First, the physiological function of oral contraceptives in preventing pregnancy will be discussed.

In its pamphlet “What you should know about: The Pill” the U.S. Department of Health and Human Services explains that “the pill works in several ways: It thickens cervical mucus which blocks the sperm; it prevents ovulation; and it prevents implantation.”18 In a much more detailed examination under the title “The Scientific Basis of Contraception” G.I.M. Swyer et al, state as follows:

The primary mechanism whereby oral contraceptives prevent pregnancy is by inhibiting ovulation. Even if ovulation should occur; further actions whereby combined oral contraceptives may prevent pregnancy include effects on the cervical mucus, rendering it hostile to sperm penetration, on tubal transport of spermatozoa and eggs, and on the endometrium, preventing blastocyst survival and implantation.\(^ {19}\)

The impact of the “primary mechanism” of birth control exercised by oral contraceptives prevents ovulation, and in that action the sperm and egg cannot meet and no beginning of human life can be formed. From a scientific standpoint there is no impact on a developing human life because conception has been prevented. Ovulation suppression is also thought to be one of the primary mechanisms that results in the many of the non-contraceptive benefits of oral contraceptives.\(^ {20}\)

If ovulation does occur, the thickening of the cervical mucus can prevent the sperm from penetrating to join with the egg, again preventing the formation of human life. Only if the “primary mechanism” of preventing ovulation has failed


\(^ {20}\) Hugo Maia Jr, Julio Casoy, “Non-contraceptive health benefits of oral contraceptives.”
and the woman has ovulated, and the thickening of the cervical mucus has failed to impede the sperm, could conception occur and the argument be made that the beginning of human life has occurred. At this point oral contraceptives can still be effective in birth control by “preventing blastocyst survival and implantation.”

A scientific description of a pre-implantation blastocyst will be utilized toward a definition of the life that exists at the point impacted by oral contraceptives when implantation is prevented. The following discussion will present an argument that the pre-implantation blastocyst is not an individual person.

Conception marks the beginning of embryonic development. It can be said that oral contraceptives blocking implantation are impacting an embryo; however, using the term embryo without considering the context of the scientific description of embryonic development is misleading as the following illustrates:

…The term embryo is easily misunderstood when taken out of the context of early development. The zygote, the morula, and the blastocyst are the earliest kinds of embryos, and there are nineteen other recognized stages before fetal development begins. Embryologists also call the blastocyst the early or pre-implementation embryo because it has not yet attached to the uterus…. [A]t about six days after fertilization, the dividing embryo confronts a crucial step in its development. It must now

21 Ibid.
implant in the uterus…. If the hormonal cues of the mother aren’t suitable, the embryo won’t attach to the uterine wall. Up to half never implant and die at this stage.  

What is the status of a blastocyst in terms of being accorded the rights of an individual in its pre-implantation state? From a scientific standpoint it is illogical to grant the blastocyst the status of an individual. In the sequence of embryonic development, the blastocyst is from four to six days old, has yet to begin cell differentiation, and is in the pre-implementation stage.  

A significant feature of the cells of the blastocyst is that they are “totipotent,” as the following explains:

That is, each blastomere is undifferentiated and remains capable, if properly manipulated, of developing into a full human being…. In nature, embryo splitting happens spontaneously in from two to five out of every 1000 human births. The result is identical (monozygotic) twins, triplets, or higher order multiples…. If biological humanness starts with the appearance of a unique diploid genome, twins and triplets are living evidence that the early embryo is not yet one human being, but a community of possibly different individuals…. during the first two postovulatory weeks “the production of a single individual versus multiple individuals is not yet irrevocable….A genetically unique but non-individuated embryo has yet to acquire determinate individuality, a stable human identity.”…. In nature, this possibility definitively comes to an end only at about fourteen days of development…. Only at this

---


23 Ibid.
point do all the cells of the embryonic disk lose their totipotency and become committed to specialized fates.\textsuperscript{24} 

Until implantation and differentiation occur, it would be accurate to say that the blastocyst has the potential to become one or two or even ten individuals. Should moral standing be attributed to a blastocyst as an individual or should we “think of the early embryo’s multiple totipotent cells as a community of many human individuals that somehow, in most (but not all) cases, eventually become one person?”\textsuperscript{25} Until implantation and the cell differentiation that leads to the development of an individual occurs, it is not scientifically logical to view the status of the blastocyst as an individual. Although oral contraceptives may prevent implantation which ends the beginning of human life, there is no impact on an individual human life. In the pre-implantation blastocyst, the individual, or in the case of twins, individuals, has yet to be formed. To accord the pre-implantation blastocyst the status of an individual human being is a moral judgment, not a scientific judgment.


\textsuperscript{25} Ibid.
In deciding *Roe v Wade*, the Supreme Court defined the point when the “unborn” obtain rights. Excerpts from that decision illustrate that definition as follows:

…the word "person," as used in the Fourteenth Amendment, does not include the unborn….In areas other than criminal abortion, the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense…. With respect to the State’s important and legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications.26

“Viability” of the fetus was determined to be the point where the State had a compelling interest in protecting the life of a fetus. In the context of this judicial ruling it is clear that a pre-implantation blastocyst would not be considered a “person in the whole sense,” with the same status as an individual human being.

---

Oral contraceptives have many uses independent of birth control and in those cases where the recipient is not sexually active, there are no moral grounds to object to their use. In cases where the use of oral contraceptives is intended to promote birth control, if the objection to their use is based on the impact on the beginning of human life, that objection carries weight only if the primary function of oral contraceptives, (suppression of ovulation and creating a barrier to sperm), has failed. Then, the moral objection hinges on granting the pre-implantation blastocyst the status of an individual human being. There is compelling scientific data regarding the definition of the pre-implantation blastocyst that refutes defining it as an individual. The U.S. Supreme Court has established a definition of moral standing for a fetus that precludes that status for a pre-implantation blastocyst. Without implantation the blastocyst cannot become “viable.” (The Supreme Court has also established the rights of individuals to have access to contraceptives, ruling first in favor of married couples in *Griswold v. Connecticut*, 381 U. S. 498, and for unmarried women in *Eisenstadt v. Baird*, 405 U.S. 438.)
CHAPTER 5. THE CASE OF PHARMACIST NEIL NOESEN

In 2002 a college student, Amanda Renz, entered a Kmart Pharmacy in Wisconsin to obtain a refill of her birth control tablets. The pharmacist on duty, Neil Noesen, upon determining that her reasons for using the medication were for contraceptive purposes, refused to dispense the refill, and he would not transfer the prescription to another pharmacy.¹ Nate Anderson, writing in Christianity Today noted as follows:

Noesen, a devout Catholic, had always refused to dispense birth control. For six years previous, he had been willing to refer patients seeking contraception to another pharmacist, but on a recent trip to Calcutta---where he realized anew that health care is about helping suffering---had convinced him that this was wrong. “Finally, my conscience caught up to me,” Noesen told CT. “I couldn’t do it anymore. I felt like I was being used by the system, that I was becoming part of the problem rather than part of the solution.”²


² Ibid.
This action generated a case against Mr. Noesen before the Wisconsin Department of Regulation and Licensing. His attorney characterized his refusal as a religious liberty issue and defended Noesen’s actions stating “My client was not judging the patient. He was judging his own heart. He sincerely believes he would be committing an act of sin to dispense [birth control], and to call someone else to dispense it.” The defense of Noeson was not persuasive.

An administrative law judge recommended that the State reprimand Noesen and that his license be subject to certain conditions. Noesen appealed the reprimand and a decision on his appeal was handed down by the Wisconsin Court of Appeals, District Three, on March 25, 2008. According to the court’s written decision, Noesen had put his employer on notice that he would exercise

---


his right to refuse to fill prescriptions based on his conscience. He had informed his employer that he wished to “exercise my right not to participate in certain tasks, including dispensing birth control pills for contraceptive purposes.”

