Conscientious Objection and Pharmacists' Professional Obligation to Ensure Access to Legitimately Prescribed Medication

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Abstract

This paper discusses legal issues surrounding pharmacists who refuse to dispense emergency contraception based on their religious views. One study reports up to thirty-one percent of pharmacists admit to not dispensing emergency contraception based on their moral or religious beliefs, leading to women’s limited access to a second chance to prevent pregnancy when their regular preventative method fails. Without a limitation on when pharmacists can deny patients access to legitimately prescribed medication, women’s fundamental right to choose whether to bear a child is no longer her choice, but her pharmacist’s choice. Legislatures must require pharmacists to act in their patient’s, not their own, best interests.
CONSCIENTIOUS OBJECTION AND PHARMACISTS’ PROFESSIONAL OBLIGATION TO ENSURE ACCESS TO LEGITIMATELY PRESCRIBED MEDICATION.

“We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views . . . and of the deep and seemingly absolute convictions that the subject inspires.”

INTRODUCTION

Inevitably, most sexually active women will experience the dread of failed protection or unsafe sex. Imagine yourself, or a woman you know, terrified after being raped, or because of inexperience, youth, or intoxication embarrassed and confused about just experiencing unsafe sex. Her face grim and desperate, feeling dejected, fearing the worst, and facing defeat, the panic and pressure would be overpowering. In such a situation, time is of the essence. A woman has only seventy-two hours to become aware of, find, and take emergency contraception (“EC”) or an unexpected pregnancy could be reality. At this vulnerable time, not the woman, but her pharmacist, holds her fate in his or her hands. Nevertheless, some women must face pharmacists who are “conscientious objectors,” or pharmacists who refuse to dispense EC based on their moral or religious beliefs. For example, one objecting pharmacist refused to dispense EC to a woman even though she was a rape victim, and another pharmacist refused to fill or even

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transfer a woman’s prescription for EC to avoid taking part in her “sin.” One pharmacist lectured a woman about her choice in birth control after the pharmacist refused to fill her prescription for EC, and another pharmacist refused a married woman’s prescription for EC despite her monogamous relationship status. Yet another woman was forced to drive more than seventy miles to a pharmacy she knew would dispense EC when no other pharmacy in her town would, and one pharmacist went so far as to lie to a woman’s physician about the availability of EC at the pharmacy. These true stories overwhelmed the headlines in 2004 and 2005, resulting in the adoption of “must-dispense” regulations, which require pharmacists to dispense EC despite their conscientious objection. After rulemakers began enacting must-dispense regulations, pharmacists claimed the regulations were a violation of their religious freedom and heatedly challenged them through a series of lawsuits. Despite the court battles, no consensus about pharmacists’ obligation to dispense EC is near. The most recent challenge to a must-dispense regulation was *Stormans, Inc. v. Selecky*, which left negligible direction for pharmacies, pharmacists, prescribers, and patients to decipher the two incompatible rights at issue in the case: patients’ right to medicine versus pharmacists’ right to religious freedom.

One study reports that just under thirty-eight percent of pharmacists admit to not dispensing EC, and just over thirty-one percent of those pharmacists surveyed cited their moral

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6 Stormans, Inc. v. Selecky, 586 F.3d 1109, 1118 n.7 (9th Cir. 2009).


8 *Stormans*, 586 F.3d at 1118 n.7.


10 *Stormans*, 586 F.3d 1109.

11 Hereinafter, “prescribers” refers to any medical professional that has the ability to prescribe EC such as physicians, nurse practitioners, and physician assistants.
or religious beliefs as the reason for refusing to dispense EC. However, pharmacists should have a professional obligation to provide their patients with access to legitimate and safe medications. Pharmacists should not have the authority to alter or refuse a prescription or over-the-counter (“OTC”) medication for any reason. Going forward, rulemakers must only allow pharmacists to alter or refuse a patient’s medication in two instances. First, when altering the medication will have little adverse affect on a patient’s prescribed treatment. Or second, when a medication is unsafe or a legitimate, medically justified reason for refusing to dispense or altering a patient’s medication exists. Such limitations on when pharmacists can refuse to dispense would not limit pharmacists’ clinical role; instead, these limitations would improve patients’ access to medication and recognize that pharmacists have a professional obligation to act in their patients’ best interests. Current regulations do not require enough from objecting pharmacists. Rulemakers must do more to protect women’s fundamental right to choose whether to bear a child. This note proposes a compromise between traditional must-dispense and referral regulations, hereinafter referred to as the “compromise” regulation. If enacted, the compromise regulation would require pharmacists to dispense EC, despite their moral objection, if pharmacists cannot refer patients requesting EC to a pharmacy or pharmacist within a reasonable distance and time. Thus, the compromise regulation protects the religious freedom of pharmacists, by not requiring that pharmacists always must dispense no matter the circumstance,

