

Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses

Kelsey C. Brodsho*

INTRODUCTION

Current debate regarding the pharmacist's role in dispensing emergency contraception threatens to overshadow a larger issue: the pharmacist's role in health care delivery. The value of prescription drugs in today's health care market cannot be denied. Likewise, the pharmacist's role in delivering health care services must not be undervalued. However, the primary relationship within the health care system remains between the patient and the physician. This article asserts that professional responsibilities of physicians and pharmacists are distinct. This distinction requires that pharmacist conscience clauses be tailored to meet the objective of the health care system. The article argues that conscience clause legislation must ultimately ensure patients access to the entire spectrum of health care services. Conscience clause legislation that does not meet this end is contrary to the tenets of the medical profession and fails to meet patient expectations.

Conscience clauses, also known as refusal clauses, were first enacted in response to *Roe v. Wade*,¹ which legalized abortion. These laws originally allowed doctors to "refuse to perform or assist in an abortion."² Today, providers rely on

© 2005 Kelsey C. Brodsho.

* J.D. expected 2007, University of Minnesota Law School.

1. See Susan Berke Fogel & Lourdes A. Rivera, *Saying Roe Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 746 (2004).

2. Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider 'Conscience,' Patient Needs*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Aug. 2004, at 1; cf. National Abortion Fed'n, *Nationwide Trends: Refusal to Provide Services* (May 27, 2005), http://www.prochoiceamerica.org/yourstate/whodecides/trends/issues_medical_

conscience objections to remove themselves from other health care processes or decisions.³ A few states allow providers to opt out of assisted suicide⁴ or any other morally or ethically objectionable situation.⁵ The availability of new technologies will likely create situations that many individuals find objectionable on moral grounds. For this reason, the current debate over pharmacist conscience clauses has ramifications far beyond access to the “morning-after pill.”⁶ Many states are introducing legislation that seeks to insulate pharmacists from a duty to fill prescriptions and/or legislation that requires pharmacists to fill all prescriptions (or assure the prescription will be filled by another pharmacist).⁷ In considering these legislative measures, state legislators must not get lost in abortion politics. Emotionally driven legislation may later threaten access to a wide variety of health care services.

THE PHYSICIAN’S ROLE VS. THE PHARMACIST’S ROLE

Physicians *prescribe* medication. Pharmacists *dispense* medication. The physician *initiates* a treatment plan. The pharmacist *implements* aspects of a treatment plan. Because the roles of the physician and the pharmacist are different, a

services.cfm (stating that forty-seven states currently have laws that allow health care providers to refuse participation in abortion services).

3. See Fogel & Rivera, *supra* note 1, at 746 (discussing refusal clauses for individual and health care institutions); Sonfield, *supra* note 2, at 1 (identifying *in vitro* fertilization, human embryo research, stem cell research, and end-of-life practices such as assisted suicide and adherence to living wills as potentially objectionable areas of health care delivery).

4. See, e.g., S.D. CODIFIED LAWS § 36-11-70 (1998).

5. See, e.g., MISS. CODE ANN. § 41-41-215(5) (1999).

6. See generally AMERICAN PHARMACEUTICAL ASS’N, EMERGENCY CONTRACEPTION: THE PHARMACIST’S ROLE (2000). Recent FDA approval of oral hormonal emergency contraception has drawn public attention to the use of post-coital contraceptives. Emergency contraception, commonly referred to as the “morning-after pill,” can effectively prevent pregnancy up to seventy-two hours following intercourse. Despite politically driven propaganda suggesting otherwise, emergency contraception utilizes the same mechanisms as daily estrogen/progestin oral contraceptives to prevent pregnancy. Specifically, both forms of contraception inhibit any of the following processes: ovulation, fertilization, transport of a fertilized egg to the uterus, or implantation of a blastocyst in the endometrium. Emergency contraception differs from other hormonal contraceptives only in dose. Emergency contraception, like all oral contraceptives, act before implantation, and are therefore not considered abortifacients. *Id.*

7. Rob Stein, *Pharmacists’ Rights at Front of New Debate*, WASH. POST, March 28, 2005, at A1.

physician's ability to conscientiously object to providing certain health services is not automatically imputed to the pharmacist. The physician has greater authority to refuse participation in the *development* of a treatment plan than a pharmacist has to interfere with an *established* treatment plan, because patient expectations of treatment plan effectuation increase after the plan is developed within the patient-physician relationship.

The physician and the patient have a central patient-provider relationship. Within the context of that relationship, the physician and the patient create medical plans to further the patient's best interests. This treatment plan is a creation of the patient-physician relationship. It would not exist but for the involvement of these individuals. The pharmacist is one of many health professionals who may be called upon to help effectuate an established treatment plan. After a physician prescribes medication, the patient consults a pharmacist to dispense the prescription. The pharmacist is a link in a chain that effectuates the treatment plan developed within the patient-physician relationship. Therefore, if the pharmacist refuses to dispense medication, he or she is necessarily interfering with a treatment plan that has previously been established between a willing provider and a consensual patient.

As the link between provider and patient, the pharmacist's duty to effectuate treatment cannot be characterized in the same way as a physician's duty to initiate treatment. The patient's expectations provide the basis for this crucial distinction. A patient who initiates a legal course of medical intervention with a physician does not expect that treatment plan to be thwarted by other health professionals.⁸ A pharmacist's interference with an established treatment plan may compromise the patient's ability to obtain services that further his or her best interests.⁹

8. See generally Fogel & Rivera, *supra* note 1 (discussing patient expectations).

9. See *Illinois Governor Issues Emergency Rule Ensuring Contraceptive Access*, LAW AND HEALTH WEEKLY, May 7, 2005, at 331 [hereinafter *Illinois Governor Issues Emergency Rule*]. Steve Trombley, president and CEO of Planned Parenthood/Chicago Area, recently framed the issue in this way:

When medical professionals write prescriptions for their patient, they are acting in their patient's best interests, a pharmacist's personal views cannot intrude on the relationship between a woman and her doctor. A pharmacist must dispense prescriptions issued by health care providers otherwise the patient's health is unnecessarily put at

One can also argue that allowing physicians to conscientiously object to providing medical services decreases patient access. This is true. However, physician refusal must be evaluated differently. This evaluation must be based on different patient expectations. The provider generally refuses services before a treatment plan has been developed. Thus, the patient does not expect a treatment plan to be effectuated. Further discussion regarding extent of physician refusals and the impact on patient access is beyond the scope of this article.

CONSCIENCE OBJECTION

Health professionals other than physicians have recently claimed the right to refuse services based on moral objections. In particular, pharmacists have asserted the right to refuse dispensing medications, such as contraceptives.¹⁰ Several professional organizations have issued policy statements regarding pharmacists' conscientious objections. The American Pharmacists Association (APhA) first announced its policy regarding conscience clauses in 1998 following the enactment of Oregon's physician-assisted suicide law.¹¹ The APhA's policy recognizes a pharmacist's individual right to "step away from participating in activity to which they have personal objections."¹² However, the APhA policy statement simultaneously supports establishing systems to ensure that the patient's health care needs are served.¹³ Thus, the APhA recognizes that a pharmacist's objection should not interfere with an established treatment plan. Likewise, the American Medical Association supports legislation requiring individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference.¹⁴

These policy statements represent the collective opinion of health care professionals and have a common denominator. Each stresses the need for seamless effectuation of an

risk.

Id.

10. See Stein, *supra* note 7.

11. Bob Reynolds, *AMA Rules on Pharmacist Conscience Clauses*, PHARMACIST.COM, June 27, 2005, http://www.pharmacist.com/articles/h_ts_0835.cfm.

12. *Id.*

13. *Id.*

14. *Id.*

established treatment plan. If a pharmacist morally objects to care delivery, the medical community believes that this refusal must not obstruct a patient's access to care.¹⁵ "No health care professional should be exempt from providing complete and accurate medical information, from making appropriate referrals, or from providing urgent care."¹⁶

If a pharmacist is unable to transfer a prescription to another pharmacist or pharmacy (for example, due to staffing or geographic limitations), the needs of the patient must trump the pharmacist's moral objection.¹⁷ As demonstrated by a recent Wisconsin case, the pharmacy community believes conscience objections should not interfere with access to care. In 2002, Neil Noesen, a Wisconsin pharmacist, refused to fill an oral contraceptive prescription. Due to his refusal, the patient waited two days to receive her prescription. Before this incident, Mr. Noesen had informed his employer he was generally unwilling to fill contraceptive prescriptions. However, he did not alert his employer that he was also unwilling to *transfer* contraceptive prescriptions to another pharmacist. A Wisconsin administrative judge found that accepted professional standards require a pharmacist who conscientiously objects to delivering health care services to transfer the prescription to another pharmacist. Because Mr. Noesen failed to transfer the prescription or tell the patient to fill the prescription elsewhere, he violated professional standards. The Wisconsin Pharmacy Examining Board found Mr. Noesen to have "engaged in practice which constitutes a danger to the health, welfare, or safety of a patient and has practiced in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist and

15. See American Medical Association, Conscience Clause: Final Report (H-295.896), http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-295.896.HTM (last visited September 24, 2005).

16. See generally Fogel & Rivera, *supra* note 1, at 726-27 (discussing patient expectations). Fogel and Rivera offer several cases to support this proposition, including *Brownfield v. Daniel*, 256 Cal. Rptr. 240 (Ct. App. 1989) (holding that absent a statutory refusal clause an emergency room must provide emergency contraception to a rape victim because the patient maintains a common law right to self-determination) and *Harbeson v. Parke-Davis*, 656 P. 2d 483 (Wash. 1983) (holding that a refusal clause allowing physicians to opt out of performing abortions did not exempt physicians from providing genetic counseling that included the option of abortion). Fogel & Rivera, *supra* note 1, at 736-39.

17. Fogel & Rivera, *supra* note 1, at 726-27.

which harmed or could have harmed a patient.”¹⁸

State law that allows conscience objection *if* a transfer can be made reflects professional standards and general medical principles of serving patients’ best interests. Each pharmacist embarked on his or her career path to serve the health needs of patients by effectuating treatment plans. If a pharmacist is unwilling to meet the needs of a particular patient and he or she does not transfer the patient to a pharmacist who is willing to meet these needs, the pharmacist in effect thwarts the goals of the medical community.

STATE LEGISLATION: TWO SIDES OF THE COIN

Most states have not yet enacted pharmacist conscience clauses. However, recent media attention regarding emergency contraception has fueled public debate regarding the role of the pharmacist.¹⁹ Increased public awareness creates increased state action; thus, many state legislatures have taken up the issue of pharmacist conscience clauses. It should be noted that in the absence of an explicit conscience objection clause, state law does not presume that a pharmacist may refuse services for moral reasons. Dispensing statutes and administrative regulations generally do not include moral objection as a legal reason justifying a pharmacist’s refusal to fill valid prescriptions.²⁰ Because moral objections are not included in enumerated refusal lists, statutory construction implies that moral objection is not an authorized reason to refuse services. However, patient experiences demonstrate that pharmacists do invoke conscience objections.²¹ Many objections are made in the absence of statutory authority.

Only four states explicitly allow pharmacists to refuse dispensing particular medications. These state laws demonstrate the scope of potential conscience clause legislation. In Arkansas and Georgia, conscience objection exemptions are narrow. Arkansas allows medical professionals

18. *In re* Disciplinary Proceedings Against Neil T. Noesen, No. LS0310091PHM (Wis. Pharmacy Examining Bd. April 13, 2005), available at <http://drl.wi.gov/dept/decisions/docs/0405070.htm>.