Noesen had also proposed a protocol to exercise his conscientious objection which stated in part the following:

Before starting work each day, I will make my conscientious objection clearly known to the rest of the pharmacy staff. I will describe that I have a conscientious objection about participating in the provision of contraceptives to patients, receiving phone calls pertaining to contracepting, or the provision of information to patients directly related to contracepting....When confronted with an objectionable situation, which most likely would be a refill or new prescription for an oral contraceptive, I understand the necessity of responding in a professional manner with the patient(s), medical staff, and pharmacy staff. I will immediately notify the patient of my conscientious objection and offer to call the prescriber or give the original prescription to the patient if it has not yet been filled.

Noesen’s employer had agreed to his conscientious objection and would allow other pharmacists on duty to fill the prescriptions he objected to, and if no other pharmacist was available, a supervising pharmacist had committed to come into the store and fill the prescription. The day in question, none of these

---

6 Ibid.

7 Ibid.
safeguards were available. The appeals court upheld Noesen’s reprimand determining that although Noesen had a right to exercise his conscience he must do so in a manner that does not violate professional standards or potentially impact the patient in a negative way. The ruling states in part as follows:

In short, Noesen abandoned even the steps necessary to perform in a "minimally competent" manner under any standard of care. He prevented all efforts Renz made to obtain her medication elsewhere when he refused to complete the transfer and gave her no options for obtaining her legally prescribed medication elsewhere. The Board could therefore properly conclude he violated a standard of care applicable to pharmacists: it does not matter which standard, because Noesen's behavior "substantially departs" from all of them…. The pharmacist failed to fulfill his portion of the compelling state interest/least restrictive alternative test for finding a violation of his right of conscience.\(^8\)

The court accepted the concept that the pharmacist could exercise a refusal clause but must not “step in the way” of the patient wishing to obtain medication, and found that Noesen did not meet that “standard of care.” Addressing patient autonomy the court noted that: “The pharmacist’s standard of care also protects patients’ autonomy and liberty interests in controlling health-care decision

\(^8\) Ibid.
making. The duty to respect patient autonomy is a fundamental ethical principle in the health professions.”9

The court also noted that: “Licensing statutes are enacted not for the benefit of the individuals licensed, but for the benefit and protection of the public.”10 The ruling discussed the following “test” for the court to apply in these matters:

When an individual makes a claim that state law violates his or her freedom of conscience, a court applies the compelling state interest/least restrictive alternative test. Under this test, the challenger must prove (1) that he or she has a sincerely held religious belief, (2) that is burdened by application of the state law at issue. Upon such a showing, the burden shifts to the state to prove (3) that the law is based in a compelling state interest, (4) which cannot be served by a less restrictive alternative. This test is strictly applied; the burden cannot be generic but must be related to the exercise of a religious belief. However, the United States Supreme Court has 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.11

9 Ibid.

10 Ibid.

11 Ibid.
The court also addressed a fundamental conflict that is part of conscientious refusal that occurs in this instance: the gender discrimination that occurs when women are denied access to contraception. Arguing that an appropriate “standard of care” must assure access to contraceptives the court supported disciplining Noesen and stated the following:

Holding Noesen accountable for his unprofessional conduct furthers the state’s interest in remedying gender discrimination in the pharmacy. Noesen refuses to participate in the provision of contraception, medication used exclusively by women to prevent pregnancy, a condition that affects only women’s health. A standard of care that ensures that women are able to obtain contraceptives in the face of a religious refusal promotes equality for women. Access to contraceptives gives women control of their fertility, enabling them to decide whether and when to become a parent. Contraception allows women to make educational and employment choices that will benefit themselves and their families.12

In its concluding remarks, the court spoke to the core issue of what occurred when Noesen both refused to fill a prescription for contraception and also took steps to prevent the prescription from being filled in stating the following:

12 Ibid.
Noesen does not seek a reasonable accommodation of his religious beliefs. He seeks to impose his own theological principles by preventing access to legal medications. The Wisconsin Constitution does not demand such subordination of the public good to Noesen’s conscience.\(^{13}\)

Referring to the “public good” is again an example of the court asserting that the licensing by the State of a professional is not for the “benefit of the individuals licensed, but for the benefit and protection of the public.” The case of Neil Noesen is an example of an individual wanting licensing standards to conform to their personal moral beliefs, so their chosen profession is not in conflict with their morals. The court accepts a conscience clause up to the point where the public good is subordinated to someone’s personal conscience. Personal conscience should not, in the professional role of a pharmacist, place a burden on a client that prevents access to legal prescriptions. That violates the basic standard of care that can be expected of a professionally licensed pharmacist. Writing in the Philadelphia Inquirer, Jane Eisner speaks to the issues involved and the potential dangers of legalizing through legislation conscience clauses as follows:

Noesen has become a household name among those debating “conscience clauses”-that is, whether professionals can refuse to perform certain services because they violate personal

\(^{13}\) Ibid.
beliefs….Such acting on a personal belief, whether religious or not, cannot be allowed to interfere with the duties of the professional and the obligations of citizenship. What is civilized life, anyhow, but a collection of compromises we make to live peaceably with one another? If the compromises are too onerous, there is always the option to opt out entirely. No one is forcing Neil Noesen or anyone else to fill prescriptions, but if he chooses to be a pharmacist-with all the protection a government license bestows-then fill prescriptions he must….The conscience clauses now being legislated do more than allow someone to forgo professional or communal obligations by following the dictates of their conscience. They allow someone to forgo those obligations with impunity. Lawmakers should think hard before they permit some people to put rights before responsibilities under the guise of faith.14

The case of Neil Noesen also presents the opportunity to focus more narrowly on the personal “beliefs” that can motivate a decision to evoke a conscience clause. Christianity Today reported an epiphany experienced by Noesen after a trip to Calcutta, when “he realized anew that health care is about helping suffering.”15 Noesen then acted on his belief that he “was becoming part of the problem,”16 and for him, these beliefs motivated his actions to prevent a


15 Nate Anderson, “Pharmacists with No Plan B.”

16 Ibid.
patient from obtaining oral contraceptives. How Noesen linked opposition to the use of oral contraceptives and a belief that “health care is about helping suffering,” is not made clear. Noesen’s Roman Catholic faith opposes any artificial barrier to procreation; however, to forge a link with “suffering” it would be necessary to believe that if ovulation is prevented by oral contraceptives, somehow someone physically suffers. If a physician has determined that a woman’s health will be dangerously impacted by another pregnancy, his prescription for oral contraceptives is intended to prevent the potential suffering and hazards of an unsafe pregnancy. This requires Noesen to structure his belief system to define the physiological mechanisms of oral contraceptives as suffering, and then assert that the suffering caused by oral contraceptives is of greater importance to prevent, regardless of any suffering that may result from an un-safe pregnancy that can be prevented by the use of oral contraceptives. The argument could be made that if the primary and secondary mechanisms of oral contraceptives failed in preventing conception and fertilization occurred, then a blastocyst may have been prevented from being implanted. In that case the beginning of human life has ended and the blastocyst to the extent it can, has suffered. Noesen is imposing both his own theological principles and his own
scientific/medical principles to justify preventing access to legal prescription medication.