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12 Sarah Shrader et al., Knowledge and Attitudes About Emergency Contraception Among Pharmacist and Physician Preceptors in South Carolina, 1 OPEN ACCESS J. CONTRACEPTION 73, Table 2 (2010) (finding that 37.6% of South Carolina pharmacists surveyed did not dispense EC and 31.4% of those pharmacists did not dispense EC because of moral and religious reasons). See also Laura A. Davidson et al., Religion and Conscientious Objection: A Survey of Pharmacists’ Willingness to Dispense Medications, 71 SOC. SCI. & M ED. 161, 164 (2010) (finding that 2% to 6% of Nevada pharmacists had a problem dispensing or transferring a prescription for ethically challenging drugs); Denise Ragland & Donna West, Pharmacy Students’ Knowledge, Attitudes, and Behaviors Regarding Emergency Contraception, 73 AM. J. PHARM. EDUC. 1, 2-3 (2009) (finding that 23.5% of pharmacy students surveyed worked in a pharmacy that did not stock Plan B, that 7.9% of participants would refuse to dispense EC when presented with a prescription, that 35% of pharmacy students incorrectly believed Plan B was the same as the abortion pill, and that 32% did not know emergency contraceptives’ mechanism of action).
but instead only requiring pharmacists to dispense if they cannot guarantee referral. In addition, the compromise regulation prioritizes patients by requiring pharmacists to be primarily responsible for ensuring that patients ultimately receive their medication.

Part I begins by briefly discussing women’s decades-long struggle for the right to use contraception and explains why the controversy surrounding EC is based on a misunderstanding of EC’s mechanism of action. Part II explores current laws regulating pharmacists’ duty to dispense and discusses the most recent court response to a must-dispense regulation. Part III assesses pharmacists’ ability to alter or refuse medications based on pharmacists’ clinical role in prescription and OTC medication. Part IV explains why rulemakers should require pharmacists’, like other health professionals, to act in their patients’ best interests as fiduciaries. Finally, this note concludes with two proposed regulations: first, the compromise regulation, which requires pharmacists to refer patients or dispense, and second, a fiduciary duty requirement, which requires pharmacists act in their patients’ best interests.

I. EXAMINING THE SYMPTOMS: WOMEN’S STRUGGLE FOR THE RIGHT TO USE CONTRACEPTION

Despite a study by the Guttmacher Institute, which indicates “virtually all women (more than 99%)” have used at least one method of contraception during childbearing years, women’s right to contraception has been an uphill battle since contraceptives first became available to the masses. By the mid-1800s condoms, IUDs, and vaginal sponges were available in pharmacies, which startled conservatives, and encouraged Congress to pass the Comstock Act of 1873, which criminalized distribution of contraception devices through the mail. Many states passed

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similar statutes; Massachusetts and Connecticut were among the most restrictive. It was not until 1965 that the Supreme Court in *Griswold v. Connecticut*\(^{16}\) found Connecticut’s Comstock law, which criminalized the use of contraception, unconstitutional and an intrusion of marital privacy, finally allowing married couples to use contraception legally. *Griswold* only protected the privacy of married couples. It was not until 1972 that the Supreme Court in *Eisenstadt v. Baird*\(^{17}\) held unconstitutional a similar Massachusetts Comstock law, which made it a felony for any unmarried persons to use contraception. The privacy right in contraception choice that *Griswold* and *Eisenstadt* recognized allowed choice in family planning that women are now accustomed to and reasonably expect from their pharmacies.

Plan B (approved in 1999),\(^{18}\) Plan B One-Step, a one pill form of Plan B (approved in 2009),\(^{19}\) Next Choice, a generic form of Plan B (approved in 2009),\(^{20}\) and Ella (approved in 2010),\(^{21}\) are the Federal Drug Administration (“FDA”) approved brands of EC available in the United States. Plan B, Plan B One-Step, and Next Choice are time sensitive, and patients must take them within seventy-two hours (or three days) after unprotected sex.\(^{22}\) Ella, the newest EC, patients must take within 120 hours (or five days) after unprotected sex.\(^{23}\) Plan B, Plan B One-

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\(^{16}\) 381 U.S. 479 (1965).

\(^{17}\) 405 U.S. 438 (1972).


\(^{19}\) Id. at 36-37.

\(^{20}\) Id. at 37.


Step, and Next Choice are available OTC for women at least 17 years old, while Ella is available by prescription only.

In 2009, the United States had 4,131,019 births, but according to the Center for Disease Control and Prevention, almost half of all pregnancies in the United States are unintended. Access and accurate knowledge about EC could safely prevent many of these unintended pregnancies. However, EC remains the most contested and misunderstood form of birth control. EC is not the “abortion pill,” which aborts an existing pregnancy. EC is a backup form of birth control that prevents pregnancy after unprotected sex. EC is markedly different from the mechanism of action in the true abortion pill Mifeprex, which is otherwise known as RU-486.

