Emergency Contraception and Conscientious Objection

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ABSTRACT: Emergency contraception—also known as the morning after pill—is marketed and sold, under various brand names, in over one hundred countries around the world. In some countries, customers can purchase the drug without a prescription. In others, a prescription must be presented to a licensed pharmacist. In virtually all of these countries, pharmacists are the last link in the chain of delivery. This article examines and ultimately rejects several standard moves in the bioethics literature on the right of pharmacists conscientiously to refuse to dispense emergency contraception. Its central thesis is that the standard 'moderate' solution to this problem is mistaken. Thus, when all publicly relevant interests are given their due, it is *not* acceptable to allow refusals in the big city, where pharmacies are plentiful, but forbid them in rural settings, where pharmacies are scarce. Rather, there should be strong public policy requiring that all pharmacists dispense emergency contraception to customers who request it, regardless of pharmacists' moral or religious objections.

1. Introduction

Emergency contraception—also known as the morning after pill—is marketed and sold, under various brand names, in over one hundred countries around the world. In some countries, customers can purchase the drug without a prescription. In others, a prescription must be presented to a licensed pharmacist.[1] In virtually all of these countries, pharmacists are the last link in the chain of delivery.

Although the issue has been most prominent in the United States, where family planning products and services are perennial sources of controversy, pharmacists' central role in dispensing emergency contraception (EC) raises the question of whether they should be granted the legal right to refuse to fill legally prescribed or saleable pharmaceuticals when doing so is at odds with their religious or moral convictions. With the arrival in Europe of at

least one new and apparently very effective form of emergency contraception that is currently under study and consideration for over-the-counter status, pharmacists there may soon have new and more consequential opportunities to impede customer access by refusing to dispense the medication.[2]

In this essay I shall defend an unconventional answer to the question of whether pharmacists should be granted the right to refuse to dispense EC. The standard answer in the bioethics literature is a qualified yes. This conventional view—sometimes referred to as the moderate view—holds that, at least where pharmacies are plentiful, pharmacists should be granted the legal right to refuse to comply with customers' requests, so long as they refer the customer to another pharmacy where there is a professional willing to dispense the prescribed drugs, and so long as this does not impose an 'undue' or 'unreasonable' burden on the customer. When re-directing a customer to another pharmacy would be a mere annoyance or slight inconvenience, an objecting pharmacist may protect his or her moral integrity by significantly restricting his or her participation in what is believed to be an immoral or evil act.

Of course, this moderate solution will continue to be strongly rejected by various stakeholders. For example, the pharmacists who claim a right to refuse either wish to avoid complicity in what they view to be serious disregard for human life or else disapprove of nonprocreative sex in general. So these professionals are unlikely to accept a solution that keeps them firmly in the causal chain leading from a woman's desire not to be pregnant to her not being so. Conversely, many women seeking EC will deny the existence of a publicly acceptable rationale for treating them any differently from how other customers are treated; why, they will ask, should the prevailing laws of the land protect *these* refusals, when most would find it absurd to protect a vegan hardware store clerk's refusal to sell fertilizer to a pig farmer, or the refusal of a bookstore clerk to sell travel books to a divorced father known by the clerk to be derelict in his much-needed child support payments? What, if anything,

distinguishes these kinds of refusals from those protected by the conventional solution? What could make EC special?

The analysis that follows aims to produce guidance for the formulation of just public policy. It is not, therefore, intended as an exploration of professional duty or virtue. This is in part because there appears to be little support in the bioethics literature of the position I shall defend, namely that strong anti-refusal public policy is a requirement of justice in a liberal democracy. Two extant views do, however, come close to my preferred approach. Julian Savulescu argues that 'when conscientious objection compromises the quality, efficiency, or equitable delivery of a [medical] service, it should not be tolerated. The primary goal of a health service is to protect the health of its recipients.'[3] But he also grants a prerogative on the part of public policy makers to determine 'what kind of health system to deliver.'[4] So while *individual* medical professionals should be 'punished through removal of license to practise' when their acts of conscience contravene established medical practice, this is because the 'place for expression and consideration of different values is at the level of policy relating to public medicine.'[5] Thus even the success of Savulescu's argument would leave open a central question at issue in the debate of conscientious objection in medicine.

The other strongly anti-refusal position defended in recent years is that of Robert F. Card. Card, however, deliberately limits himself to a concern with 'professional ethical obligations.' He therefore remains agnostic on the question of whether his arguments support any particular legal or regulatory measures. Since Card is correct that 'not every moral obligation is (or ought to be) codified into law,' there is good reason to ask whether his or any other arguments can support public policy mandating that a pharmacist must choose between dispensing EC and removal from his or her position.[6]

While questions concerning the nature of professional duty and virtue are undoubtedly important, I want to go further. For in their roles as citizen-legislators, participants in a democracy choose to protect and promote their legitimate interests in various

ways. Sometimes this involves creating laws that define inviolable spheres, such as those that protect private property. Sometimes it involves state sanctioned measures intended to generate investment, spur innovation, and induce participation in a certain enterprise or economic sector. If the relevant fundamental interests are sufficiently important, regulations and requirements will be established alongside educational subsidies, tax breaks, and competition-limiting licensing requirements, in order to ensure congruence between the populace's needs and the operation of the resulting sector. It is therefore important to ask whether there is a sound case in favor of the state's imposing a certain regulatory framework on a profession that serves vital citizen interests. This is true even if there is such a thing as demanding and determinate professional obligations of the sort Card defends. In the end I will argue that the conventional answer to our public policy question is mistaken; that is, when all publicly relevant interests are given their due, it is *not* acceptable to allow refusals in the big city, where pharmacies abound, but forbid them in the rural countryside, where they are scarce. Rather, there ought to be strong public policy requiring all pharmacists to dispense emergency contraception to customers who request it, regardless of the pharmacist's moral or religious objections.