Noesen is also imposing a burden on the woman seeking oral contraceptives without any apparent willingness on his part to share in that burden. The inconvenience of waiting for another pharmacist to fill the prescription or going to another pharmacy is borne exclusively by the woman seeking oral contraceptives. If an unwanted pregnancy occurs due to failure to obtain oral contraceptives based on actions by Noesen, he accepts no responsibility for the subsequent suffering or expense of the mother in surviving the pregnancy or raising the child. Noesen is acting with impunity in his role as a licensed pharmacist to serve only the self-interest of his own belief system. He acts without regard for the consequences upon the women his refusal impacts. In Noesen’s act of relieving his own personal burden of conscience he is allowed to be free from sharing in, or taking responsibility for, the burdens he creates on others. At the very least, imposing these burdens on the patient violates concepts of fairness and potentially constitutes an abuse of the power given to a licensed pharmacist. If the pharmacist chooses to impose these burdens, he should have a moral obligation to share in the responsibility for them.
CHAPTER 6. RELIGIOUS TRADITIONS REGARDING ORAL CONTRACEPTIVES

In his July 25, 1968 encyclical letter, Humanae Vitae, Pope Paul VI clearly prohibits the use of oral contraceptives. Under the heading “Unlawful Birth Control Methods” Pope Paul VI states as follows:

Therefore We base Our words on the first principles of a human and Christian doctrine of marriage when We are obliged once more to declare that the direct interruption of the generative process already begun and, above all, all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children….Similarly excluded is any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation—whether as an end or as a means.¹

Pope Paul VI makes a distinction between the Church’s teaching on “natural” birth control to regulate birth and contraceptives to explain why the former method is acceptable and the latter is not acceptable when he states the following:

Neither the Church nor her doctrine is inconsistent when she considers it lawful for married people to take advantage of the

infertile period but condemns as always unlawful the use of means which directly prevent conception, even when the reasons given for the later practice may appear to be upright and serious. In reality, these two cases are completely different. In the former the married couple rightly use a faculty provided them by nature. In the later they obstruct the natural development of the generative process.\(^2\)

The reference to reasons “upright and serious,” appears to be a prelude to an argument that there is no situation that can justify using oral contraceptives. Pope Paul VI goes on to assert the following:

Neither is it valid to argue, as a justification for sexual intercourse which is deliberately contraceptive, that a lesser evil is to be preferred to a greater one, or that such intercourse would merge with procreative acts of past and future to form a single entity, and so be qualified by exactly the same moral goodness as these. Though it is true that sometimes it is lawful to tolerate a lesser moral evil in order to avoid a greater evil or in order to promote a greater good, it is never lawful, even for the gravest reasons, to do evil that good may come of it—in other words, to intend directly something which of its very nature contradicts the moral order, and which must therefore be judged unworthy of man, even though the intention is to protect or promote the welfare of an individual, of a family or of society in general.\(^3\)

\(^2\) Ibid.

\(^3\) Ibid.
Clearly the Pope is stating that oral contraception in the context of sexual activity is never justified to prevent a “greater evil,” which can be presumed to be a pregnancy that would seriously impact the health of the woman, “the welfare of an individual.” This does not address the use of oral contraceptives by women who are not sexually active but wish to, for example, mitigate their risk of ovarian cancer or take treatment for acne vulgaris. Pope Paul VI concludes this section of the Encyclical with the statement: “Consequently, it is a serious error to think that a whole married life of otherwise normal relations can justify sexual intercourse which is deliberately contraceptive and so intrinsically wrong.”^4 The Pope has made clear a prohibition against oral contraceptives within marriage and it is clear that those claiming the Roman Catholic faith are bound to the Pope’s direction. In his encyclical letter, Pope Paul VI goes on to admonish public authorities, scientists and doctors and nurses. Writing to public authorities he states as follows:

And now We wish to speak to rulers of nations. To you most of all is committed the responsibility of safeguarding the common good. You can contribute so much to the preservation of morals. We beg of you, never allow the morals of your peoples to be undermined.

^4 Ibid.
The family is the primary unit in the state; do not tolerate any legislation which would introduce into the family those practices which are opposed to the natural law of God. For there are other ways by which a government can and should solve the population problem—that is to say by enacting laws which will assist families and by educating the people wisely so that the moral law and the freedom of the citizens are both safeguarded.  

The admonition, “do not tolerate any legislation which would introduce into the family those practices which are opposed to the natural law of God.” could be construed as a mandate to oppose any legislation that permits access to oral contraceptives. So interpreted, this is the strongest action statement proposed by the Pope as a directive to take action against general use of oral contraceptives.

Writing to scientists the Pope essentially asks that they strive to educate and prove scientifically the Church’s position. He states as follows:

Our next appeal is to men of science. These can considerably advance the welfare of marriage and the family and also peace of conscience, if by pooling their efforts they strive to elucidate more thoroughly the conditions favorable to a proper regulation of births...[M]edical science should by the study of natural rhythms succeed in determining a sufficiently secure basis for the chaste limitation of offspring. In this way scientists, especially those who are Catholics will by their research establish the truth of the

---

5 Ibid.
Church's claim that there can be no contradiction between two divine laws—that which governs the transmitting of life and that which governs the fostering of married love.\(^6\)

The Pope also admonishes doctors and nurses. The statement of Pope Paul VI to doctors and nurses is as follows:

Likewise we hold in the highest esteem those doctors and members of the nursing profession who, in the exercise of their calling, endeavor to fulfill the demands of their Christian vocation before any merely human interest. Let them therefore continue constant in their resolution always to support those lines of action which accord with faith and with right reason. And let them strive to win agreement and support for these policies among their professional colleagues. Moreover, they should regard it as an essential part of their skill to make themselves fully proficient in this difficult field of medical knowledge. For then, when married couples ask for their advice, they may be in a position to give them right counsel and to point them in the proper direction. Married couples have a right to expect this much from them.\(^7\)

The statement emphasizes that they should fulfill their “Christian vocation.” The statement that doctors and nurses must “support those lines of action which accord with faith and with right reason,” can be interpreted as a directive to

\(^6\) Ibid.

\(^7\) Ibid.
oppose oral contraceptives as a means of birth control. The Pope also references the ability to give “right counsel,” but there is no statement that would support preventing access to oral contraceptives for non contraceptive uses.

Expanding on how the teachings of the Roman Catholic Church impact bioethics, Christopher Tollefsen and Joseph Boyle state as follows:

Professions and groups of people with special competence are organized to serve the common good, but this does not imply that professionals are to be available simply to satisfy the desires of others….In addition to the requirements of their own professional integrity; professionals are, like everybody else, bound by general moral norms. The implication is that health care professionals are to assist those in need of health care in accord with their own legitimate professional standards and must not do anything they regard as morally wrong. However, Catholic teaching rejects the appeal to considerations such as these to justify what is often called medical paternalism….This element of Catholic bioethical teaching may appear to provide an endorsement from a surprising corner: the modern exaltation of patient autonomy. But this is no all-purpose endorsement of autonomy. Rather, it is an indication of who should make the final decision about whether a given treatment is to be provided. The teaching does not require health care professionals to provide services they think are wrong…nor does it imply that patient…refusal is morally correct, but only that they make the final decision.  

---

Based on this interpretation of the Catholic teachings, Noesen was within his rights to refuse to provide services that he thought were wrong. However, in refusing to forward the prescription for oral contraceptives to another pharmacy, he prevented the patient from making the “final decision,” which is not in accord with the Catholic principles of bioethics described by Tollefsen and Bryce. The authors also point out that the Church’s opposition to contraceptives goes beyond simply “the prohibition of killing the innocent.”\textsuperscript{9} The Church views the choice of using contraceptives as “being contrary to the good life,” and as violating the “mutual self-giving,” that is the center of the “unitive” function of the “conjugal act.”\textsuperscript{10} These arguments speak to the nature of marriage as defined by Catholic Church as grounds for the opposition to contraceptives.