Mifeprex, which is unavailable at pharmacies, terminates a pregnancy through the first 49 days, by blocking a hormone that the body needs for pregnancy to continue. The heated debate over EC arises because conscientious objectors believe EC is an abortifacient like Mifeprex. Yet, according to the mainstream scientific community, this is inaccurate. The difference in opinions lies in conscientious objectors’ definition of an “existing pregnancy.” The scientific community

24Plan B Labeling Information, supra note 3, at 1; NEXT CHOICE, supra note 22.
28FDA’s Decision Regarding Plan B: Questions and Answers, FOOD AND DRUG ADMINISTRATION (April 30, 2009), http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm. EC works by releasing a high dose of levonorgestrel, the exact same hormone used in traditional birth control. Id.
31See Vandersand v. Wal-Mart Stores, Inc., 525 F. Supp. 2d 1052, 1054 (C.D. Ill. 2007) (“Vandersand refused to dispense emergency contraceptives based on his scientific understanding that those drugs or combination of drugs act with a significant abortifacient mechanism in a manner and to a degree that ordinary birth control drugs do not.”); Menges v. Blagojevich, 451 F. Supp. 2d 992, 997 (C.D. Ill. 2006) (“Plaintiffs allege that Emergency Contraceptives work with a significant abortifacient mechanism of action.”); Morr-Fitz, Inc. v. Blagojevich, 901 N.E.2d 373, 378 (Ill. 2008) (“[Plaintiff] has formed a professional opinion ‘about teratogenic or abortifacient drugs and their destruction of what he considers is human life,’ and he believes that Plan B has an ‘abortifacient mechanism of action.’”).
believes pregnancy begins when a fertilized egg implants into the wall of a woman’s uterus (implantation).\(^{32}\) For example, the Guttmacher Report on Public Policy states, “According to both the scientific community and long-standing federal policy, a woman is considered pregnant only when a fertilized egg has implanted in the wall of her uterus . . . ”\(^{33}\) Thus, EC, which acts before an egg implants into a woman’s uterus, *prevents* pregnancy and does not abort an existing pregnancy. In contrast, conscientious objectors typically believe pregnancy begins at fertilization. As an example, the objecting pharmacist in the case *Noesen v. Department of Regulation and Licensing, Pharmacy Examining Board*, stated that he “objected to a[ny] ‘procedure involving a drug or device that may prevent the implantation of a fertilized human ovum. This includes, but is not limited to, drugs which are prescribed as contraceptives . . . ’”\(^{34}\) Because EC may work after fertilization, conscientious objectors consider EC an abortifacient, because it *prevents* even though it does not *disturb* an already implanted ovum.

The Obama administration clarified federal policy on the difference between an abortion and contraception on February 18, 2011, when the administration partially revised federal health care provider statutes put in place in 2008 by the Bush administration.\(^{35}\) The federal health care provider statutes prohibited discrimination against certain health care

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34 751 N.W.2d 385, 388 n.2 (Wis. Ct. App. 2008).

providers who refuse to participate in abortions.\textsuperscript{36} However, the statutes were also broadly construed to protect conscientious objectors.\textsuperscript{37} The Obama administration did not change the protections afforded to those who refuse to participate in abortions, but did clarify the misunderstanding about the scope of the statutes in protecting all conscientious objectors, particularly, the definitional difference between abortion and contraception.

The Department agrees with concerns that the 2008 [statutes] may have caused confusion as to whether the federal statutory conscience protections allow providers to refuse to treat entire groups of people based on religious or moral beliefs . . . . The [statutes] were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable. [T]he comments reflect that the [statutes] caused significant confusion as to whether abortion also includes contraception . . . . \textit{There is no indication that the federal health care provider conscience statutes intended the term “abortion” included contraception.}\textsuperscript{38}

Therefore, although EC is an easy target in the abortion debate, the overwhelming consensus is that EC is not the same as an abortion. The best way to prevent abortion is to prevent unintended pregnancies. EC can help achieve this. Rulemakers should not complicate access to EC by allowing pharmacists to refuse to dispense. While rulemakers may wish to protect those who refuse to perform an abortion, rulemakers should limit the protections provided to those who refuse to provide preventative care, like EC.

\textbf{II. AN UNSUCCESSFUL TREATMENT: CURRENT REGULATIONS}

Regulations addressing medical conscientious objectors that began after \textit{Roe v. Wade}\textsuperscript{40} made it legal for women to receive abortions. States take one of three stances on conscientious objection:

\begin{footnotesize}
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  \item \textsuperscript{36} \textit{Id.}
  \item \textsuperscript{37} \textit{Id} at 3.
  \item \textsuperscript{38} \textit{Id} at 26.
  \item \textsuperscript{40} 410 U.S. 113 (1973).
\end{itemize}
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(1) Some states mandate that pharmacists and pharmacies must dispense EC regardless of their religious views ("must-dispense" regulations);\(^4\)

(2) Some states permit pharmacists and pharmacies to refuse to dispense EC if dispensing is contrary to their religious views ("no duty to dispense" regulations);\(^4\)

\(^4\) See 225 ILL. COMP. STAT. 85/19 (West 2010) ("Nothing contained in this Act shall be construed to prohibit a pharmacist licensed in this State from filling or refilling a valid prescription for prescription drugs which is on file in a pharmacy licensed in any state . . . ."); N.J. STAT. ANN. § 45:14-67.1 (West 2011) ("A pharmacy practice site has a duty to properly fill lawful prescriptions for prescription drugs or devices that it carries for customers, without undue delay, despite any conflicts of employees to filling a prescription and dispensing a particular prescription drug or device due to sincerely held moral, philosophical or religious beliefs . . . . If a pharmacy practice site does not have in stock a prescription drug . . . the pharmacy practice site shall offer . . . to locate a pharmacy that is reasonable accessible to the patient . . . and transfer the prescription there . . . ."); WIS. STAT. § 450.095 (West 2011) ("[A] pharmacy shall dispense lawfully prescribed contraceptives drugs and devices and shall deliver contraceptive drugs and devices restricted to distribution by a pharmacy to a patient without delay . . . .").