19. See Stein, *supra* note 7.

20. See Fogel & Rivera, *supra* note 1 (arguing that conscience objections do not appear in lists of enumerated rights to refuse, such as in the case of known drug interactions when a pharmacist has a duty not to harm the patient by filling a contraindicated prescription).

21. See Stein, *supra* note 7.

to refuse to perform abortion services and provide or dispense contraceptives in all or most circumstances.²² Pharmacists in Georgia are not required to fill prescriptions for emergency contraceptives.²³ South Dakota legislation encompasses several different types of objections. South Dakota allows pharmacists to refuse services used to “[c]ause an abortion; or [d]estroy an unborn child . . . or; [c]ause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.”²⁴ This statutory language could result in a political debate that ultimately loses sight of a patient’s access to health services.

A recently enacted Mississippi law demonstrates that pharmacists can be granted wide discretion under conscience clause legislation. Mississippi adopted a conscience clause that allows “a health-care provider [to] decline to comply with an individual instruction or health-care decision for reasons of conscience.”²⁵ This legislation removes the conscience clause from the abortion context. Furthermore, it equates a physician’s refusal with that of all other health care providers, including pharmacists. Without assurance that a patient is referred to a professional who will meet his or her health care needs, this law compromises ultimate objectives of the health care delivery system. Mississippi’s conscience clause signals an alarming trend. Thirteen states introduced legislation in 2005 that would allow pharmacists to refuse to provide services.²⁶ Several of these proposed measures are similar to the Mississippi law, and many neglect to provide adequate assurance that patients will receive timely access to health care services.²⁷

22. ARK. CODE ANN. § 20-16-304 (1973) (“Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information.”).

23. GA. COMP. R. & REGS. § 480-5-.03(n) (2001) (“It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs.”).

24. S.D. CODIFIED LAWS § 36-11-70 (1998). Note that under currently accepted medical definitions, daily contraceptives and emergency contraception would not fall under the conscience objection exemption.

25. MISS. CODE ANN. § 41-41-215(5) (1999).

26. See National Council of State Legislatures, *Pharmacist Conscience Clauses: Laws and Legislation* (June 2005), <http://www.ncsl.org/programs/health/ConscienceClauses.htm> (last visited Oct. 10, 2005).

27. See, e.g., H.B. 5085, 2005 Gen Assem., Jan. Sess. (R.I. 2005) (“A health care provider has the right not to participate, and no health care provider

Not all 2005 state action supported the proliferation of pharmacist conscience clauses. Three states explicitly stated pharmacists must fill valid prescriptions. In April 2005, Illinois's governor issued an emergency rule to ensure that pharmacies fill prescriptions without delay.²⁸ Pharmacy boards in Massachusetts and North Carolina stated that pharmacists who impede patients' access to prescription medication will be disciplined.²⁹ Several other states also introduced legislation that would require pharmacists to fill prescriptions.³⁰

REALITY STRIKES

The medical community agrees that while health professionals may be given statutory rights to refuse health services for moral reasons, refusal cannot prevent patients from receiving "the information, services, and dignity to which they are entitled."³¹ In theory, laws and institutional policies

shall be required to participate, in a health care service that violates his or her conscience."); H.B. 1255, 2005 Leg., 80th Sess. (S.D. 2005) ("Any health care provider has the right not to participate, and no health care provider shall be required to participate, in a health care service that violates the provider's conscience."); S.B. 76, H.B. 1383, 104th Gen Assem., Reg. Sess. (Tenn. 2005) (authorizing pharmacists and pharmacy owners and operators to decline to fill a particular type of prescription on the grounds that filling such prescription violates the pharmacist's or owner/operator's religious principles, requiring written notice of such conscientious objections); H.B. 183, 2005 Gen. Assem., Reg. Sess. (Vt. 2005) ("A health care provider has the right not to participate, and no health care provider shall be required to participate, in a health care service that violates his or her conscience."); *see also* National Council of State Legislatures, *supra* note 26 (summarizing 2005 legislation).

28. *See* JILL MORRISON, THE NAT'L WOMEN'S LAW CENTER, DON'T TAKE NO FOR AN ANSWER: A GUIDE TO PHARMACY REFUSAL LAWS, POLICIES AND PRACTICES 5 (2005), http://www.nwlc.org/pdf/8-2005_DontTakeNo1.pdf; *Illinois Governor Issues Emergency Rule*, *supra* note 9.

29. *See* MORRISON, *supra* note 28, at 5.

30. *See, e.g.*, S.B. 644, 2005 Legis., Reg. Sess. (Cal. 2005) (authorizing a pharmacist to decline to dispense a prescription on ethical, moral, or religious grounds only if his or her employer is able to reasonably accommodate the objection, without creating undue hardship); S.B. 458, 93d Gen. Assem., Reg. Sess. (Mo. 2005) (requiring pharmacists to fill prescriptions against religious beliefs unless an employer can accommodate a request not to do so); A.B. 3772, S.B. 2178, 211th Legis., Reg. Sess. (N.J. 2005) (prohibiting pharmacists from refusing to dispense medication solely for philosophical, moral, or religious reasons); H.B. 2807, 77th Legis., Reg. Sess. (W. Va. 2005) (prohibiting pharmacists and other persons involved in dispensing medicines from refusing to fill prescriptions); *see also* National Council of State Legislatures, *supra* note 26 (summarizing 2005 legislation).

31. *See* Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Aug.

that allow pharmacists to transfer prescriptions to another pharmacist do not interfere with established treatment plans. However, in practice these laws may delay health care services and harm patients. For example, if a pharmacist objects to filling an emergency contraception prescription, the time required to transfer the prescription to an alternate pharmacist delays administration of the drug and decreases its effectiveness.³² Young patients, patients in rural areas, and individuals seeking weekend services may be particularly vulnerable to denied access.³³ In many foreseeable situations, a pharmacist's moral objection may delay or prevent the receipt of prescription medication. Pharmacists who refuse to provide services or transfer prescriptions to colleagues act contrary to professional objectives. Unnecessary delays or obstructions by pharmacists jeopardize treatment plans established by physicians and patients.

State legislatures and professional licensing boards have vast discretion to authorize the actions of health professionals. Health and safety interests guide these policy decisions. No general right to health care exists, but it is well established that individuals have a right to access birth control services.³⁴ Conscience clause legislation that does not assure patient access to contraceptive services likely conflicts with reproductive liberty interests. Presuming the unconstitutionality of pharmacists' absolute right to interfere with established treatment plans, states legislatures that wish to address this issue have two permissible strategies. First, states may require pharmacists to fill all prescriptions. Alternately, states may pass conscience clause legislation that assures patient access to health care services by prescription transfer or other similar procedure. Either option theoretically "solves" the current contraceptive debate, but state legislators must realize that this policy decision in effect defines the pharmacist's role in the patient-physician relationship. It likely will guide dispensing regulations for other controversial medication in the future. Conscience clause debate should not be clothed in abortion politics. Rather, its focus should be on

2005, at 7.

32. See, e.g., AMERICAN PHARMACEUTICAL ASS'N, *supra* note 6.

33. See MORRISON, *supra* note 28, at 3; Rob Stein, *Birth Control? Some Druggists Say No*, SEATTLE TIMES, March 28, 2005, at A5.

34. See *Eisenstadt v. Baird*, 405 U.S. 438, 441-43 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

whether a pharmacist has a right to interfere with a treatment plan established by a patient and his or her primary health care provider.