Many other viewpoints regarding oral contraceptives exist, even in faiths closely aligned to the Roman Catholic faith. Writing in the Encyclopedia of Women and World Religion, Kathleen O’Grady states as follows:

\begin{flushleft}
\textsuperscript{9} Ibid. \\
\textsuperscript{10} Ibid. 
\end{flushleft}
Unlike the Catholic tradition, the Eastern Orthodox Church does not discern a moral difference between artificial or natural birth control methods. They note that many Church Fathers, as well and the Pauline texts in the New Testament, do not strictly limit sexual intercourse to procreation; the Orthodox position is that sexual intercourse also constitutes an expression of love within the marriage contract. No official statement has been made on prohibitions for artificial contraceptives, while abortion, infanticide and permanent sterilization have been condemned. The Orthodox Church allows a married couple to make their own decisions on contraceptive use.\textsuperscript{11}

O’Grady reports that prior to the 1930s “all Christian denominations were united in their firm rejection of contraceptives.”\textsuperscript{12} The Church of England was the first to depart from this unanimous rejection of contraceptives. The 1930 Lambeth Conference advocated “the use of artificial contraception when abstinence was deemed impracticable.”\textsuperscript{13} Following the action by the Church of England O’Grady comments as follows:

The Federal Council of Churches (1931) equally adopted a policy of conservative advocation for artificial birth control methods. Most major Protestant traditions followed suit, and by 1961, the

\textsuperscript{11} Kathleen O’Grady, “Contraception and Religion, A Short History,” The Encyclopedia of Women and World Religion, Serinity Young et al. (eds), Macmillan 1999.

\textsuperscript{12} Ibid.

\textsuperscript{13} Ibid.
National Council of Churches declared a liberal policy on contraceptive use, subject to mutual consent between couples.\textsuperscript{14}

Within the various sects of the Jewish and Islamic faiths O’Grady reports that different views are held both supporting and opposing the use of contraceptives.\textsuperscript{15}

In their article, Religious and Cultural Influences on Contraception, Amirrtha Srikanthan and Robert L. Reid, MD, confirm the positions regarding use of contraception as reported by O’Grady and quoted above. Srikanthan and Reid also report that the Hindu faith in general does not prohibit the use of contraceptives and “regards the decision to use contraception as personal matter for women that is not usually within the scope of religious injunction.”\textsuperscript{16} They also cite Buddhism, Confucianism and Taoism as finding the use of

\textsuperscript{14} Ibid.

\textsuperscript{15} Ibid.

contraceptives acceptable.\textsuperscript{17} In their discussion of religious attitudes toward contraception Srikanthan and Reid note as follows:

Despite the importance of religion in influencing decisions, practitioners of a faith do not necessarily adhere to the prescribed doctrines of their faith. Ninety-five percent of women in North America will use a contraceptive method at some point during their reproductive years, despite the prohibition of modern contraception by some religions.\textsuperscript{18}

Speaking specifically regarding the use of contraceptives by Roman Catholic women, Jenifer Ohlendorf, M.S., R.N., and Richard J. Fehring, Ph.D., R.N., report that 19.6\% of those women utilized oral contraceptives.\textsuperscript{19} They also list other contraceptive methods used by Roman Catholics including female sterilization (13.9\%), male sterilization (3.6\%), and condoms (11.7\%).\textsuperscript{20} The authors speculate that the use of contraceptives in these instances may be a result

\textsuperscript{17} Ibid.

\textsuperscript{18} Ibid.


\textsuperscript{20} Ibid.
of a lack of understanding of Roman Catholic teachings on “family planning and sexual ethics.”  

They also suggest the following:

...although RC [Roman Catholic], couples know the Church’s teachings on contraception and sterilization, they view themselves as “autonomous adults,” and downplay or ignore the role of he Church’s official teachings in forming their consciences on the issue of family planning.

In concluding comments Ohlendorf and Fehring state: “Perhaps the most important finding from this analysis of this large data set is that there is a mixed influence of religion on woman’s contraceptive practices.”

---

21 Ibid.
22 Ibid.
23 Ibid.
CHAPTER 7. LEGISLATION IMPACTING CONSCIENCE CLAUSES

Given that acting professionally as a pharmacist, or operating a pharmacy, requires a license issued by the state, should the states allow those license holders to operate in a way that is dictated by their personal beliefs and in opposition to the scope of their license? Such practices have the potential of creating conflicts between patient and provider. Across the nation, legislation has been enacted to address the conflict between patient and provider’s rights when the provider wishes to evoke a conscience clause and opt out of providing services. According to the National Conference of State Legislators, Arkansas, Georgia, Mississippi, and South Dakota have passed laws allowing a pharmacist to refuse to dispense emergency contraception drugs.1 The National Conference of State Legislators also reports that Colorado, Florida, Maine, and Tennessee are reported to have broad refusal clauses that do not specifically mention pharmacists. California law states that pharmacists have a duty to dispense prescriptions and can only refuse

to dispense a prescription, including contraceptives, when their employer approves the refusal and the woman can still access her prescription in a timely manner. California also requires the State Board of Pharmacy to create and provide a sign informing a patient of his or her right to timely access to a prescribed drug or device that a licensed pharmacist has refused to dispense based on ethical, moral, or religious grounds. Pharmacists authorized to make such a refusal, or their employers, must post the sign visibly at or near the entrance of the business. In contrast, a New Jersey law, which became effective November 2007, prohibits pharmacists from refusing to fill prescriptions solely on moral, religious, or ethical grounds. In Arizona, a bill which would permit “a pharmacy to refuse to provide drugs or devices that are prescribed to accomplish an abortion or emergency contraception if the pharmacy objects in writing on moral or religious grounds” passed both state legislative houses but was vetoed by the governor on April 13, 2005. In her veto message, Arizona Governor Janet

---

2 Ibid.

3 Ibid.

Napolitano stated that “providers have no right to interfere in lawful decisions made by patients and their doctors….” Governor Napolitano’s veto message and the New Jersey law are emphatic in requiring pharmacists to dispense prescription medications and they resolve the conflict strictly in favor of patient rights. The California law strikes a balance between provider and patient rights, protecting the pharmacist’s right to make decisions based on their conscience, but at the same time assuring that the patient will receive their medications, and making sure that the patient is advised of their rights.

In Illinois, Governor Rod R. Blagojevich resolved the issue in favor of patient’s rights. On April 1, 2005, the Governor issued an emergency rule that “clearly defines the responsibilities of licensed retail pharmacies in Illinois to fill all FDA approved birth control prescriptions….“ The formal text of the emergency rule is very clear in directing a pharmacy to provide the contraceptives, including ordering them if necessary or transferring the

5 Ibid.

prescription to another pharmacy. It is also clear that the rule applies directly to a “pharmacy,” not a pharmacist, thereby shifting the burden of seeing that the prescription for contraceptives is filled to the business entity rather than the individual pharmacist. The rule also clarifies how it affects the traditional scope of practice of a pharmacist when it states that:

Nothing in this subsection…shall interfere with a pharmacist’s screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions…drug-food interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, or clinical abuse or misuse….  

On August 16, 2005, the Governor’s office announced that a legislative committee sanctioned with the authority to make emergency rules permanent, “voted to make permanent Governor Rod R. Blagojevich’s emergency rule that ensures pharmacies in Illinois fill women’s prescriptions without delay or hassle.” In response to the committee’s action the Governor stated as follows:

7 Ibid.

8 Ibid.

9 Ibid.
Women can feel confident from here on out, that when they have a signed prescription from their doctor for birth control and go to a pharmacy that sells birth control—they’ll get their medication quickly without questions or lectures. When we began this battle, we said that filling prescriptions for birth control is about protecting a woman’s right to have access to medicine her doctor says she needs. Nothing more. Nothing less.\textsuperscript{10}

The Governor’s statement treats the patient’s rights issue as essentially a civil rights issue; it is within a woman’s civil rights to have access to legally prescribed medications.