\(^4\) See ARK. CODE ANN. § 20-16-304(4) (West 2010) ("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 . . . ."); ARIZ. REV. STAT. § 36-2154 (West 2011) ("A pharmacy . . . or any employee of a pharmacy . . . who states in writing an objection to abortion, abortion medication, emergency contraception or any medication or device intended to inhibit or prevent implantation of a fertilized ovum on moral or religious grounds is not required to . . . participate in . . . emergency contraception or any medication or device intended to inhibit or prevent implantation of a fertilized ovum. The pharmacy . . . or employee of the pharmacy . . . shall return to the patient the patient’s written prescription order."); Colo. REV. STAT. § 25-6-102(9) (West 2010) ("No private institution or physician, nor any agent or employee of such institution or prescriber, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal."); FLA. STAT. ANN. § 381.0051(6) (West 2010) ("The provisions of this section shall not be interpreted so as to prevent a physician or other person from refusing to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons; and the physician or other person shall not be held liable for such refusal."); GA. CODE ANN. § 16-12-142(b) (West 2010) ("Any pharmacist who states in writing an objection to any abortion . . . shall not be required to fill a prescription for a drug which purpose is to terminate a pregnancy . . . ."); GA. COMP. R. & REGS. 480-5-.03(n) (West 2010) ("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."); MISS. CODE. ANN. § 41-107-5(1)-(3) (West 2010) ("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."); ME. REV. STAT. ANN. tit. 22 § 1903(3) & (4) (West 2009) ("No private institution or physician or no agent or employee of such institution or physician shall be prohibited from refusing to provide family planning services when such refusal is based upon religious or conscientious objection."); S.D. CODIFIED LAWS § 36-11-70 (West 2010) ("No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to: (1) Cause an abortion; or (2) Destroy an unborn child . . . . No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy . . . ."); TENN. CODE. ANN. § 68-34-104(5) (West 2010) ("No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptives procedures, supplies, and information when such refusal is based upon religious or conscientious objection . . . .").
And some states mandate that pharmacists and pharmacies must refer patients presenting an EC prescription to a different accepting pharmacy or pharmacist, and mandate that pharmacists return patients’ prescriptions (“referral” regulations).  

The first group, the must-dispense regulations, are highly contested by pharmacists and pharmacies. One of the most controversial must-dispense regulations was in Illinois. It required that “[u]pon receipt of a valid, lawful prescription for contraceptive, a pharmacy must dispense the contraceptive, or a suitable alternative permitted by the physician, to the patient or the patient’s agent without delay, consistent with the normal timeframe for filling any other prescription.” Illinois pharmacists and pharmacies challenged the rule in federal court, and later in Illinois’ Supreme Court, alleging that the rule violated their right to religious freedom and violated their religious beliefs that life begins at conception. Neither case resulted in a definitive ruling on the substantive issues. Illinois eventually repealed the regulation, replacing it with less demanding regulation which reads, “[U]nprofessional and [u]nethical conduct shall include, but not be limited to: [u]nreasonably refusing to compound a valid prescription.”

Like Illinois, the Washington State Board of Pharmacy in 2007 promulgated another well known and highly contested must-dispense regulation. The Washington regulation defined pharmacists’ unprofessional conduct as “destroy[ing] unfilled lawful prescription[s]; refus[ing]...

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43 See CAL. BUS. & PROF. CODE § 733(b)(3)(West 2010) (requiring a pharmacist to “dispense drugs and devices . . . pursuant to a lawful order or prescription unless . . . the [pharmacist] refuses on ethical, moral, or religious grounds to dispense a drug or device . . . A [pharmacist] may decline to dispense a prescription drug or device . . . if the [pharmacist] has previously notified his or her employer . . . and the [pharmacist’s] employer can without creating undue hardship, provide a reasonable accommodation of the [pharmacist’s] objection. The [pharmacist’s] employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the [pharmacist’s] refusal to dispense the prescription or order.”).

44 68 ILL. ADM. CODE 1330.91(j) (West 2005), amended by 68 ILL. ADM. CODE 1330.30 (West 2010).

45 Id.


48 68 ILL. ADM. CODE 1330.30 (West 2010).
to return unfilled lawful prescriptions; [or] violat[ing] a patient’s privacy.” 49 The regulation required pharmacists and pharmacies to “deliver lawfully prescribed drugs . . . in a timely manner consistent with reasonable expectations for filling the prescription.” 50 A Washington pharmacy and pharmacists challenged the regulation in the seminal case Stormans, Inc. v. Selecky.51 The pharmacy and pharmacists alleged that the Washington regulation “impinge[d] on their constitutional right of free exercise of religion, arguing that the rules force[d] them to choose between their religious beliefs as Christians and their livelihood.” 52 The District Court issued an injunction against the Washington must-dispense regulation; however, the Ninth Circuit Court of Appeals overturned the District Court’s injunction, ruling that the District Court based the injunction on the wrong legal standard and that the injunction was overly broad.53 Most interesting about Stormans is the Ninth Circuit’s dicta. Dictum is part of a court’s opinion that is not essential to the decision but is still regard as highly influential. 54 The Ninth Circuit’s dicta explained why Washington’s must-dispense regulation was in fact constitutional. The Ninth Circuit stated,