2. Background

Because it has seen the lion's share of actual pharmacist refusals to dispense EC, I shall use the United States as a case study for what may become increasingly common worldwide. Currently, there is just one product specifically marketed in the United States as emergency contraception. This is Barr Laboratories' *Plan B*.[7] After a protracted and politically heated approval process, Plan B was approved by the U.S. Food and Drug Administration (FDA) in August 2006 for over-the-counter sale to women and men 18 years of age or older.[8] Further litigation by reproductive rights advocates led to a March 2009 court order enjoining the FDA

to extend over-the-counter access to 17-year-olds.[9] Plan B is now sold over-the-counter at pharmacies by pharmacists and clerks who must verify a prospective buyer's age by inspecting an approved form of identification. (This of course raises further ethical issues concerning access for those who might not have the proper identification, but I shall leave those issues aside in this essay.)[10]

As I have already noted, Plan B and other forms of emergency contraception are kinds of 'morning after pill.' They should not be confused with *Mifeprex*, also known as RU-486 or 'the abortion pill.' Mifeprex contains mifepristone and misoprostol, and is used to terminate an established pregnancy (defined by the medical community as post-implantation embryonic life). Plan B, by contrast, consists of 1.5mg of the progestin Levonorgestrel (LNG), a synthetic hormone. Studies have shown conclusively that Plan B neither interrupts an established pregnancy nor increases the frequency of fetal abnormalities.[11]

While Plan B does not interfere with established pregnancies, there has been some discord over its specific mechanisms of action. The scientific consensus is that the primary mechanism is that of preventing or postponing ovulation, although many who have moral or religious concerns about EC claim that it can prevent implantation of the fertilized egg into the uterus, thereby preventing pregnancy by depriving the zygote[12] of the environment it needs to survive. Recent clinical data has shown that LNG affects the uterine environment only when it has already acted to inhibit ovulation. So when the uterine environment is affected, it is already highly unlikely that a fertilized egg will encounter that environment.[13]

The effectiveness of EC is expressed as the reduction in a woman's expected chance of becoming pregnant (if she and her partner had used no other form of contraception). So we should read the claim on Plan B's label that it is 89% effective like this: 'if 100 women had unprotected intercourse once during the second or third week of their cycle and were not treated with ECPs [i.e. emergency contractive pills], about 8 would become pregnant.

Following treatment with ECPs, only 1 or 2 women would become pregnant, a 75% to 89% reduction.'[14]

While the most recent studies of EC suggest that it can remain effective if started between 73 and 120 hours after intercourse, the effectiveness declines significantly as time passes. Waiting 12 hours to take Plan B decreases its effectiveness rate by 50 percent, with further decreases occurring linearly with time.[15] So health care providers encourage women to take EC as soon as possible after unprotected intercourse to increase their chances of preventing an unintended pregnancy.

3. Conscience, Cogency, and Neutrality

A common and necessary first step in any discussion of whether states ought to protect a pharmacist who refuses to dispense certain medications is to address the possibility of damning similarities to white service providers who refuse to serve black customers. Reflection on these racist refusals quickly reveals that there is no unqualified right to act on one's conscience. Still, many more questions are generated by this revealing example than are closed by it. For example, are we entitled to dismiss claims grounded in racist convictions because such convictions are at bottom utterly false and morally odious? Or must the state refrain from evaluating the ultimate validity of the racist's attitudes, and base its stance instead on independent facts about the potential harm to very weighty interests of those whose lives would be affected were racists permitted to act as their conscience dictates? And even if the state is permitted to impose laws based on the premise that racist beliefs are utterly false, could just laws ever be predicated on the premise that a certain religious or moral belief is false?

I believe that, in general, ordinary moral thinking and academic scholarship come down on the same sides on these questions: they hold, first, that the state may legitimately

declare racist beliefs false, and may properly invoke this stance in a sound justification of anti-discrimination legislation; second, they hold that a just state must refuse even to take up the question of whether any specific religion, religion as such, or even irreligion is true or false. This is the general outlook embodied in the familiar ideal of the separation of church and state. True, this ideal remains nebulous at the margins. Still, it plausibly entails that the state should remain neutral both among religions, and between religion and irreligion. It therefore seems to commit its proponents to the view that highly contested metaphysical convictions should play no substantive role in the justification of public policy. Of course, not everyone is a proponent. But separation of church and state is a widely held position in favor of which much can be said.

Unfortunately, accepting this position would again seem to make resolving the issue of pharmacists and EC all the more difficult. For in the case of racist professionals, the patent falsity of the underlying beliefs could be combined with facts about the potential harm to minorities' interests to yield a determinate and cogent policy solution. Since minorities are full-fledged citizens, and since false racist convictions have no standing and so no claim to accommodation, many race-related policy choices have clear answers. But if the state is debarred from basing its policy decisions in other areas on its best judgment regarding the truth or falsity of the moral or religious belief underlying a claim of conscience, then it is unclear how relevant the analogy involving the racist professional is, let alone how reasonable it is to hope for a determinate solution to the EC issue. How can we know what kinds of accommodation to accord religious and metaphysical convictions if we must remain neutral on the question of their cogency?

One answer that has been offered seeks to replace the cogency of the proposition believed with the sincerity of the believer. In their essay on pharmacists' refusals to fill EC prescriptions, Eva and Hugh LaFollette argue first against an unqualified right to conscientious refusal, and then go on to state conditions under which a *qualified* right might

exist. Drawing parallels with the procedure for winning exemption from military conscription owing to one's conscientious objection to war, LaFollettes say that a pharmacist claiming an exemption should establish 'the plausibility, sincerity and centrality of [his or her] beliefs.'[16] Assume for now that proving sincerity and centrality are indeed conditions for winning such an exemption. What about plausibility? Consider a religiously motivated refusal. At first blush, the plausibility condition seems to put the state in precisely the position that the conventional church/state doctrine sought to avoid. When a conscientious objection is religiously based, do LaFollettes really wish to have the state evaluate an exemption claim by ruling on the plausibility of its religious foundations? In fact, they do not. When they flesh out what they mean by 'plausibility,' it is clear they mean something more like 'plausible-sounding to the agent':

> Not all conscience is created equal; not all conscience should be treated equally. Conscience differs in several relevant ways…[One is] Plausibility: Can she explain and offer a plausible justification for her belief *or is she just parroting the views of others*?[17]

Here the test of plausibility appears to concern the agent's ability to cite what she takes to be reasons supporting *her own* view. Whether they are good reasons appears irrelevant. Later, the condition of plausibility is linked to 'giv[ing] a clear rationale for [one's] beliefs.'[18] This suggests that LaFollettes, like most citizens and philosophers, do not want legislatures and tribunals judging the substantive merits of highly contentious beliefs when conflicts between conscience and medicine arise. A careful accounting of the agent's belief system seems to be enough for them.

In contrast, LaFollettes are plausibly more permissive with regard to certain other beliefs, claiming that 'If someone said that she was conscientiously opposed to feeding their children or stopping at traffic lights, then, barring some powerful explanation, we would not think that they are forwarding moral beliefs, no matter how sincerely uttered.'[19] Here

LaFollettes appear in step with the views of ordinary folk: some beliefs (such as racist beliefs) can be dismissed out of hand, while others, regardless of their truth or falsity, cannot be dismissed, and this is sometimes owing to the complex reasons behind the church/state separation doctrine and its extension to various other non-religious metaphysical views.

Consider now one line of questioning that LaFollettes envisage being pressed by a government tribunal charged with testing the sincerity of refusals. In the case of pharmacists who refuse to dispense EC on the ground that it implicates them in killing another human, LaFollettes suggest that the tribunal be guided by the principle that 'barring a convincing argument, these pharmacists should also oppose capital punishment and modern warfare, because 90% of the casualties are civilians.'[20] Putting the issue of the practicality of such tribunals aside for now, we must ask: where would this intellectual cross-examination end? What would constitute a 'convincing argument'? After all, plausibility does not entail truth. And if tribunals can go this far in demanding a thoughtful and consistent rationale for pharmacists' views on EC and just war, why can they not pose the problem of evil to those who base their objections on explicitly religious grounds, refusing to grant exemptions for those who cannot marshal a convincing argument for the existence of a benevolent God in a world full of unthinkable and seemingly unnecessary suffering?

I believe that these problems reveal serious flaws in the moderate view to which LaFollettes appear sympathetic. In contrast, a strong anti-refusal position would avoid the need for tribunals, and thus the need to define the limitations to their lines of questioning. Of course, most proponents of the anti-refusal stance nevertheless wish to protect religious liberty, so any vindication of a strong anti-refusal view will have to explain why it does not unduly restrict that liberty. I address this issue a bit later. I shall first turn to a few other arguments that have been put forward as elements of a successful resolution to this debate. Showing why these arguments fail will clear the way for my preferred approach, which favors a strong anti-refusal position.

4. Doing, Allowing, and the Need for Substantive Moral Analysis

Consider Robert F. Card's claim that the moderate view is fatally unstable. Recall what this view says: pharmacists have the right to refuse when, and only when, they are willing to refer the customer to another willing professional, and when this does not impose an undue or unreasonable burden on the customer. Card, quite correctly, notes that replacing a duty to dispense with a duty to refer 'does not remove the pharmacist from the causal chain of events that leads to the use of EC, an act that is considered morally wrong by such objecting pharmacists.'[21] Since it is this causal complicity that troubles these pharmacists, replacing the one duty with the other will not allay their worries.

This is certainly a difficult obstacle for the moderate position to overcome. Card claims that taking up this challenge will require the moderate to defend 'an intrinsic moral distinction between 'doing' and 'allowing',' since 'a staunch defender of pharmacists' right to conscientious objection…sees no ethical difference between dispensing the medication herself and allowing another willing pharmacist to do so.'[22] Card then claims that proponents of the moderate position have failed to justify the distinction between doing and allowing, and so therefore seem forced to choose between the two options that do not presuppose the validity of that distinction, namely allowing all refusals and allowing none of them. But surely this account of the troubled pharmacist's mindset is inaccurate. For it seems clear that objecting pharmacists themselves embrace the moral difference between doing and allowing. If they did not, they would take themselves to have the same and as much reason to interfere with another pharmacist's dispensing EC as they do to refrain from dispensing it themselves. Yet the pharmacist who quits her job because she is forced to dispense EC does not then take herself to have *as good and as strong* a reason to interfere with third party transactions. Of course, she is likely to think she has *some* reason either to do this or else to act politically to

effect a change in policy that constrains third parties. But these will not be precisely the same reasons that led her to quit her job, if only because in staying in her job, the person dispensing EC would have been *her*. The purported equivalence between doing and allowing would entail that anti-EC pharmacists are, by their own lights, morally required to dispense EC if this would lead to the frustration of two additional requests by two other customers at two other pharmacies. (This could happen if, contrary to fact, the amount of EC dispensed is determined by clients' weight and if all pharmacies drew from the same, limited stock. Then, dispensing EC to an obese woman could deplete the available supply, thereby ensuring that two other customers' requests go unmet.) Many objecting pharmacists would, however, show differential concern to avoid their own involvement in wrongdoing, as when they choose to feed and clothe their own children instead of sending the money to an organization that could use the same amount of money to feed and clothe two (or more) other neglected children.

So proving that there is a morally significant distinction between doing and allowing cannot be the key to vindicating the moderate view, since the objecting pharmacist's complaint presupposes the validity of that distinction. Her complaint is precisely that by referring, she is *doing* something immoral, not merely *allowing* it to happen. Those who wish to require objecting pharmacists to refer but not to dispense must, therefore, identify the morally significant difference that could justify granting an exemption from actively filling the latter causal role but not from actively filling the former.

Perhaps the difference derives from the fact that, sometimes, rationales that favor adopting distal causal roles over more proximate ones stem from purely psychological considerations. Consider a political activist who cannot stomach joining one of the two (in his view) viciously compromised major parties, but who realizes that one is much better than the other on the issues that matter most to him. He may decide that while he just cannot stomach campaigning vocally for the better party's presidential nominee, he can bring himself to hold his nose and write a sizable check to the nominee's campaign. Morally speaking, it may be

that there is no significant difference between these two types of contribution. But it may be morally relevant that one type is preferred because of its smaller psychological footprint.

This line of thought is unlikely to sway an objecting pharmacist. Since what is at issue is causal complicity in a perceived seriously wrongful act, contemplation of the result at the end of the causal chain will likely cast a dark pall on all intermediate causes, not simply those closest to the dreaded effect. So proponents of the conventional view cannot appeal to the possibility of a psychological difference in holding that it is wrong to force pharmacists to dispense all drugs directly, but permissible to force them to issue referrals for all drugs they refuse to dispense. But then if the moral distinction is not grounded in psychological facts, what could be its source?

One possible answer is that unlike the case of the political activist, there is an objective moral difference between facilitation and direct involvement. This answer, however, threatens to tie the moderate's hands, and for familiar reasons. In order to determine the moral similarities and differences between two courses of action, and thus in order to determine which is worse, it seems we must have a substantive assessment of the moral nature of each. Yet there is no moral content-neutral way to determine the relative badness or wrongness of two alternatives. But then which perspective shall we take up for the purposes of this evaluation? From the perspective of many objecting pharmacists, the moral gravity of each is determined by explicitly religious or otherwise socially contested metaphysical propositions. From the perspective of state officials wishing to remain agnostic on the merits of religious or metaphysical outlooks, the result will be a wholly different evaluative comparison. And yet there seems to be no escaping the need to rely on *some* substantive moral analysis of the various needs and interests centrally affected by any policy decision in this area. A detailed causal description does not suffice.

For further confirmation of this methodological need, assume for the moment that the state may legitimately recognize pharmaceutically induced zygote-interference as a morally

bad consequence. Then, a defender of both the moderate view and the strong anti-refusal view might argue that if (1) EC only rarely has this effect, (2) many attempts to purchase EC are by women who simply want it on hand should they need it, and (3) some woman who do take the pills would not have become pregnant anyway, then there is a *de minimis* probability that dispensing EC inserts a pharmacist into a causal chain ending with what is *ex hypothesis* a morally bad outcome.[23] As Card is quick to point out, virtually *every* human action has this probability, and it would be absurd to hold that every one of these actions should not be performed because of such remote possibilities.

Still, it does not follow from the fact that the odds of a bad result are minuscule that an action having those odds is (even pro tanto) permissible. Even if a gun was outfitted with a million (or more) chambers and just one bullet, it would still be wrong to point it into a crowd and pull the trigger. Clearly, if anything separates this case from the case of implantation-blocking EC, it is the fact that relevant, legitimate, and morally powerful interests conspire to render pulling the trigger impermissible, while rendering dispensing or taking EC permissible. Just as one increases others' risk of injury and death by legitimately driving one's car, so too might one permissibly increase the risk to a zygote by dispensing a legal medication to a reasonable and autonomous third party while on the job. Whether this is in fact permissible, and whether it is permissible legally to require such dispensation, depends evidently on how the totality of legitimate and relevant interests interact to yield a certain moral conclusion about this particular policy. Thus, even if Card's reductio against the argument invoking a real probability of harm does very little work on its own, reflection on it points us again to the need carefully to assess the substantive interests relevant to the state's decision on this issue.

5. Monopoly and Compensation

Although the moderate view does not fall to Card's arguments, it has also proven difficult to vindicate. Let us, then, consider another standard move that proponents of the moderate position make in defense of their view. This line often begins with an argument *supporting* a *prima facie* right to refuse. Then the argument proceeds via the claim that, in many cases, pharmacists' *prima facie* right fails to rise to an all-things-considered right because 'the pharmacist is in a privileged position vis-à-vis potential clients.'[24] As Elizabeth Fenton and Loren Lomasky put it:

> The institutional structure within which pharmacy is practiced has advantaged one party, and that advantage is secured to some extent at the expense of the other…[W]e claim that some limitation of pharmacists' right to choose their clients is justifiable compensation to that clientele for having their own domain of choice limited [through licensing and other regulations that restrict the options of clients by limiting pharmacists' competition].[25]

Since pharmacists benefit from the monopoly-, cartel-, or guild-like status conferred on their profession by the state, and since this scheme itself limits the freedom of clients to enter into pharmacy-related interactions with others, it is reasonable to restrict the right of pharmacists to choose with whom they interact—and this is a matter of compensatory justice.

Fenton and Lomasky are quick to point out that the compensation is owed not by the pharmacy profession to its clients, as if the former were being punished for a wrong they had perpetrated on the latter. Rather, compensation is owed *by the state* to patrons of pharmacies as a means of ensuring that the 'distribution of burdens and benefits [of regulatory policy is rendered] more acceptable.'[26] This means that the moderate's position follows not from an ideal of reciprocity between the two groups, but from an ideal of *evenhandedness* on the part of policy makers and, ultimately, the populace of a representative democracy. Unfortunately, this solution runs afoul of a problem familiar from attempts in ethics and political philosophy to work out the demands of reciprocity. This is the difficult problem of articulating a criterion of equitability in benefits.

It is true that pharmacists receive a 'shield[] from competition' from the state. But on the other side of the coin is the fact that clients receive the benefit of 'protection from unqualified practitioners and [their] own uninformed or impulsive predilections.'[27] What, then, is the basis for saying that the benefits and burdens of pharmacy laws and regulations are unjust or inequitable? By way of analogy, imagine the following discussion and ultimate agreement between two acquaintances. 'Hello Bill, it's John. Look, I need some help moving Wednesday. I know you're on a deadline with your freelance writing, but it might be worth your while. I've been told that I can hire help for $200 per day, but I'd prefer to spend the day with a friend.' 'Sounds OK to me, John. I suppose I can just work longer on my article on Thursday. There is one catch, however. My wife is pregnant. If she happens to go into labor, I'll need to leave. You'll probably want to prorate my compensation, but I have to insist on a guaranteed $200 for the day.' 'OK, that's fine. I really want you to help, and I'll take my chances that your kid can wait until Thursday! See you Wednesday.'

Are these terms equitable, or not? Each receives a benefit that is important to him, and which seems worth the cost incurred (lost money for one, lost time for freelance work for the other). Yet one acquires a freedom that the other does not: Bill has a qualified right to refuse to work, whereas John has no right to refuse to pay. Is this unfair? One might argue that it is, on the ground that Bill took advantage of John. In order to avoid exploitation, Bill should have agreed to lesser pay for less than full work. But this is unpersuasive. The existence of perfectly decent alternative options for John forecloses the possibility that Bill exploited him. In going in for the deal, John took a chance, one that was evidently worth it to him to take. I can see nothing, then, that suggests these terms are not equitable.

The point here is not that this imaginary scenario and the choice over EC policy are exactly parallel. They are not. For one thing, I am primarily concerned with the issue of justified state legislation, not with the sort of private bargaining central to the story. This might suggest that there is no analogue in the EC case to the element in the story that leads to

the seemingly fair arrangement between Bill and John. In the latter case, the imbalance is voluntarily agreed to; in the former, it is imposed and backed by the coercive force of the state. But to conclude that this difference impugns the 'liberty imbalance'[28] in the EC case would be to ignore the very argument that moderates like Fenton and Lomasky offer in favor of the *prima facie* right of pharmacists to refuse. Let me explain.

While it may be true that bargaining of the sort seen in the interaction between Bill and John should play a very small role in the context of democratic legislation, there are nevertheless *structural* similarities between the two domains that are instructive and morally revealing. In the bargaining case, few would think that benefits and burdens were inequitable if Bill had simply accepted the job for $200, sans neonatal exemption. For as I have noted, we can point to nothing in this bargain that could taint the resulting agreement. But then it is difficult to find a reason to impugn the *further bargaining* that leads to Bill's escape-clause. Likewise, Fenton and Lomasky offer little defense of their claim that the path of democratic governance that leads to the establishment of a guild of pharmaceutical gatekeepers is a path to inequitable benefits. Far from identifying a problematic imbalance, their account of the genesis of the pharmacy profession shows only that different groups get different things out of the arrangement. In this, things are rather similar to the case of Bill and John. Just as the legitimacy-conferring qualities of a situation of fair bargaining are preserved even when Bill insists on and wins his exemption, so too might a policy permitting pharmacists to refuse be the result of *further workings of a reasonably just and morally insightful system of democratic governance*. This would be the case if that system gives moral arguments a fair hearing and if the *prima facie* right to refuse is as well-founded as Lomasky and Fenton assume. We would then have no clear reason to conclude that the 'extra' freedom won by Bill through bargaining is any more legitimate than the extra freedom granted to pharmacists by the combination of democratic regulation of pharmaceuticals and the recognition of a strongly supported *prima facie* right to refuse.

I am therefore not persuaded that the liberty imbalance introduced by democratic governance calls for any *compensation* whatsoever. If there are further constraints that should be incorporated into a system of pharmaceutical regulation that already benefits each stakeholder group far above what they would have received without regulation, these will not emerge from the sort of moral bookkeeping Fenton and Lomasky employ. For one thing, it is inherently problematic—and perhaps impossible—to weigh vastly different benefits on the same scale. Yet even when there *are* clear departures from equality in benefits, these may be unimpeachable, as in when they are the result of either fair bargaining or legitimate democratic governance. So a story highlighting the protection from competition accorded to pharmacists fails to establish even a *prima facie* right to compensation on behalf of their customers. This means that the proper response to an evident liberty imbalance must be guided by further substantive moral analysis, and not merely by the tallying up of each side of the moralist's ledger.

6. Voluntarily Incurred Obligations

Building on their claims that pharmacists have a 'liberty right'[29] of conscientious refusal and that pharmaceutical regulation generates a liberty imbalance that favors pharmacists and calls for compensation, Fenton and Lomasky proceed to argue that 'a nuanced response to moral disagreement' will often lead to a geographically-relative policy permitting (to use their examples) refusals in New York City but forbidding them in rural Kansas. This hybrid line 'may be as good as any way to respond to all the interests at stake.'[30] It is now time to assess those substantive interests, since this is what I have repeatedly said is the crux of the issue. I am not convinced that pharmacists possess anything approaching a liberty right to refuse to dispense legally available medicines. Nor do I believe that previous attempts to solve this issue have treated women's interests with the respect and concern they warrant.

I have already noted some of the difficulties involved in determining when a right to conscientious objection is genuine. Where is a moderate to draw the line between allowable rationales for refusals and rationales that miss the mark? How does the proponent of the strong pro-refusal line justify burdening women in order to accommodate moral, metaphysical, or religious convictions that many others do not share and which are in any case already ignored or overridden by public policy that makes the drugs legal in the first place?

While Fenton and Lomasky seem content (at least for the sake of their argument) to accommodate conscientious objections founded upon 'even eccentric moral stances,'[31] we have encountered reasons to require much more discrimination than they provide guidance for. Just as no rights to refuse are possessed by real estate agents who do not want to sell a house to an interracial couple, no matter how strongly rooted in, say, an eccentric religious faith, no right exists simply because a service provider disagrees with the personal moral choices a client might make in his daily life. A feminist pharmacist may not refuse to dispense a non-emergency product (for a skin rash, say) simply because the customer runs a legal pornographic website which she (rightly) believes to be immorally degrading toward women. Yet even in the midst of secure convictions such as this, it is no easy task to uncover the necessary publicly acceptable standard that rationales for refusals must meet. Such difficulties are evident in Kent Greenawalt's attempt to articulate one sort of moderate view. In the course of his argument, Greenawalt grants that it may well be permissible to allow a nurse anesthetist to refuse on religious grounds to assist in a reproductive sterilization. Yet he also holds that a nurse who refuses to assist in elective plastic surgery on the ground that 'attempts to revise the aging process [are] a sin against God's creation' would, for the purposes of public policy, possess 'less than a conscientious objection.'[32] But what could make the difference in these cases? It cannot lie in the fervency with which the beliefs are held, as we can easily imagine that each nurse's convictions are held with equal zeal. Nor can

the difference be found in the extent to which the view is embraced by other members of society. For why should numbers justify here, if they do not justify the state's establishment of the religion favored by the majority? And as we have seen, some of the reasons counting against the establishment of a state religion also count against granting rights to refuse that hinge essentially on substantive evaluations of the plausibility of the religious outlook from which they emerge. So is Greenawalt claiming that a right to free religious expression *as such*—in contrast with a right to the free exercise of *this* or *that* religion—entails a right to refuse assistance with sterilizations but not assistance with plastic surgery? It is difficult to see how these divergent determinations could be common implications of a single and coherent civil libertarian outlook embodying neither a preference for this or that religion, nor a preference for religion or irreligion as such.

Once we realize that not just any claim to conscience is publicly acceptable, and that not every restriction of a citizen's set of options is unjust, we will see that it is insufficient simply to assert, as Greenawalt does, that 'there is a powerful reason not to force people to choose between offending their consciences and foregoing a major vocational option.'[33] For just as there may be no publicly acceptable rationale for according moral weight to a given invocation of conscience, there may be nothing wrong with 'forcing' citizens to make Greenawalt's choice. By way of analogy, there seems nothing in principle wrong with requiring at least one parent in a household to choose between spending more quality time with his or her children and working eight hours a day, five days a week, for a living wage or salary. But if we are willing to 'force' parents to make *this* choice between a decent wage and more time with their children, then in saying that a pharmacist should not have to make *her* choice between dispensing EC and a life as a non-pharmacist, we would be saying that a life as a non-pharmacist is a greater deprivation than 4,680 fewer non-fatigued hours spent with one's child (using the arbitrary measure of one extra hour per weekday until the child is 18 years old). I conjecture that very few are willing to say this.[34]

Since we are in urgent need of a way to rule on different claims to conscience without having to rule on the truth or falsity of this or that fundamental worldview, we seek bases for refusals that can appeal to arguments that could be offered by those who differ in their beliefs concerning many fundamental religious and metaphysical issues. Public policy that utilizes only secular grounds available to all has been plausibly held to provide a firm basis for civic respect, respect for those of differing faiths (or no faith at all), the protection of religious freedom, and the protection of religious minorities. Of course, such protections will be justified only if it is permissible for the state to recognize the importance that religion has in the lives of many conscientious citizens of good will. And this is indeed something a liberal state should acknowledge. But we must not confuse this acknowledgement with the claim that any given religion should survive or thrive, since this is precisely what is denied by many other conscientious citizens. This suggests that the only acceptable rationale available is the importance of protecting the free exercise of religion or conscience *as such*, given the importance this has in the lives of so many of our fellow citizens. Yet in that case, we will need an argument showing that society deprives a pharmacist of adequate freedom to express her religious convictions, or to act on her conscience, if a job she *voluntarily* pursues or holds—to the exclusion of many other viable career paths—requires her to dispense EC. This seems a difficult case to make.

7. Women's Interests and the Case Against Refusals

We must now address the burdens that would be imposed upon women who wish to procure EC from objecting pharmacists. Fenton and Lomasky suggest that the very project of identifying the relevant burdens faced by women may be problematic given that such pharmacists insist 'that it is the nascent human life that is in dire jeopardy, not the prospective mother.'[35] Yet this line of thought is misguided because it encourages evenhandedness

between conflicting parties simply because each party's conviction has a mirror image emanating from the other's worldview. When the political admissibility of a worldview is itself questionable, mirror images might not in fact deadlock political deliberation. I have already explained why the pharmacist's claims should not be given the unscrutinized weight in liberal political argument that they so often receive in the moderate's framework. On the other side, however, we have women's clearly relevant interests in reproductive autonomy and in having access to a safe medication that can obviate the need to undergo an invasive surgical procedure. These are likely to be the very considerations that justified the state's regulatory approval of the drug in the first place. Other such considerations likely include the plausible and widely held—yet hardly dispositive—conviction that even if EC did work by interfering with zygote-implantation, that which is interfered with is not yet a person, but instead a microscopic mass of cells without significant moral status.[36] EC is legal because it safely permits women to exercise autonomy over their reproductive future and to avoid the need for abortions by ingesting medication that interferes with microscopic entities inside their own bodies. For all these reasons, EC would be a great advance in women's reproductive freedom and autonomy, *even if* it worked only by blocking implantation. Since it works primarily by blocking *fertilization*, its appeal should be all the stronger among those who are duly sensitive to the interests of women.

Reproductive autonomy is not only an important moral value, it is also widely seen as a deeply personal one. Decisions to conceive are often made between partners who often keep them as closely guarded secrets for months, sometimes years. Similarly, attempts to prevent a pregnancy, especially after intercourse, are very often not shared with anyone. So when there is a possibility that a trip to the pharmacy will result in a refusal or public confrontation, many women will find it too emotionally difficult to go through with. Others who request the drug but are denied will suffer further panic and dread as the likelihood that EC will work decreases rapidly as time passes. We therefore cannot say, as many moderates wish to, that

when a reasonably prompt referral is possible, refusals are matters of mere inconvenience to a client. For some women, the prospect of denial will lead them to *never become a client* in the first place; for others, each moment that passes will raise the chances of an unintended pregnancy. This may or may not be the stuff of emergencies, but these are not negligible costs of convenience, either. And in a context in which claims to conscience are given the scrutiny they deserve, they will often be decisive.

8. Conclusion

The era of women's reproductive autonomy is but a miserably small fraction of human history. And despite continuing advances in the right direction, the persistent threat of rape and sexual assault appears impossible to eliminate.[37] In this essay I have tried to show that the debate over EC and conscience has seen far too many bald invocations of the demands of conscience or religious freedom and far too little consideration of the freedom of women to exercise control over their reproductive future in a liberal society that remains properly agnostic on highly contestable metaphysical and religious convictions. Because cogent, publicly acceptable rationales for the strong anti-refusal position pose no significant threat to a fully adequate scheme of religious liberty or freedoms of conscience, and because the moderate and pro-refusal views do threaten women's reproductive autonomy, pharmacists should be forced to choose between dispensing EC and finding another way to make a living.[38]

NOTES

[1] The Associated Press, 'New Morning-after Pill ellaOne works up to five days,' (January 29, 2010).

[2] Faculty of Sexual & Reproductive Healthcare, Royal College of Obstetricians and Gynecologists, 'New Product Review: Ulipristal acetate (ellaOne),' www.ffprhc.org.uk/admin/uploads/ellaOneNewProductReview1009.pdf (October 2009).
[3] Julian Savulescu, 'Conscientious Objection in Medicine,' *BMJ: British Medical Journal*, 332, 7536 (2006): 294-297, p. 296.
[4] Savulescu, op. cit., 297.
[5] Savulescu, op. cit., 296.
[6] Robert F. Card, 'Conscientious Objection and Emergency Contraception,' *The American Journal of Bioethics*, 7, 6 (2007): 8-14, p. 9.
[7] While sale of generic forms of the original two-pill version of Plan B began in August 2009, the Food and Drug Administration recently approved for sale Barr Laboratories' one-dose version called *Plan B One-Step*. See 'FDA Approves New Plan B Labeling,' *Wall Street Journal* (July 14, 2009).
[8] No research evidence was offered for the age restriction, suggesting it was a move in concert with the initial rejection, which later investigation revealed to be based in part on FDA's Deputy Operations Commissioner's personal concerns about 'extreme promiscuous behaviors such as the medication taking on an 'urban legend' status that would lead adolescents to form sex-based cults centered around the use of Plan B.' See L.L. Wynn, Joanna N. Erdman, Angel M. Foster, James Trussell, 'Harm Reduction or Women's Rights?' *Studies in Family Planning*, 38, 4 (2007): 253-267, p. 254.
[9] L.L. Wynn, et. al., op. cit.
[10] Because EC is now available without a prescription in the U.S., I will often refer to pharmacists' refusal to dispense legally available medications, as opposed to their refusal to fill valid prescriptions. I do not think anything important turns on a legal drug's over-the-counter status, and I therefore believe that my conclusion in the EC case also generates implications for medications that require prescriptions.
[11] James Trussell and Elizabeth G. Raymond, 'Emergency Contraception,' http://ec.princeton.edu/questions/ec-review.pdf (May 2008), p. 5; Frank Davidoff and James Trussell, 'Plan B and the Politics of Doubt,' *Journal of the American Medical Association*, 296, 14 (2006): 1775-1778, p. 1776.
[12] Technically a zygote (fertilized egg) becomes a blastocyst in the days immediately preceding implantation. Assuming that the reader is more familiar with the term 'zygote,' I will continue to use it to refer to the product of fertilization that may or may not implant in the uterine wall.
[13] Marta Durand, et. al., 'Late Follicular Phase Administration of Levonorgestrel as an Emergency Contraceptive,' *Contraception*, 71, 6 (2005): 451-457, p. 455.
[14] Felicia H. Stewart, James Trussell, and Paul F. A. Van Look, 'Emergency Contraception,' in Robert A. Hatcher, et. al. (eds.), *Contraceptive Technologies* (New York: Ardent Media, 2004): 279-303, p.286.
[15] Rebecca H. Allen and Alisa B. Goldberg, 'Emergency Contraception: A Clinical Review,' *Clinical Obstetrics and Gynecology*, 50, 4 (2007): 927-936, p. 930; Davidoff and Trussell, op. cit., p. 1775; Stewart, Trussell, Van Look, op. cit., p. 287.
[16] Eva LaFollette and Hugh LaFollette, 'Private Consciences, Public Acts,' *Journal of Medical Ethics*, 33 (2007): 249-254, p. 250.
[17] LaFollette and LaFollette, op. cit., p. 249 (emphasis added).
[18] LaFollette and LaFollette, op. cit., p. 250.
[19] LaFollette and LaFollette, op. cit., p. 252.
[20] LaFollette and LaFollette, op. cit., p. 251.
[21] Card, op. cit., p. 9.
[22] Card, op. cit.

[23] Card, op. cit., p. 11; LaFollette and LaFollette, op. cit., p. 252.
[24] Elizabeth Fenton and Loren Lomasky, 'Dispensing with Liberty: Conscientious Refusal and the 'Morning-After Pill',' *Journal of Medicine and Philosophy*, 30 (2005): 579-592, p. 585.
[25] Fenton and Lomasky, op. cit.
[26] Fenton and Lomasky, op. cit., p. 586.
[27] Fenton and Lomasky, op. cit., p. 585, 586.
[28] Fenton and Lomasky, op. cit., p. 588.
[29] Fenton and Lomasky, op. cit., p. 580.
[30] Fenton and Lomasky, op. cit., p. 589.
[31] Fenton and Lomasky, op. cit., p. 583.
[32] Kent Greenawalt, 'Objections in Conscience to Medical Procedures: Does Religion Make a Difference?' *University of Illinois Law Review*, 4 (2006): 799-825, p. 821.
[33] Greenawalt, op. cit., p. 820.
[34] Additionally, we do not think we must exempt objecting pharmacists from (any portion of) their tax liability on the ground that these monies are used to sustain a legal system that permits behavior they deem morally odious. Yet the imposition of tax liabilities is backed by the coercive apparatus of the state: those who do not pay may suffer serious penalties. Why, then, must the state exempt pharmacists from fulfilling an obligation they voluntarily incur through the free choice of their occupation, when it does not exempt them from an obligation they must discharge on pain of state coercion? If free exercise of religion and conscience is not threatened in the coercive context of taxation, why is it threatened in the voluntary occupational context?
[35] Fenton and Lomasky, op. cit., p. 583. It is also interesting to note that while Fenton and Lomasky are quick to grant a prima facie right to pharmacists protecting them from being forced to dispense EC, they show much more reluctance in acknowledging that women who are refused EC and become pregnant are forced to incur an especially morally salient fate: 'Note also that failure to receive emergency contraceptive services does not amount to infliction of mandatory motherhood; conception may not have occurred, and, whatever the wishes of the pharmacist, subsequent abortion is available if pregnancy does in fact eventuate' (582).
[36] For a persuasive argument against this conviction that in another context would call for a sustained response, see Don Marquis, 'Why Abortion is Immoral,' *The Journal of Philosophy*, 86, 4 (1989): 183-202. As I go on to note, the specific mechanism of action of EC helps us to largely bypass critiques such as Marquis's 'future like ours' account of moral status. For while it seems to make sense to say 'I was once a zygote,' it seems bizarre to say 'I was once a gamete.' So it is much less clear that even a successful sperm has 'being a human' in its future. By blocking fertilization instead of implantation, EC helps us block the relevance of arguments designed to show that an early zygote has the same moral status as a normal person. Still, the legitimate and powerful interests of women that I describe in the text would be eminently relevant to an argument claiming that pharmacists should be required to dispense EC even if it did work by blocking the implantation of a fertilized egg. Think here again of the risk of death we impose on others by driving our car. If the risk is small enough, and if the interests on the other side weighty enough, then there may well be nothing wrong with actions that carry a predictable risk of bad outcomes. (Here I'm assuming for the sake of argument that the destruction of a zygote is a bad outcome.) Since the pharmacist has a choice in whether or not she will (continue to) be materially involved in the events that create such risks, the arguments I present place the burden back on her to explain why she should not have to dispense EC as part of her voluntarily held job.

[37] In the context of my broader argument, the fact of rape lends considerable support to a policy requiring all hospitals—including Catholic hospitals—to carry, offer, and dispense EC to all patients who show signs of sexual assault.

[38] For very helpful comments on previous versions of this essay, I would like to thank Katrien Devolder, Elizabeth Fenton, Beth Jordan, Ann McCall, and Richard W. Miller.