The law enacted by California is an example of granting the right of conscience refusal to pharmacists while at the same time protecting the rights of patients to have access to legal prescriptions. Arizona Governor Janet Napolitano’s position denies pharmacists the option to exercise their personal beliefs by refusing to fill a prescription. Illinois Governor Rod R. Blagojevich makes clear he sees this issue as one of women’s rights. With regard to provider’s rights and patient’s rights, the positions above provide examples of both accommodation and prohibition. However, this begs the question posed regarding the appropriateness of the states addressing conscience clauses through

\textsuperscript{10} Ibid.
legislation. Stated another way, other than defining the scope, role, and duties of
a license holder of a state issued license, should the state legislate
accommodations empowering license holders to define for themselves how they
will fulfill the duties of that license? Focusing on the case of Neil Noesen, should
an accommodation be legislated in a secular society that reveres separation of
church and state to accommodate a pharmacist’s Roman Catholic faith? In 1984
Mario Cuomo, then Governor of New York, discussed similar issues in the
context of his Roman Catholic faith and role as a member of state government in
a lecture delivered at the University of Notre Dame. Governor Cuomo stated in
part the following:

I protect my right to be a Catholic by preserving your right to
believe as a Jew, a Protestant or non-believer, or as anything you
choose. We know that the price of seeking to force our beliefs on
others is that they might some day force theirs on us….When
should I argue to make my religious values your morality? My rule
of conduct your limitation? ...I believe I have a salvific mission as
a Catholic. Does that mean I am in conscience required to do
everything I can as a Governor to translate all my religious values
to the laws and regulations of the State of New York or the United
States? ...Must I, having heard the Pope renew the Church’s ban on
birth control devices, veto the funding of contraceptive programs
for non-Catholics or dissenting Catholics in my State? I accept the
Church’s teaching on abortion. Must I insist that you do? By law?
By denying you Medicaid funding? …These are only some of the
questions for Catholics. People with other religious beliefs face
similar problems….Almost all Americans accept some religious
values as a part of our public life….Our public morality, then—the
moral standards we maintain for everyone, not just the ones we insist on in our private lives—depends on a consensus view of right and wrong. The values derived from religious belief will not—and should not—be accepted as part of the public morality unless they are shared by the pluralistic community at large, by consensus….The arguments start when religious values are used to support positions which would impose on other people restrictions they find unacceptable….I think it’s already apparent that a good part of this Nation understands—if only instinctively—that anything which seems to suggest that God favors a political party or the establishment of a state church, is wrong and dangerous….I should start, I believe, by noting that the Catholic Church’s actions with respect to the interplay of religious values and public policy make clear that there is no inflexible moral principle which determines what our political conduct should be. For example, on divorce and birth control, without changing its moral teaching, the Church abides the civil law as it now stands, thereby accepting—without making much of a point of it—that in our pluralistic society we are not required to insist that all our religious values be the law of the land….We must keep in mind that we are a nation of laws—when we like those laws and when we don’t.\(^{11}\)

Have the states, in enacting conscience clauses, placed upon women seeking oral contraceptives “restrictions they [women] find unacceptable?” Have the states, in enacting conscience clauses, allowed religious values to determine state laws and regulations? Can these religious values meet the standard proposed by

Governor Cuomo for public morality of being based on a “consensus view of right and wrong?” The California legislation protects both the pharmacist and the patient, so one individual’s beliefs are not forced on the other and no unacceptable restrictions are placed on the patient. The California statute balances religious values and public policy making “clear that there is no inflexible moral principle which determines what our political conduct should be.” The balance achieved by California’s statute is in keeping with an admonition of Pope John Paul II from a letter to the XXVI World Day of Peace as follows:

Today the many peoples who make up the one human family are increasingly concerned that freedom of conscience, which is essential for the freedom of every human being, be recognized in practice and safeguarded by law….It is essential that the right to express one’s own religious convictions publicly and in all domains of civil life be ensured…. This year I wish to consider specifically the importance of respect for the conscience of every person, as a necessary basis for peace in the world….No human authority has the right to interfere with a person's conscience….This in turn necessarily requires that each individual’s conscience be respected by everyone else; people must not attempt to impose their own “truth” on others….To deny an individual complete freedom of conscience…or attempt to impose a particular way of seeing the truth, constitutes a violation of that individual’s most personal rights….It should be noted that freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection.

12 Ibid.  
13 Ibid.
When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.\footnote{John Paul II, Message of His Holiness Pope John Paul II for the XXIV World Day of Peace: “If You Want Peace, Respect The Conscience OF Every Person,” \url{http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_08121990_xxiv-world-day-for-peace_en.html}, accessed 11/8/2008.}

If the state legislatures decide to enact statues that allow license holders to operate in a way that is dictated by their personal beliefs and in opposition to the scope of their license, which in effect is protecting the rights of the provider to act professionally based on their conscience, the patient’s rights to access legal prescription medication must be equally protected. Without this balance, the states are protecting the rights of one group at the expense of another, and specifically in the case of oral contraceptives, as Governor Blagojevich observed, infringing on the rights of women to “have access to medicine her doctor says she needs.”\footnote{“State Commission Gives Permanent Approval to Gov. Blagojevich’s Emergency Rule Protecting Illinois Women’s Right to Birth Control,” Office of the Governor: News; Rod R. Blagojevich Governor, \url{http://www.idfpr.com/NEWSRLS/081605JCARContraceptivePermRule.pdf}, accessed October 31, 2008.} The legislative response to conscience clauses for pharmacists ranges from prohibiting to enabling them. Although some legislation mandates
protection for the patient to ensure access to prescription medications, some does not. Viewed as a basic civil rights issue, it is incumbent on state legislatures to respect the rights of all. The varied nature of current legislation indicates that this is not an issue that engenders moral certitude in crafting legislative responses.
CHAPTER 8. DUTY BASED ETHICS

In applying to conscience clauses the moral theory of duty based ethics, or ethical formalism, as proposed by Immanuel Kant, three of his key concepts will be examined: the individual as an autonomous moral agent; the categorical imperative; and the “formula of the end in itself,” Kant’s prohibition against using an individual as a means to an end.

Immanuel Kant, in the “Grounding for the Metaphysics of Morals,” states that “…autonomy is the ground of the dignity of human nature and of every rational nature.”\(^1\) Within that “dignity of human nature,” Kant argues that “…freedom belongs universally to the activity of rational beings endowed with a free will.”\(^2\) The autonomy of free will is essential to Kant’s moral theory. Kant states: “Autonomy of the will is the property that the will has of being a law to itself.…”\(^3\) It the individuals inherent autonomy of will that makes them a self-


\(^2\) Ibid.

\(^3\) Ibid.
legislating moral agent in Kant’s theory. Edmund D. Pellegrino, M.D., referencing both Kant and John Stuart Mill explains why this autonomy should not be restricted stating the following:

Morally, autonomy encompasses the right of persons to freedom of conscience and to respect as agents capable of making their own judgments in accord with freely arrived at decisions…Autonomy gets its status as a moral right of humans from the fact that human beings have the capacity to make rational judgments about their own lives, choices and interests. Self-governance deserves respect because it is the way human beings actualize their powers of choice, and choice is a distinctly human activity. To obstruct the capacity for autonomy is to assault an essential part of a person’s humanity, because the choices we make are so much an expression of our membership in the human community, of who we are or what we want to be as individual members of that community. Human beings are owed respect for their autonomy because they have an inherent dignity.4

Catholic teachings generally support Kant’s concepts of human dignity and self-governance. In Catholic teaching, the dignity is a gift from God, and proper moral choices should conform to the Church’s teaching of God’s truth. The following passage describes a person as having dignity and the autonomy of free

will from the perspective of Catholic teaching. William E. May states in his book titled Catholic Bioethics and the Gift of Human Life the following:

The first dignity proper to human beings is the dignity that is theirs simply as living members of the human species…endowed with the capacity to know the truth and the capacity to determine our lives by freely choosing to conform our lives and actions to the truth….The second kind of dignity is the dignity to which we are called as intelligent and free persons capable of determining our own lives by our own free choices.⁵

John Stuart Mill also championed personal autonomy in his writing “On Liberty.” In that writing Mill’s context is in regard to society not having the right to have the power to impose upon an individual for their “own good, either physical or moral.”⁶ However, he certainly speaks to the autonomy of free will when he states: “In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.”⁷


⁷ Ibid.
It is from the autonomy of free will that Kant derives the categorical imperative, the rational actions of a self-legislating moral agent. Kant states as follows:

Reason, therefore, relates every maxim of the will as legislating universal laws to every other will and also to every action toward oneself; it does so not on account of any other practical motive or future advantage but rather from the idea of the dignity of a rational being who obeys no law except what at the same time he enacts himself.  