[T]he Free Exercise Clause “embraces two concepts[ ]–freedom to believe and freedom to act.” The first is absolute but, in the nature of things, the second cannot be. Conduct remains subject to regulation for the protection of society. . . . There is a general public interest in ensuring that all citizens have timely access to lawfully prescribed medications.55

In other words, the Ninth Circuit affirmed that pharmacists have the freedom to believe what they want about EC, but that pharmacists do not have the freedom to act by disadvantaging others because of their beliefs. Further, the Ninth Circuit insisted that, “[t]he mere possession of

49 WASH. ADMIN. CODE § 246-863-095(4) (West, 2010).
50 WASH. ADMIN. CODE § 246-869-010 (West, 2010).
51 586 F.3d 1109 (9th Cir. Wash. 2009).
52 Id. at 1138.
53 Id. at 1140.
54 BLACK’S LAW DICTIONARY 519 (9th ed. 2009).
55 Stormans, 586 F.3d at 1128, 1139 (citing Cantwell v. State of Conn., 310 U.S. 296, 303-04 (1940)).
religious convictions which contradict the relevant concerns of a political society does not relieve the citizen from the discharge of political responsibilities.” 56 *Stormans* is encouraging news for all women because the Ninth Circuit recognized that patients’ right to medication trumps professionals’ objection. The Ninth Circuit remanded the case to the District Court, where the District Court was to rule consistently with the Ninth Circuit’s opinion.57 Unfortunately, the District Court never reached a decision on the regulation’s constitutionality because on July 7, 2010, the Washington State Board of Pharmacy decided to amend the disputed must-dispense regulation.58 The board amended the regulation to require pharmacists only refer patients to another pharmacist or pharmacy, instead of requiring pharmacists to dispense.59 However, on November 4, 2010, the board again reevaluated and decided to go forward with the case leaving the disputed must-dispense regulation as is, thus instead of allowing pharmacists to refer patients, the regulation still requires pharmacists dispense despite objection.60 Until the District Court hears the *Stormans* case again on the new court date, November 28, 2011, 61 the must-dispense regulation remains in effect for all Washington pharmacists. Nevertheless, the Ninth Circuit’s dicta is predictive and suggests that must-dispense regulations are constitutional.

**III. MORE THAN COUNT AND POUR: CLINICAL DUTY TO DISPENSE WHEN A LEGITIMATE MEDICAL REASON EXISTS**

When a pharmacist denies a patients’ request for EC, pharmacists are asserting authority to change a prescribed treatment without patient or prescriber consent. Rulemakers should not

56 *Id.* at 1129 (citing Minersville Sch. Dist. v. Gobitis, 310 U.S. 586, 594-95 (1940)).  
57 *Id.* at 1142.  
58 *Stormans*, Inc. v. Selecky, No. C07-5374 RBL (9th Cir. July 12, 2010).  
59 *Id.*  
61 *Id.*
allow pharmacists to assert such broad authority to alter or refuse medication. Pharmacists’ authority to alter or refuse medication must be limited to prevent pharmacists from overstepping their clearly defined clinical role in patient care, which is to ensure that medication is safe and for a legitimate medical reason.

Pharmacist’s clinical role has recently increased. Pharmacists’ clinical role developed in hopes to utilize pharmacists’ knowledge of medications, reduce drug costs, decrease side effects, and improve both patient outcomes and drug adherence. Pharmacists’ clinical role allows them to provide services that other health care professionals traditionally performed, such as immunizations, diabetes counseling, asthma care, and general medication management.

State rulemakers seem to agree that pharmacists’ clinical roles should have clearly defined boundaries. In almost all instances when rulemakers regulate pharmacists’ clinical role, rulemakers require prescribers to remain primarily responsible for decision-making and allow prescribers the authority to override pharmacists’ clinical choices. For example, consider “therapeutic interchanges,” which allow pharmacists to use their clinical authority to change a prescribed medication. Even though therapeutic interchanges give pharmacists a considerable clinical role, pharmacists only have authority to change a medication to a specific different class.


63 Kyle R. Copeland, The Emerging Clinical Role of Pharmacy, PHARMACY TIMES OFFICE OF CONTINUING PROFESSIONAL EDUCATION, https://secure.pharmacytimes.com/lessons/201101-03.asp (last visited Mar. 12, 2011) (describing pharmacists as “ideal to monitor chronic diseases such as asthma, diabetes, hyperlipidemia, and hypertension, and provide routine immunizations.”)