Onora O’Neill summarizes the concept of the categorical imperative as follows:

…what maxims or fundamental principles could be adopted by a plurality of agents….Principles that cannot serve for a plurality of agents are to be rejected: the thought is that nothing could be a moral principle which cannot be a principle for all. Morality begins with the rejection of non-universalizable principles. This idea is formulated as a demand, which Kant calls “the Categorical Imperative”….Act only on the maxim through which you can at the same time will that it be a universal law.

Another way to state this is to assert that what is applicable as a moral choice for one, must be applicable to all, by virtue of each independent moral agent reaching

---

8 Immanuel Kant, “Grounding for the Metaphysics of Morals”

the same rational decision to self-legislate their will to conform to the same moral choice. According to Kant, principles that have moral validity must be universal for all moral agents.

It is the ability to act as autonomous rational beings from which Kant derives his assertion that the free will of man must be an end to itself. Kant states as follows:

Now I say that man, and in general every rational being, exists as an end in himself and not merely as a means to be arbitrarily used by this or that will. He must in all his actions, whether directed to himself or to other rational beings, always be regarded at the same time as an end….This principle of humanity and of every rational nature generally as an end in itself is the supreme limiting condition of every man’s freedom of action….For all rational beings stand under the law that each of them should treat himself and all others never merely as means but always at the same time as an end in himself. Hereby arises a systematic union of rational beings through common objective laws, i.e., a kingdom that may be called a kingdom of ends….A rational being belongs to the kingdom of ends as a member when he legislates in it universal laws while also being himself subject to these laws. He belongs to it as a sovereign, when as legislator he is himself subject to the will of no other.10

Kant’s definition of an individual as an end in himself requires respect for a person’s autonomy and mandates that individuals not be used by others as a

10 Immanuel Kant, “Grounding for the Metaphysics of Morals.”
means to an end. The following is drawn from O’Neill’s summary of this concept:

[the] “Formula of the End in Itself,” which demands that we treat “humanity in your own person or in the person of any other never simply as a means but always at the same time as an end”…is a highly articulated version of a demand for respect for persons…it demands less directly that we act in ways that respect, so leave intact, other’s capacities to act….To use another is to treat him or her as a thing or tool and not as an agent….To treat others who are specifically human in their finitude…as “ends” requires that we support one another’s fragile capacities to act, to adopt maxims and to pursue their particular ends.11

Kant’s duty based ethics present three key concepts that can be applied to conscience clauses: the individual as an autonomous moral agent, the categorical imperative, and the “formula of the end in itself.” If a patient wants a prescription filled for oral contraceptives they are acting as an autonomous moral agent. If they are taking oral contraceptives for birth control, they have made a decision, which would be supported by various religious teachings, that this use of oral contraceptives is morally acceptable to them. If the pharmacist refuses to fill that prescription, they are preventing the patient from acting as an autonomous moral agent. The pharmacist has restricted the patient’s ability to act, and on the

11 Onora O’Neill, “Kantian Ethics.”
pharmacist’s part, this would not be acceptable within the tenets of duty based ethics. Has the patient equally so inhibited the pharmacist’s ability to act by requiring the pharmacist to dispense oral contraceptives, an act the pharmacist feels violates their personal beliefs thereby denying them their right to an autonomous conscience? This is not so by virtue of the defined professional relationship between patient and pharmacist. No one is required to be a pharmacist but everyone is required to go to a pharmacist to receive prescription medications.

Can a pharmacist’s or medical provider’s conscientious refusal to provide services based on their personal moral or religious beliefs stand the test to become universal law as defined by duty based ethics? It cannot, because at its core as a principle it fails to be adoptable by a plurality of agents. Would pharmacists accept that they could be denied legal prescription medications based on moral definitions that they did not themselves believe? A physician seeking his own medical care would not accept that medications could be withheld from him based solely on the pharmacist’s personal moral or religious values, contrary to medical need. There is too wide a range of grounds for a provider’s moral or religious objections to provide services for conscience based objections to become universal principles. For example, if as a provider I believe illegal drug use is
immoral; may I withhold legal prescription medications from a patient suffering from long term drug abuse? Julie Cantor, J.D., and Ken Baum, M.D., J.D., offer similar scenarios that challenge the idea of conscience based objections becoming universalizable principles when stating as follows:

If pharmacists can reject prescriptions that conflict with their morals, someone who believes that HIV-positive people must have engaged in immoral behavior could refuse to fill those prescriptions. Similarly, a pharmacist who does not condone extramarital sex might refuse to fill a sildenafil prescription for an unmarried man.\textsuperscript{12}

If we consider the refusal to provide medical services in more neutral terms, it even more dramatically fails the test to become universal law. We would not accept a maxim that states: A valid medical treatment or legal prescription medication can be withheld from a patient if the provider does not want to give it to him. That is in essence the definition of what conscience refusal clauses empower if we remove from them references to contraception, or to controversial concepts such a definition of when life begins, and remove any lofty ideals of moral conscience. If we look at that statement as the core of what is being

articulated in refusal clauses, it immediately becomes something all would reject as an unacceptable maxim to govern delivery of medical services. Refusal to provide treatment or services based on religious or moral beliefs would not stand the test of becoming a categorical imperative and therefore is an immoral act as defined by ethical formalism.

What occurs when pharmacists refuse to dispense oral contraception on the basis of their personal morals? Clearly they are acting to stop something, the use of oral contraceptives, that they believe should not occur, and they are using the patient as a means to this end. This imposition of personal morals upon the patient can also involve imposing differing views of conception. Referencing emergency contraception Cantor and Baum note as follows:

In some cases, a pharmacist’s objection imposes his or her religious beliefs on a patient. Pharmacists may decline to fill prescriptions for emergency contraception because they believe the drug ends a life. Although the patient may disapprove of abortion, she may not share the pharmacist’s beliefs about conception. If she becomes pregnant, she may then face the question of abortion—a dilemma she might have avoided with the morning after pill.13

13 Ibid.
The pharmacist, by exercising a conscientious refusal, restricts the patient’s ability to act on her own behalf and uses the patient as a means to the pharmacist’s own end, their desire to prohibit the use of oral contraception. This is again clearly immoral behavior as defined by ethical formalism.

The pharmacist may argue that it is they that are being used as a means to an end. Since the role of the pharmacist is to dispense prescription medication, this argument would hardly be convincing. If the pharmacist has defined the use of oral contraceptives as immoral then they could, as in the case of Pharmacist Neil Noesen, claim that they are being used as a means to conduct an immoral act. Noesen’s position is based on his Roman Catholic faith, a position not universally held among the world’s religions. The legality of oral contraceptives and their use by women for decades reflects the position that the pluralistic society granting a pharmacist his license does not view oral contraceptive use as immoral. Again, this argument is also repudiated by virtue of the defined professional relationship between patient and pharmacist. No one is required to be a pharmacist but everyone is required to go to a pharmacist to receive prescription medications. In an eloquent elaboration on this point R. Alta Charo, J.D., states as follows:

And it is here that licensing systems complicate the equation: such a claim [to personal autonomy] would be easier to make if the states did not give these professionals the exclusive right to offer
such services. By granting a monopoly, they turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding control over a public good constitutes an abuse of the public trust…  

However, the pharmacist’s moral principles are uniquely theirs and it can be argued that the dignity and respect that they deserve as autonomous moral agents requires accommodation beyond simply asserting that if there are legal medications that you object to dispensing, don’t become a pharmacist. Cantor and Baum note: “Society does not require professionals to abandon their morals….Though pharmacists voluntarily enter their profession and have an obligation to serve patients without judgment, forcing them to abandon their morals imposes a heavy toll.” In counterpoint Robert F. Card argues: “…that there is no absolute right to object, since it would be immoral for a provider to deny medical treatment to a patient based solely on (e.g.) his or her race… providers are medical professionals who lack an absolute right to object.”

---


15 Ibid.

Card’s objection is another example of applying concepts of the categorical imperative to conscience refusal clauses. His argument points to the inability to universalize decisions by a provider to withhold services based on personal beliefs. If a personal belief that contraception is immoral is allowed to justify denying access to prescription oral contraceptives, then why not allow equal authority to other personal beliefs? The belief that those of a certain race should be denied prescription medications, or that those who are very elderly, and therefore not worthy of receiving scarce medical resources, should be denied prescription medications, would be branded as racist and ageist, respectively, and undoubtedly be condemned as civil rights violations.

The application of duty based ethics provides a secular assessment to evaluate the moral validity of the pharmacist’s conscience clause. It is not reasonable to believe that in a pluralistic society, or even among philosophers, Kant’s theories will be universally accepted. However, his basic concepts of the dignity of man, the autonomy of man’s free will, and the belief that fundamental moral maxims, such as the categorical imperative, must have universal applicability, resonate, in whole or part, through both the teachings of the Catholic Church and the writings of John Stuart Mill. The pharmacist’s conscience clause is found to be morally unsound when assessed utilizing duty
based ethics. As defined by duty based ethics, the pharmacist’s conscience clause violates the individual’s inherent dignity by negating the individual’s ability to act upon their free will as an autonomous moral agent. The pharmacist’s conscience clause fails to meet the standards of a categorical imperative; it cannot be universalized to all moral agents. Finally, the pharmacist’s conscience clause is immoral based on duty based ethics because it uses an individual, the patient, as a means to an end by denying them legal prescription medication, that end being satisfaction of the pharmacist’s personal moral beliefs.
CHAPTER 9. CONCLUSION

Pharmacist conscience clauses are neither morally nor professionally justified. In this conclusion, the arguments that render pharmacist conscience clauses professionally unjustified will be discussed, followed by an explanation of why pharmacist conscience clauses are also morally unjustified.

When refusing to dispense prescription medication, the pharmacist is failing to perform a primary function of their scope of practice as a licensed pharmacist. As noted by Charo, this is also a violation of the “public trust” granted the pharmacist as the exclusive entity that can dispense prescription medication, and dispensing prescription medication is central to the scope of practice of a pharmacist. As health care professionals, for pharmacists to claim equal standing with physicians who claim a right to conscientious objection to opt out of performing procedures, is duplicitous. A physician opting out of one procedure is eliminating only a small part of the duties encompassed within their scope of practice. A license granting the status of a physician encompasses a wide variety of potential duties. Physicians can avoid conflicts of conscience by choice of specialty, while the “specialty” of a pharmacist is exclusively dispensing prescription medication. Even if the physician has chosen a specialty
that includes certain procedures or duties that conflict with their conscience, opting out of those procedures will not eliminate the primary function of their specialty. For example, an obstetrician/gynecologist whose conscience conflicts with writing prescriptions for oral contraceptives can limit their practice to prenatal care and birthing or to gynecologic oncology, thereby still fulfilling primary functions of their specialty.

Another way pharmacists who refuse to dispense prescriptions or oral contraceptives are failing to perform one of the crucial elements of their primary scope of practice is that they are failing to exercise scientific clinical judgment. It is within the pharmacist’s scope of practice to review prescriptions for potential drug therapy problems with other medications the patient is taking which could arise from therapeutic duplication, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, clinical abuse, or misuse or other drug interactions based on the science of pharmacology. This element of the pharmacist’s scope of practice is significant enough that Illinois Governor Rod R. Blagojevich specifically articulated in his order requiring pharmacies to dispense prescription oral contraceptives that pharmacists were still to carry out the clinical assessment of the prescription for drug therapy problems. As Wicclair noted, the pharmacist refusing to dispense medications by evoking a conscience clause is
making a moral judgment rather than a clinical judgment. A pharmacist’s license comes with the expectation that clinical assessments will be made based on the science of pharmacology; it is not a license to make moral assessments.

In addition to failing to perform a duty within the essential scope of their practice when refusing to fill prescriptions for oral contraceptives, pharmacists are violating current standards of care in the medical profession. The current standard of care in the medical profession rejects paternalism and emphasizes patient autonomy. This is reflected in the statement in the Pharmacists Code of Ethics that “[a] pharmacist respects the autonomy and dignity of each patient…[and a] pharmacist promotes the right of self-determination….”\(^1\) The trend toward rejection of paternalism in favor of enhanced patient autonomy has emerged alongside the growth of the field of bioethics. Referencing the emergence of the more formal field of bioethics in the 1970s, O’Neill states: “During these years no themes have become more central in large parts of bioethics, and especially in medical ethics, than the importance of respecting individual rights and individual autonomy.”\(^2\) The refusal by a pharmacist to fill a

\(^{1}\) “Code of Ethics for Pharmacists,” American Pharmacists Association.

\(^{2}\) Onora O’Neill, “Autonomy and Trust in Bioethics.”
prescription is a direct affront to the ideals of respecting patient rights and patient autonomy. It is also a return to paternalism. Erich H. Loewy, M.D. states: “An attempt to impose one’s own set of values on another when one has the power to do so is…a form of paternalism.”3 When a pharmacist prevents a woman from obtaining legally prescribed oral contraceptives, that pharmacist is doing so because they are opposed to the use of oral contraceptives, and they are imposing their belief on the patient.

In these circumstances, the pharmacist is also interfering with the relationship between the physician and his patient. It is within the physician’s scope of practice to diagnose and then prescribe the appropriate prescription medication. Having made the determination to prescribe oral contraceptives, the physician has made the decision that it is in the best interest of his patient to do so. This determination is made based on a medical evaluation/examination, an evaluation that is not within a pharmacist’s scope of practice to perform. The training to make such a medical evaluation is part of earning the degree of medical doctor, not the degree of pharmacist. Nor is the authority to make such a

medical evaluation/examination included in the duties granted to a pharmacist by their license. The professional inappropriateness of a pharmacist interfering with the doctor/patient relationship was articulated by Arizona Governor Janet Napolitano when she stated that “providers have no right to interfere in lawful decisions made by patients and their doctors…”\(^4\)

If a pharmacist’s insistence on evoking a conscience clause was an intrinsic right of the profession, there would have been no need for the American Pharmacists Association to modify their code of ethics to allow a pharmacist to “step away” but not “step in the way,” when evoking a conscience clause to refuse to dispense prescription oral contraceptives. Nor would there be any need to enact legislation permitting a pharmacist to evoke a conscience clause to protect the pharmacist from receiving sanctions after refusing to dispense legal prescription medication. The concept of legislation that establishes the right for a holder of a state issued license to opt out of performing the duties required of that license is troubling in and of itself. In essence, laws allowing medical professionals to opt out by exercising a conscientious objection are allowing the

\(^4\) Arizona State Senate, Forty-seventh Legislature, First Regular Session, Fact Sheet For H.B. 2541.
providers to self-determine what aspect of the duties allowed by their license they will or will not perform. Applying the concept of the universality requirement of a categorical imperative to this kind of legislation, one could argue that the states must also allow the right of conscientious objection to all holders of state issued licenses. Where a state issued teaching credential is required to teach in elementary school, should teachers be allowed to refuse to teach students based on the teacher’s individual beliefs? If a teacher refused to teach students who held different religious beliefs than held by the teacher, cries of discrimination and violations of civil rights would undoubtedly lead to sanctions against that teacher. Yet a Roman Catholic pharmacist, in states that allow pharmacist conscience clauses, can refuse based on their faith to dispense oral contraceptives to an Episcopalian patient, whose faith condones the use of oral contraceptives. Legislatively sanctioned pharmacist conscience clauses are flawed legislation, and in the case of oral contraceptives they indirectly renounce findings of the Supreme Court.