64 See infra notes 65-67.
of drugs that do not significantly change a patient’s prescribed treatment, such as a brand-name drug to a generic drug.\textsuperscript{65} A prescriber can completely override pharmacists’ authority to perform a therapeutic interchange by directing the pharmacist to fill the prescription “as written.”\textsuperscript{66} One physician emphasized the theory that pharmacists’ clinical role should be limited by physicians or other prescribers when he stated that, “[p]rescription authority must always be in the hands of the physician. The pharmacist can aid in the process but not replace it.”\textsuperscript{67}

A. Limiting Pharmacists’ Clinical Role to Allow Pharmacists Authority to Refuse to Dispense Only When a Legitimate Medical Reason Does not Exist

There are only two instances when pharmacists’ clinical role should allow pharmacists authority to alter a medication or refuse to dispense. First, when altering the medication will have little adverse effect on patients’ prescribed care, or second, when a medication is unsafe or a legitimate, medically justified reason for refusing to dispense or altering a medication exists, such as drug allergies, inability to pay, an unsigned prescription, an altered prescription, suspicious drug seeking behavior, pregnancy, physician shopping, an illegible prescription, or prescriber error.\textsuperscript{68} Rulemakers should require pharmacists’ have a legitimate medical reason for refusing to dispense because medical reasons, not religious ones, should dictate what medication a patient receives. Requiring pharmacists to dispense lawful prescriptions despite their

\begin{itemize}
\item \textsuperscript{65} See Am. College of Clinical Pharmacy, 25 ACCP Position Statement Guidelines for Therapeutic Interchange, PHARMACOTHERAPY 1666, 1666-67 (2005) (describing therapeutic interchange as “dispensing of a drug that is therapeutically equivalent to but chemically different from the drug originally prescribed . . . [a]lthough usually of the same pharmacologic class . . . [i]n most cases, the interchanged drugs have close similarity in efficacy and safety profiles.”).
\item \textsuperscript{66} VIRGINIA POOLE ARCANGelo & ANDREW M. PETERSON, PHARMACOTHERAPEUTICS FOR ADVANCED PRACTICE: A PRACTICAL APPROACH 896 (Margaret Zuccarini et al. eds., 2d. ed. 2006) (describing strategies that block pharmacists from interchanging prescriptions).
\item \textsuperscript{67} Phyllis Maguire, Doctor-Pharmacist Collaborations: Cure for Errors or Threat to Autonomy?, ACP INTERNIST (March 2000), http://www.acpinternist.org/archives/2000/03/collab.htm (citing D. Craig Brater, FACP, chair, Council of Medical Societies).
\item \textsuperscript{68} See 21 C.F.R. § 1306.04(a) (2011) (using the “Legitimate Medical Purpose” standard to regulate controlled substances). \textit{See also} RICHARD R. ABOD, PHARMACY PRACTICE AND THE LAW 190 (David Cella et al. eds., 5th ed. 2008) (“Only prescriptions written for a ‘legitimate medical purpose’ in the ‘usual course of professional practice’ are valid under the law. [S]ome examples . . . include [f]raudulent or forged prescriptions . . . [p]rescriptions written by individual practitioners that exceed the usual course of their professional practice.”).
\end{itemize}
conscientious objection would not reduce pharmacists’ clinical role like Susan Winckler, Vice President of Policy and Communications for the American Pharmacists Association, argued when she stated, “You don’t need a pharmacist at all if you’re going to just require them to dispense medications. That takes away their clinical role.” 69 Pharmacists’ clinical role entails delivering patients the safest medication in the correct dose for a particular ailment, taking into consideration side effects and interactions, and providing advice. Pharmacists’ clinical role does not entail choosing which medication is morally appropriate for a patient.

B. Clinical Role in OTC Medications

All forms of EC, except Ella, are available OTC. 70 Pharmacists have their most extensive clinical role in OTC medication because prescribers are not even present or necessary for such transactions; thus, pharmacists are only accountable to their state’s requirements for dispensing. 71 Just because a medication is available OTC, does not mean that pharmacists can refuse the medication for any reason, and this was certainly not the rationale behind the FDA approving OTC medications. 72 The rationale behind approving a medication for OTC status is that the medications’ “benefits outweigh their risk, the potential for misuse and abuse is low, consumers can use them for self-diagnosed conditions, they can be adequately labeled, [and] health practitioners are not needed for the safe and effective use of the product.” 73

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70 Plan B Labeling Information, supra note 3, at 1; NEXT CHOICE, supra note 22; Ella Labeling Information, supra note 23, at 9.
72 See infra notes 72-73.
of EC allows for greater EC access that pharmacists should not be able to take away from their patients. Pharmacists should have the same clinical role in dispensing OTC medications as they do in dispensing prescription medications; pharmacists should only be able to refuse to dispense OTC medications when a legitimate medical reason exists for doing so. A legitimate medical reason for refusing EC available OTC would include: 1) to prevent a drug interaction; 2) if the patient is already pregnant; 3) if a patient will use the medication unsafely; 4) if the patient is 16 years old or younger; or 5) if the patient cannot secure payment.

C. Other Controversial Medications

Pharmacists’ ethical conflicts with medications are not just limited to EC. Ethical conflicts also arise when pharmacists dispense other controversial medications, such as physician-assisted suicide medications, placebo pills, syringes, erectile dysfunction medications, and AIDS medications. Regulations concerning other controversial medications support the theory that pharmacists should only be able to alter or refuse to dispense a medication when a legitimate medical reason exists. For example, consider controlled substances. Some pharmacists refuse to dispense controlled substances because of their potential for abuse and resale on the black market. One controlled substance regulation states that pharmacists’ clinical role in controlled substances is to ensure that the controlled substance prescription is for a “legitimate medical purpose.” “A prescription for a controlled substance . . . must be issued for a legitimate medical purpose . . . . The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the

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74 FDA Announces Framework for Moving Emergency Contraception Medication to Over-the-Counter Status, FOOD AND DRUG ADMINISTRATION, (April 30, 2009) http://www.fda.gov/ScienceResearch/SpecialTopics/WomensHealthResearch/ucm134291.htm (“Foremost in the Agency’s concerns is to establish a framework that strikes a balance between providing access to medicines considered safe and effective and ensuring the right policies are in place to promote their safe use.”).
pharmacist who fills the prescription.” 75 Thus, as Richard Abood, described in Pharmacy Practice and The Law, professional judgment of the pharmacist may warrant questioning the patient’s choice of drug, and “in an extreme case, may make a decision not to dispense the medication,” but “[d]ecisions to intervene and/or not dispense, however, should be based upon patient safety . . . .” 76 One court further described pharmacists’ clinical role as “[n]ot requir[ing] [pharmacists] to have a ‘corresponding responsibility’ to practice medicine. What is required of [pharmacists] is the responsibility not to fill an order that purports to be a prescription . . . [which the pharmacist] knows that the issuing practitioner issued it outside the scope of medical practice.” 77 Thus, rulemakers should not hesitate to require pharmacists to dispense when a medication is safe and legitimate because this requirement is already inherently part of pharmacists’ clinical role. Pharmacists are acting outside the scope of their clinical role when they refuse to dispense for religious reasons; pharmacists only have the clinical authority to alter a medication or refuse to dispense when the medication is illegitimate or unsafe.

IV. PROPOSED TREATMENT: ACTING IN PATIENTS’ BEST INTERESTS

The American Pharmacists Association described pharmacists as “health professionals who assist individuals in making the best use of medications.”78 In addition, pharmacists’

75 21 C.F.R. § 1306.04(a) (2011).
77 U.S. v. Hayes, 595 F.2d 258, 261 (5th Cir. 1979) (emphasis added). See also Ryan v. Dan’s Food Stores, Inc., 972 P.2d 395, 406 (Utah 1998) (explaining that pharmacists are not mandated to question every prescription but only when “a prescription that is irregular on its face—‘no date, no physician signature, an obviously toxic dose’ . . . requires further inquiry . . . . [A] pharmacist cannot use [a controlled substance regulation] as a basis to refuse to fill a prescription.”) (emphasis added).
primary job is to dispense medication. However, because pharmacists are professionals they inherently have additional professional obligations, other than just dispensing medication, that arise because of their professional status. In general, all medical professionals have a duty to act in their patients’ best interests. Medical professionals accept this increased duty because they receive high remuneration, respect from the community, and a monopoly over society’s health care. Patients and legislatures allow medical professionals to have a monopoly over health care because patients want safe and legitimate medical care when they need it, such as in an emergency, and patients want professionals whom they can trust with confidential information.

When pharmacists refuse to dispense, they are breaking their obligation to society to be dependable dispensers of medication and keepers of confidential information. Consider for example, a pharmacist in Nampa, Iowa, who refused to fill a patient’s prescription for Methergine, a drug used to stop bleeding after childbirth or an abortion. The pharmacist questioned the patient and the patient’s prescriber about whether the medication was being used to stop bleeding from an abortion. When the patient and the patient’s prescriber would not disclose the patient’s confidential information, the pharmacist refused to dispense the medication and refused to refer the patient to another pharmacist. Conscientious objectors like this Nampa pharmacist are inappropriately taking advantage of patients’ vulnerable situations. Not only are such pharmacists refusing to dispense when they know patients can only receive their prescriptions from pharmacists, they are also using patients’ confidential information to protest

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80 See Griffin v. Phar-Mor, Inc., 709 F. Supp. 1115, 1118 (S.D. Ala. 1992) (“Therefore, a patient wishing to fill a prescription is compelled to trust a pharmacist because the patient cannot legally have the prescription filled by a non-pharmacist.”).
82 Id.
83 Id.
abortion. Rulemakers should not allow pharmacists to take advantage of defenseless patients in this way, and must require pharmacists to act in their patients’ best interests. The best way to achieve this is through fiduciary duties.

A. Pharmacists as Fiduciaries.

Fiduciary duty is defined as “[a] duty of utmost good faith, trust, confidence, and candor owed by a fiduciary to the beneficiary [such as a patient]; a duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person.” The rationale behind requiring medical professionals to act as fiduciaries is that patients are particularly vulnerable. Rulemakers do not want professionals to use their superior bargaining power and knowledge to the disadvantage of patients. Traditionally, courts have not directly addressed the scope of pharmacists’ fiduciary duties to patients. A few courts have held that pharmacists have at least a fiduciary duty of confidentiality. An Alabama court described this relationship between a pharmacist and patient as one of “extreme trust” and that the “patient puts complete trust in the pharmacist to... fill the prescription in accordance with the doctor’s orders.”

This note proposes that rulemakers enact regulations that require pharmacists to act as fiduciaries toward their patients, protecting patients from the moment a prescriber writes a prescription to the end of the transaction when the pharmacist fills it. The compromise regulation this note proposes is simply requiring pharmacists to act in the best interests of their

84 BLACK’S LAW DICTIONARY 581 (9th ed. 2009).
85 Maxwell J. Mehlman, The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?, 25 CONN. L. REV. 349, 367-69 (1993) (explaining that fiduciary duties developed because of the unequal bargaining power between parties, and that to remedy this, fiduciary duties require the stronger party to refrain from using his or her superior power to take advantage of the weaker party and require that the stronger party act in the weaker party’s interests).
patients. Pharmacists’ fiduciary duties do not require a strict must-dispense type regulation if referral is possible. If referral is possible, pharmacists have acted in a patient’s best interests. However, the referral must be both in a timely manner and within a reasonable distance to satisfy pharmacists’ fiduciary duties. If referral is not possible, the burden should not be on patients to find a potential solution. Pharmacists must maintain primary responsibility to act in patients’ best interests and dispense the medication. Because pharmacists are required under the proposed compromise regulation to dispense if they cannot refer patients to another pharmacy or pharmacist, pharmacists will work harder at finding a referral, and thus providing patients with better access to medications.

B. Pharmacists’ Fiduciary Duties When Pharmacies Refuse to Stock EC

Inevitably, some pharmacies may refuse to stock EC when faced with the compromise regulation proposed in this note.88 Stormans made it clear that “[no] single pharmacy [may] be required to stock every single medication that might possibly be prescribed, or to maintain specialized equipment that might be necessary to prepare and dispense every one of the most recently developed drugs.”89 Today, most large retailers like CVS and Wal-Mart stock EC; therefore, almost all communities will have access to EC even if pharmacists are required to dispense despite objection.90 However, smaller pharmacies may refuse to stock EC. To remedy this, rulemakers should continue to require pharmacists to act as fiduciaries towards their

89 Stormans, Inc. v. Selecky, 586 F.3d 1109, 1135 (9th Cir. 2009).
90 Plan B Is Now Available Without a Prescription, CVS PHARMACY, http://www.cvs.com/CVSApp/promoContent/promoLandingTemplate.jsp?promoLandingId=1031 (last visited Mar. 11, 2011) (stating that Plan B is available at CVS pharmacies); Wal-Mart to Carry Plan B Emergency Contraception, WAL-MART CORPORATE (Mar. 3, 2006), http://walmartstores.com/pressroom/news/5665.aspx (describing Wal-Mart’s recent reverse of its policy not to carry EC after feeling pressure from various states. “[T]he fact that this is an FDA-approved product, we feel it is difficult to justify being the country’s only major pharmacy chain not selling it.”).
patients. Thus, pharmacists at pharmacies who refuse to stock the EC must continue to provide a dependable referral for patients, even though those pharmacists would not have the ultimate obligation of dispensing if referral is not possible, like those that stock EC under the proposed compromise regulation. However, rulemakers may need to consider further regulating pharmacies that refuse to stock EC. Future regulations could include requiring pharmacies to post conspicuous notice to patients that the pharmacy does not stock EC, or requiring pharmacies to stock EC if community demand meets a predetermined level.

V. PRESCRIBED REGIMEN: STATUTORY PROPOSALS

There are two ways that rulemakers can protect patients from objecting pharmacists. First, rulemakers should enact regulations that require pharmacists to dispense medication if referral is impossible. Second, rulemakers must ensure that pharmacists’ uphold their professional obligations to patients by requiring pharmacists to act as patients’ fiduciaries. Below are the proposed regulations that provide a workable balance between the interests of pharmacists, pharmacies, and patients.

Compromise Regulation

A pharmacist has a duty to dispense all lawful prescriptions and over-the-counter medications without undue delay, unless the medication is unsafe or a legitimate medical reason exists for refusal. A pharmacist with a sincere moral opposition to any medication may refer the patient to another pharmacist or dispensing entity within a reasonable time and distance. If the pharmacist cannot locate any other pharmacy or entity that the pharmacist knows will dispense the medication to the patient, the pharmacist must dispense despite his or her objection if the pharmacy stocks the medication.

A Pharmacist’s Fiduciary Duty

A pharmacist shall act as a fiduciary towards his or her patients. A fiduciary must act with utmost good faith and loyalty to put the interests of the patient above his or her own whenever reasonable. A pharmacist’s fiduciary duty requires the pharmacist to dispense medication despite his or her objection when either referral to a pharmacist or dispensing entity within a reasonable time and distance cannot be achieved.
CONCLUSION

“The question here is whose conscience counts. This is about a woman’s most
fundamental right of choosing when to have a child.” 91 A solution that meets all pharmacists’
and patients’ needs will never be achieved, but the ideal solution must balance patients’ right to
medication and pharmacists’ freedom of religion while prioritizing patient safety and medication
access, without completely disregarding pharmacists’ religious beliefs. Ultimately, conscientious
objectors must accommodate patients and fulfill their foremost professional
obligation—providing patients with access to safe and legitimate medications.

91 Sarah Sturmon Dale, Can a Pharmacist Refuse to Dispense Birth Control?, TIME (June 7, 2004), available at
http://www.time.com/time/magazine/article/0,9171,994380,00.html (citing Gloria Feldt, president of Planned Parenthood).