State issued professional licenses function in the secular world of laws and regulations. The United States Supreme Court established long ago a woman’s right to have access to legally prescribed oral contraceptives. Allowing a licensed pharmacist to refuse to dispense prescriptions for oral contraceptives enables the
pharmacist to deny a woman her rights as established by the Supreme Court’s interpretation of the Constitution of the United States. No profession or professionals should have the authority to impede the civil rights of a United States citizen. The Supreme Court also casts light on the discussion of the moral validity of pharmacist’s conscience clauses.

If the moral claim against oral contraceptives is made on a right to life basis, the case of Roe v. Wade provides a starting point for discussion. In that case, the United States Supreme Court asserted that: “the unborn have never been recognized in the law as persons in the whole sense… [and that] with respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability.” 5 In terms of equal protection as granted by the Fourteenth Amendment, the Court also asserted in Roe v. Wade that the word person “does not include the unborn.”6 If the secular morality defined by the United States Supreme Court in Roe v Wade is applied to the physiological function of oral contraceptives, there can be no conclusion reached other than to assert that oral

5 Roe et Al. v. Wade, District Attorney of Dallas County, No. 70-18, Supreme Court of The United States.

6 Ibid.
contraceptives do not impact a person. If ovulation is prevented, or if the sperm is prevented from reaching the ovum, there is no conception, and therefore no way to scientifically assert that the beginning of a human life has been impacted. Even if conception occurred, and oral contraceptives functioned by preventing implantation, it would be a blastocyst that was impacted. A blastocyst is a group of totipotent cells—not an individual. Furthermore, a non-implanted blastocyst would not have the capacity for the “capability of meaningful life outside the mother's womb,” another definition of personhood from Roe v Wade. A secular—scientific, legal, view of oral contraceptives and how they prevent pregnancy will not support the view that oral contraception use is wrong because it ends the life of an individual. A pharmacist whose objection to oral contraceptives is based on a moral view placing emphasis on right to life is not relying on scientific or legal grounds, but solely on beliefs rooted in theology.

Pharmacist Neil Noesen claimed the theology of his Roman Catholic faith to justify his actions in refusing to dispense oral contraceptives. As a Roman Catholic himself, it is clear that Noesen should not participate in any form of birth control that uses barrier or artificial means. Whether or not his faith compels him

\[\text{\textsuperscript{7} Ibid.}\]

92
to require others to approach birth control in the same manner is an open question. It can be concluded that preventing someone from exercising their right to make an independent choice to use oral contraceptives based on their own conscience is contradictory to the following admonition from Pope John Paul II when he wrote as follows:

No human authority has the right to interfere with a person’s conscience....This in turn necessarily requires that each individual’s conscience be respected by everyone else; people must not attempt to impose their own “truth” on others....To deny an individual complete freedom of conscience...or attempt to impose a particular way of seeing the truth, constitutes a violation of that individual’s most personal rights....

The Roman Catholic pharmacist who is imposing their own “truth” regarding the use of oral contraceptives by denying a patient their prescription is counter to the Pope’s admonitions, and the Church’s respect for the autonomy of the individual. As evidenced by the quote from Governor Mario Cuomo’s speech, there is a struggle between achieving balance with one’s faith and dispensing the duties of secular activities, such as being a governor. Likewise this struggle can present

---

8 John Paul II, Message of His Holiness Pope John Paul II for the XXIV World Day of Peace: “If You Want Peace, Respect The Conscience of Every Person.”
itself with regard to the secular activity of being a pharmacist. Governor Cuomo asserts that there must be recognition of this struggle when he states as follows:

Our public morality, then—the moral standards we maintain for everyone, not just the ones we insist on in our private lives—depends on a consensus view of right and wrong. The values derived from religious belief will not—and should not—be accepted as part of the public morality unless they are shared by the pluralistic community at large, by consensus… in our pluralistic society we are not required to insist that all our religious values be the law of the land…. We must keep in mind that we are a nation of laws—when we like those laws and when we don’t.  

Governor Cuomo defines his role as governor as being responsible to a “public morality” representing the “pluralistic community at large,” a morality reached by “consensus.” As is the role of a governor, the role of a pharmacist is a secular pursuit. When a pharmacist uses their personal religious beliefs to dictate a refusal to dispense prescription oral contraceptives, they do not represent all religious views, and they are imposing their view on the patient, overriding the patient’s own conscience and personal autonomy. By choosing a secular profession, the pharmacist must accept the boundaries imposed on that profession by the secular society that grants his pharmacist’s license, including the “public

---

9 Governor Mario Cuomo, “Religious Belief and Public Morality: A Catholic Governor’s Perspective.”
morality” and cannot “insist that all our religious values be the law of the land.” Whereas the Catholic Church may grant a marriage license, the Church may not license a pharmacist. Although the Roman Catholic Church prohibits oral contraceptive use for the faithful, John Paul II’s statement regarding respecting each individual’s conscience and that “people must not attempt to impose their own ‘truth’ on others” certainly can be interpreted to mean that the Church does not require that its teachings regarding oral contraceptives be imposed on others. Using a claim of the Roman Catholic faith to justify a pharmacist’s refusal to dispense oral contraceptives does not take into account that even among Roman Catholics the Church’s teachings on oral contraceptives are not universally followed, and fails to respect the religious faiths that accept oral contraceptive use. In addition, because refusing to dispense oral contraceptives is forcing the pharmacist’s own truth on others and fails to recognize the autonomy of the patient’s conscience, when taking all of these factors into consideration, claiming simply the Roman Catholic faith’s opposition to oral contraceptives does not provide a persuasive moral argument to justify a pharmacist’s refusal. In the final analysis, secular pursuits such as the duties of a pharmacist are best analyzed by a standard of secular morality such as duty based ethics. With such an analysis, a pharmacist’s refusal clause is found to be immoral. As discussed
thoroughly in Chapter 8, a pharmacist evoking a conscience clause is violating three essential tenets of duty based ethics. By refusing to honor a physician’s prescription for legal medications, the pharmacist is robbing the patient of their inherent dignity by negating the patient’s ability to act upon their free will as an autonomous moral agent. Granting pharmacists the right to evoke a conscience clause fails to meet the standards of a categorical imperative; it cannot be universalized to all moral agents regarding decisions to dispense all prescription medications. The pharmacist’s conscience clause is also immoral based on the tenets of duty based ethics because it uses an individual, the patient, as a means to an end. In denying a patient legal prescription medication, the pharmacist is using the patient as a means to the end of satisfying the pharmacist’s personal moral beliefs.

A pharmacist is given a license that grants a monopoly over dispensing prescription medications; it is not a license to decide whether or not a doctor’s order to fill a prescription should be allowed. Based on the reasons articulated throughout this thesis, pharmacist conscience clauses are neither professionally nor morally justified.
BIBLIOGRAPHY


Frangos, Jason E. BA, Christina N. Alavian, MD, Alexa B. Kimball, MD, MPH, “Acne and oral contraceptives: Update on women’s health screening


Pope John Paul II, Message of His Holiness Pope John Paul II for the XXIV World Day of Peace: “If You Want Peace, Respect The Conscience of Every Person,”

Pope Paul VI, Encyclical Letter: Humanae Vitae, July 25, 1968,


ELECTRONIC DOCUMENTS AND COURT CASES:


