Pharmacists and the Duty toDispense Emergency Contraceptives

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Pharmacists and the "Duty" To Dispense Emergency Contraceptives

Jennifer E. Spreng, J.D.*

ABSTRACT: Stories abound of both women with prescriptions turned away at the pharmacy door and members of the most trusted health care profession losing jobs and running afoul of ethics rules. Scholars have spilt much intellectual ink divining whether a pharmacist must dispense Plan B, the primary emergency contraceptive. Now, many are calling for a common law "duty to dispense" that could serve as a foundation for a wrongful pregnancy action against a dissenting pharmacist.

Such a duty simply does not arise from established tort principles or pharmacist-specific precedents. Only in rare circumstances will a pharmacist and customer have the type and quality of relationship giving rise to a duty to dispense.

Nevertheless, law changes over time and makes allowances for unique circumstances. Pharmacists are taking on more responsibility for drug therapy. They have an awkward role in the distribution of Plan B. Moreover, while the law may protect pharmacists' consciences, it may not be so receptive to pharmacists-as-activists. Dissenting pharmacists can take practical steps to protect themselves today, but tomorrow is another day.

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Any errors are obviously my own.
"We're happy, but we're not thrilled," said Frank Manion, a senior attorney for the American Center for Law and Justice and the attorney for several southern Illinois pharmacists suspended without pay from their jobs at a Walgreens store after they refused to comply with the company policy to distribute Plan B, a form of emergency contraception. Manion was referring to a mid-October 2007 settlement of a lawsuit against the state of Illinois, with Walgreens as intervening plaintiff, challenging an Illinois regulation that some pharmacists believed virtually forced them to violate their religious beliefs. "It's not exactly what we had looked for," Manion said to explain his enigmatic reaction. "What we had wanted was a full and unambiguous recognition of the right of conscience by the state." Instead, the settlement will save many pharmacists' jobs, but it will not relieve pharmacies from their obligation under Illinois regulations to sell emergency contraception.

The Illinois Pharmacists Association was perhaps even less thrilled than Manion about the half-way house result in this primary legal challenge to one of the strictest "must fill" regulations in the country. Spokesman Michael Patton argued that the settlement circumvented the real issue: whether pharmacists have a legal right not to perform services that violate their religious beliefs. Moreover, the settlement does little for small pharmacy owners lacking staff or colleagues to make sure women receive the drug.

Contraceptives create complex legal and moral issues for many pharmacists. Evidence supports the claim that oral contraceptives taken daily or on an emergency basis are abortifacients, but state statutes do not provide pharmacists with the same protection from participating in abortions that they do physicians, nurses and other health care professionals. Refusing to dispense contraceptives based on religious scruples has cost many pharmacists their jobs. Government leaders are pursuing "must fill" legislation and regulation that would force some pharmacists

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4 "Morning After" Pill Suit, BELLEVILLE NEWS-DEM., supra note 1.
6 Id.
7 Id.
8 "Morning After" Pill Suit, supra note 1.
9 Strong evidence supports their view – even contraception advocates concede that the Yuzpe protocol of emergency contraception has the post-fertilization effects that concern refusing pharmacists. See infra text and note at 75.
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to choose between their careers and their consciences. Some states find other ways to make practicing pharmacy consistent with sincerely held religious beliefs difficult. Commentators argue refusal to dispense is sex discrimination actionable under public accommodations laws, which threatens pharmacy owners, many of whom are themselves women. One pharmacist received professional discipline for refusing to dispense contraceptives. Opinion-makers are often extremely hostile, and abortion rights activists talk as though they would like to eliminate religious believers from the health care industry.

Tort law is a brighter spot in the law for pharmacists. Some commentators argue that pharmacists are at risk of wrongful conception or other common law


13 E.g., Cal. Bus. & Prof. Code § 733(b) & (c) (requiring a pharmacist to fill all prescriptions with a clause protecting conscience only to the extent of Title VII); Ill. Admin. Code tit. 68, § 1330.91(j) (creating a regulatory duty to fill contraceptive prescriptions); Minn. R. 6800.2250(C) (prohibiting pharmacists from refusing to dispense a prescription reasonably expected to be dispensed in pharmacies).


15 Wisconsin Department of Regulation & Licensing, Press Release (May 1, 2005) (stating that Neil Noesen was reprimanded and his pharmacy license limited because he “failed to clearly inform the managing pharmacist that he would not transfer a prescription for oral contraceptives, and failed to provide information to a patient regarding her options for obtaining a refill of her prescription which he refused to dispense or transfer”).

16 E.g., Jabari Asim, Conscience Behind the Counter, washingtonpost.com (Apr. 5, 2005) (arguing that “[i]f your personal beliefs hinder your ability to do your job, it may be prudent to look into another line of work”); Ellen Goodman, Dispensing Morality, washingtonpost.com (Apr. 9, 2005) (arguing that “the drugstore is not an altar. The last time I looked the pharmacist’s license did not include the right to dispense morality”).

17 For example, the ACLU says its goals are to “avoid[] impositions on people who do not share the beliefs that motivate the refusal, and protect[] the religious practices of insular sectarian institutions while insisting on compliance with general rules in the public, secular world.” ACLU Reproductive Freedom Project, Religious Refusals and Reproductive Rights (2002) (emphasis added). That sort of language will not convince anyone of the ACLU’s tolerance or evenhandedness. See also Susan Berke Fogel & Lourdes A. Rivera, Saving Roe Is Not Enough: When Religion Controls Healthcare, 31 FORDHAM URB. L.J. 725 (2004) (“Religious restrictions on health care services are based on religious beliefs and doctrine, not on scientific research, medical trials, or health outcomes. While it is appropriate for individuals to decide what role religion will play in their personal health care decisions, it is not appropriate for corporate health care entities to impose those beliefs on physicians and patients and the communities they serve in a manner that supplants sound medical decision making and patients’ rights”); Claire A. Smearman, Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists, 48 ARIZ. L. REV. 469, 525 (2006) (quoting with approval Rebecca Cook’s description of the view that human life begins at fertilization as “theo-physiology”).
liability to potential customers if they refuse to sell the drugs. Though fourteen states provide some conscience protection for pharmacists, only six give them a defense to civil liability. Some of these statutory conscience protections could run afoul of the Establishment Clause of the United States Constitution. Nevertheless, despite uncertainty as to pharmacists' defenses, a plaintiff's prima facie case is far more speculative, because as this article will discuss, there is no generalized common law duty to sell a woman a drug. Without a duty, there is no tort liability.

Protecting refusing pharmacists on both the front and back ends of civil litigation is also a critical public policy issue: pharmacies simply cannot be staffed without them. They make up a huge portion of what is already a profession stretched thin. National surveys from the past decade show that more than thirty-five percent of pharmacists say they would refuse to dispense an abortifacient, and the number increases to almost forty-five percent in certain regions, such as the midwest and southeast. A 2000 study, conducted at approximately the same time the “emergency

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22 See Conscientious Objectors, supra note 20.


25 See Jed Miller, The Unconscionability of Conscience Clauses: Pharmacists’ Consciences and Women’s Access to Contraception, 16 HEALTH MATR 237, 240 (2006) (reviewing surveys). Admittedly, most of the surveys discussed in Mr. Miller's article are more than ten years old, but attitudes may not have
contraceptive" drug "Plan B" received approval from the Food and Drug Administration, showed that one-fourth of the pharmacists in New Jersey and one-fifth in Oregon had reservations about dispensing emergency contraceptives, though only four and ten percent respectively would refuse to dispense. A more recent study conducted in 2005 in Atlanta, Philadelphia and Boston produced similar results. These dissenting pharmacists are at serious risk of liability: when pharmacists use independent judgment when dispensing medication or deny a customer prescribed medication, they attract lawsuits.

This article identifies key facts and crafts legal theories to support litigators' arguments that pharmacists do not have common law duties to sell emergency contraception that could leave them exposed to liability for torts such as wrongful conception. Because tort law is always a moving target, the article also describes plausible counterarguments and strategies for meeting them. Part one describes the two forms of emergency contraception and their mechanisms of use. Part two describes three variables that will drive pharmacists' legal duties arising from emergency contraception: continuing changes in the pharmacy profession; the Food and Drug Administration's recent decision that the primary emergency contraceptive regimen, Plan B, may be sold without a prescription; and the distinction between passive conscientious objection to the sale of emergency and daily oral contraceptives and actual civil disobedience or activism on the job. Part three "clears away some of the brush" by showing how oft-cited cases of constitutional moment reveal no discernable duty to dispense. Part four analyzes pharmacists' duties from leading cases, assessing their applicability in a tort action for wrongful conception/pregnancy. Part five reviews statutory and regulatory duties and their applicability as sources for a duty to dispense. The article concludes that many pharmacists can be confident in the short term that a wrongful conception/pregnancy action will fail on the duty element, but as predictable circumstances change, courts might be inclined to impose duties. Therefore, the article also sug-

26 Conrad, supra note 25.
28 S. Craig Smith, Meeting the Defenses, TRIAL, May 1998, at 58.
29 E.g., supra note 18.
30 See infra at p. 222.
31 See infra at p. 228.
32 See infra at p. 233
33 See infra at p. 241.
34 See infra at p. 243
35 See infra at p. 250.
36 See infra at p. 261.
37 See infra at p. 273.
gests along the way several strategies refusing pharmacists may wish to consider to minimize their exposure.

Too many commentators create the false impression of a zero sum game where women's reproductive health care and the religious scruples of providers are involved. Most in the academic literature who write about pharmacists and contraceptives focus on winners and losers or rallying the faithful of whatever persuasion, though a few are genuinely interested in determining the substance of the various players' rights and making realistic policy proposals. Though this article focuses on defending those who refuse to dispense contraception based on conscience, it does not take the two-dimensional view that women's concerns are unimportant or need to be vanquished so that those of pharmacists can prevail. Within a few years, most pharmacists will be women, and women predominate among religious


39 Among those with intriguing ideas include the following: Melissa Duvall, Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women, 55 Am. U.L. Rev. 1485 (2006) (thoughtfully weighing burdens on both pharmacists and women arising from distribution of emergency contraception); Heather M. Field, Increasing Access to Emergency Contraceptive Pills Through State Law Enabling Depending Pharmacist Prescribers, 11 U.C.L.A. WOMEN'S L.J. 141 (2000) (proposing increased access to emergency contraceptives by enhancing pharmacist prescribing authority, which would indirectly result in fewer women seeking the drug from pharmacists who do not want to distribute it); Natalie Langlois, Life-Sustaining Treatment Law: A Model for Balancing a Woman's Reproductive Rights with a Pharmacist's Conscientious Objection, 47 B.C. L. Rev. 815 (2006) (relying on an analogy with the law requiring transfer of a patient from a refusing facility if she does not want additional life-preserving treatment or sustenance); Vischer, supra note 38 (proposing minimal state regulation in the area so that the pluralist marketplace of ideas can operate); Tom C.W. Lin, Treating an Unhealthy Conscience: A Prescription for Medical Conscience Clauses, 31 Vt. L. Rev. 105, 131-34 (2006) (employing law and economics analysis); Matthew White, Conscience Clauses for Pharmacists: The Struggle to Balance Conscience Rights with the Rights of Patients and Institutions, 2005 Wis. L. Rev. 1611 (2005) (advocating a number of "split-the-difference" solutions, such as transferring prescriptions to non-objectors; allowing pharmacists to refuse for any conscience-related reason; requiring pharmacists to give notice to both employers and customers of what drugs they will and will not dispense; punishing pharmacists who confront woman seeking emergency contraception); Jessica Yoder, Pharmacists' Right of Conscience: Strategies for Shaping Respect for Pharmacists' Beliefs While Maintaining Adequate Care for Patients, 41 VAL. U.L. Rev. 975 (2006) (proposing specific statutory language that would protect conscience rights if pharmacists inform employers of their religious concerns and refer patients or transfer prescriptions to non-objecting pharmacists).

40 As at least one commentator notes, this zero-sum conception of the needs and rights of both groups may arise from fears on both sides that to concede a battle may be to lose a war and is thereby limiting progress for all. Brietta Clark, When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict, 82 OR. L. Rev. 625, 631 (2003).

practitioners. Protecting religious liberty protects liberty unmodified, including contraceptive rights. Determining pharmacists' legal rights also indirectly elucidates those of their customers, rendering legal disputes between them less likely by making the outcome more predictable. Only to those who seek to use courts to change public policy is this not a positive development.

Most importantly, however, one's views of women's infinite aspirations and how society could encourage and promote them are not functions of whether one has some sympathy for refusing pharmacists. It is tragic that those who purport to speak for women think that such a dynamic and diverse group of human beings who make up more than one-half of the world's population must smite the comparatively limited needs of refusing pharmacists in order to achieve their own fulfillment. This cannot be so. The same communitarian values that would respect the needs of refusing pharmacists are foundational to women's flourishing, too.

Therefore, a foundational principle of this work is that protecting pharmacists' conscientious objection protects women: the women who are half of all pharmacists, the women who are quite comfortable with a pharmacist whose ethics are consistent with their own, and ironically, the women who value access to contraception, which is better protected when flourishing religious institutions and their members serve as mediating institutions to blunt the activities of a far-more-imposing state. “Women” are not a monolithic group. Failure to acknowledge this underscores the reality that access to emergency contraception may be less a matter of rights entitlement than an eloquent symbol of everything emanating from conditions when women as human beings are least valued.

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42 The Barna Group reports that 50 percent of American women as opposed to 44 percent of American men on any given weekend have attended a religious service that is not a wedding, funeral or some other special event. See The Barna Group, Church Attendance, available at http://www.barna.org/FlexPage.aspx?Page=Topic&TopicID=10 (last visited Jul. 21, 2007). I have seen statistics citing differentials as great as almost two to one.


46 See supra note 23.

47 That many pro-life patients prefer pro-life doctors is evident from the number of pro-life medical professionals' groups that make physician searches available. See, e.g., http://www.aaplog.org/ (website of the American Association of Pro-Life Obstetricians and Gynecologists).


49 Abortion and Divorce Law, supra note 45, at 155-81.

50 It runs to almost epidemic levels that those speaking on behalf of “women” will claim their personal policy preferences benefit all women while it is easily demonstrable that they benefit very
The Problem:
Emergency Contraception and Its Mechanisms of Action

The term “emergency contraception” can refer to either hormonal drugs taken within 72-120 hours after intercourse for the purpose of preventing pregnancy or “off-label” use of oral contraceptive pills normally taken one a day throughout a cycle. Though many people refer to emergency contraception as “the morning after pill,” this term is misleading. Emergency contraception is a series of pills that can be efficacious if the regimen begins within 72 hours of intercourse, though earlier is better.

The names and significance of the biological events that occur in the first two weeks after an instance of sexual intercourse that will ultimately result in a pregnancy are subjects of considerable dispute. “Fertilization,” or the colloquial term, “conception,” usually refers to the union of a male sperm and female ovum.
which produces a “zygote.” Some believe that pregnancy begins at this time, and the zygote formed is worthy of some if not considerable human rights protection. Others believe a pregnancy, and a being worthy of human rights protection, does not exist until more than a week later, after the zygote has traveled up the mother’s Fallopian tube and implanted in her uterus. State statutes and jurisprudence are also fractured on this point. Nevertheless, the contentious debate over vocabulary probably has less significance for pharmacists’ tort duties than appears at first glance; it is much more relevant to a pharmacist’s claims to religious liberties defenses.

The various forms of emergency contraception have “pre-fertilization effects” that stop zygotes from forming at all: suppressing ovulation, thickening the cervical mucus, and movement of the Fallopian tubes. Though not abortifacient, however, pre-fertilization effects do have moral significance. Roman Catholics, for example, have serious moral concerns about emergency contraception, because all contraception interferes with the unitive and procreative purposes of sexual intercourse bound up with the ideal of self-giving love between husband and wife. A pharmacist may conscientiously object to dispensing emergency contraception on the basis of its pre-fertilization effects.

More contentious are allegations that emergency contraception has “post-fertilization effects.” The post-fertilization period is divisible into the period between fertilization and implantation and then the period after implantation. If a form of emergency contraception has a post-fertilization effect, those who believe a new human life begins at conception would label the effect abortifacient. The most cited such possible effect is thinning of the uterine lining, which makes implantation of a fertilized zygote more difficult. Whether emergency contraception acts to interfere with implantation remains disputed and may depend on the regimen at issue.

56 Id. at 626.
57 E.g., CONGREGATION FOR THE DOCTRINE OF THE FAITH, RESPECT FOR HUMAN LIFE (issued Feb. 22, 1987); Robert L. Stenger, Embryos, Fetuses, and Babies: Treated as Persons and Treated with Respect, 2 J. Health & Biomedical L. 33, 66 (2006) (arguing from moment of conception zygotes should be treated “with respect” as human lives but perhaps not as human beings).
58 See Weisser, supra note 18, at 870-71.
61 I describe these in depth in a companion piece. See Conscientious Objectors, supra note 20.
62 Id. See generally JOHN PAUL II, MAN AND WOMAN HE CREATED THEM (Michael Waldstein, ed., 2006); BENEDICT M. ASHLEY, JEAN DEBLOIS & KEVIN O’ROURKE, HEALTH CARE ETHICS: A CATHOLIC THEOLOGICAL ANALYSIS 73-86 (2006); PAUL VI, OF HUMAN LIFE (issued Jul. 25, 1968)
64 Even proponents of emergency contraception concede that the “Yuzpe method” has a post-fertilization effect. E.g., David A. Grimes & Elizabeth G. Raymond, Emergency Contraception, 117 Pediatrics 1448, 1448 (2006). Whether Plan B has such an effect is not clear. E.g., Kahlenborn, supra note 60, at 468. Interestingly, even some American Catholic bioethicists inclined to support the
Some consider the term "emergency contraception" itself to be a bit of a misnomer, arguing that it is neither for an "emergency" nor a "contraceptive." The potential post-fertilization effect converts such drugs from "contraceptives" to "abortifacients." Moreover, while the Plan B regimen decreases the pregnancy rate after unprotected intercourse from approximately eight percent to one percent, an eight percent risk of pregnancy is not an "emergency," in light of evidence showing that only three percent of women who had experienced condom breakage, two percent of inconsistent condom users and one percent of inconsistent pill users had used emergency contraception as a backup. After all, a woman does continue to have other legal options, such as medical or surgical abortion and carrying the child to term, in the unlikely chance that she becomes pregnant.

One thing is very clear, however: conversations about emergency contraception quickly become mired in even the most basic efforts to define terms. Happily, it is at least possible to describe the various methods of emergency contraception with reasonable agreement.

**Off-label Emergency Contraception: The “Yuzpe Method”**

For several decades, the primary form of emergency contraception was the "Yuzpe method," named after the doctor who first prescribed it in the 1970s. The Yuzpe method is a combination of numerous daily oral contraceptive pills taken in larger doses than recommended in FDA-approved labeling. The woman takes one half of the dose within 72 hours of intercourse and the other half twelve hours later.
hours later. Its effectiveness rate may be as low as 50-66 percent. Statistical data indicates that the Yuzpe method must have at least some mechanism of action other than prevention of ovulation, some of which would be post-fertilization or to some, abortifacient effects. The Yuzpe method is also no fun for the user. Fifty percent of users report nausea—with vomiting in twenty percent of cases—as well as headaches, breast tenderness, abdominal pain and dizziness.

In the late 1990s, the Food and Drug Administration approved a product based on the Yuzpe regimen, the “Preven Emergency Contraceptive Kit.” After the FDA approved Plan B, an even more effective regimen with fewer side effects, Preven’s manufacturer voluntarily withdrew it from the market in light of Plan B’s fast-growing popularity. A doctor may still prescribe and a woman may still use a Yuzpe method regime, but only by putting together the appropriate daily oral contraceptive pills.

**RU-486: Emergency Contraceptive and Medical Abortion**

A drug with a wider range of effects is mifepristone, often known by its brand name, RU-486. The FDA approved RU-486 in September 2000 primarily for the purpose of inducing medical abortions at up to forty-nine days gestation. As approved by the FDA, the RU-486 regimen involves oral ingestion of 600 mg of mifepristone and then two days later, of 0.4 mg of another drug, misoprostol. The mifepristone operates to terminate the pregnancy by detaching the embryo or fetus from the uterine wall where it had previously implanted, and the misoprostol then induces contractions to expel the fetus and other products of conception from the uterus. The drug is 96 percent effective as an abortifacient.

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73 Id.
74 Joseph B. Stanford & Rafael T. Mikolajczk, Letter to the Editor: Emergency Contraception, 117 PEDIATRICS 1448, 1448 (2006); see also, J. Trussell, et al., Estimating the Effectiveness of Emergency Contraceptive Pills, 67 CONTRACEPTION 259 (2003). Efficacy measurements for emergency contraception can be confusing to understand. One approach is to prescribe the drug to a group of women after intercourse, count the number of pregnancies, and divide by the number of women, which allows a doctor to tell a patient how likely it is that she will get pregnant, no doubt her primary concern. On the other hand, many such women would not have gotten pregnant even if they had not followed the particular emergency contraception regime. Better studies are crafted to calculate a proportionate reduction in pregnancy as a result of using the regime. Ellerton, supra at 72.
75 Grimes & Raymond, supra note 64, at E-182.
76 Ellerton, supra note 72.
77 Melanie A. Gold, Emergency Contraception: To the Editor, 117 PEDIATRICS 1448-50 (Apr. 4, 2006).
78 Planned Parenthood Cincinnati Region v. Taft, 444 F.3d 502, 505 (6th Cir. 2006).
79 Id. A protocol of 200 mg of mifepristone and 0.8 mg of misoprostol, an off-label regimen known as the “Schaff protocol,” can induce an abortion at up to sixty-three days gestation, and both the AMA, id. at 505-06 & n.2, and the American College of Obstetricians and Gynecologists, Planned Parenthood Cincinnati Region, 444 F.3d at 506 n.2, encourage this latter usage because of its higher rates of efficacy and fewer side effects.
80 Taft, 444 F.3d at 505 n.1.
81 Wyser-Pratte, supra note 70, at 1133.
Research shows that varying doses of mifepristone have a contraceptive effect if administered within 72 hours post-intercourse, but the side effects are particularly unpleasant, and it is questionable whether women would choose it over Plan B within the 72-day window when Plan B is efficacious. RU-486 protocols may also have post-fertilization but pre-implantation effects as well, depending on when they are ingested during the ovulatory cycle. Among other mechanisms, they seem to interfere with endometrial development, rendering implantation more difficult, and apparently the effect increases as the dose size increases. Partly because mifepristone is so closely associated with abortion and also because patients' eyes bulge at its cost, side effects, and complex regimen of office visits and follow up, doctors shy away from prescribing it, especially when other forms of emergency contraception such as Yuzpe and Plan B are available.

**Plan B**

Plan B is an emergency contraception regimen of two doses of 0.75 mg of levonorgestrel taken twelve hours apart. It can be effective if commenced up to 72 hours after intercourse, but according to the label, the regimen's efficacy increases the sooner it begins. Among the many attractions of the regimen are the decreased likelihood of unpleasant side effects and the higher efficacy rate compared to the Yuzpe method.

**Post-fertilization effects: hotly disputed**

That they know Plan B prevents or terminates pregnancies does not mean

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84 Id. at 345 & 346.
86 Cramping and bleeding are "expected with this treatment" in amounts that would certainly concern most women. See FDA PATIENT INFORMATION SHEET, supra note 83. Five to eight percent of women using the regimen will still need a surgical procedure to end the pregnancy or stop the bleeding. *Id.* More serious side effects are possible, and the FDA recently became aware of four women who died of sepsis after using RU-486, an infection of the bloodstream known to be a potential side effect of any form of abortion. *Id.*
87 RU-486 requires at least three office visits to complete the regimen. *Id.*
88 *Where to Get RU-486, supra* note 85. This resource discusses the results of a September 24, 2001 Kaiser Family Foundation survey indicating that only 1 percent of general practitioners and 6 percent of gynecologists gave RU-486 to patients in the first year it was available in the United States. Only 12 percent of abortion specialists offered the drug. In the Kaiser survey, 37 percent of gynecologists said they personally opposed its use, and some doctors were concerned about protests or violence, but more practical concerns predominated the decision not to prescribe the drug such as "a lack of patient demand" (62 percent), "not interested in performing abortions" (49 percent—interestingly, a larger number than those doctors personally opposing its use), and not having available space for women who must stay on site after taking the pill in order to await its effects (48 percent).
89 Carton Text, supra note 66.
90 *Id.*
residents know how. Evidence supports the conclusion that Plan B has a post-fertilization effect despite the difficulty of proving it. The Yuzpe method and Plan B work primarily by stopping ovulation, but studies show that the Yuzpe method does not do so consistently, which means that at least the Yuzpe form of emergency contraception must have other effects. When Plan B is administered after ovulation—so that the drug could not operate to stop ovulation—substantially fewer pregnancies occur than would have been expected if Plan B had no effect other than to stop ovulation. Other variables could explain the difference, but not necessarily all of it.

Plan B could have several post-fertilization effects. One of the most likely would be to damage the endometrium of the uterus so that a blastocyst could not survive. The drug contains one of the same hormones as in oral contraceptives, which impair the uterus' receptivity of the blastocyst for implantation. Daily oral contraceptives are also known to decrease the thickness of the endometrium, making implantation more difficult, though not necessarily impossible. Even those convinced of Plan B's merits do not rule out post-fertilization effects. Moreover, the widely held assumption is that Plan B does have such effects, even among those with no incentive to promote the theory. According to the Food and Drug Administration and Barr Pharmaceuticals, Plan B's manufacturer, Plan B "works mainly by preventing ovulation . . . [and] it may also prevent . . . attachment of a fertilized egg to the uterus . . . ." Manufacturers of the French drug NorLevo, essentially the same as Plan B, say that one of its mechanisms of action is "modification of the uterine lining," which renders implantation, not

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92 Gemzell-Danielsson & Marions, supra note 82, at 342; Grimes & Raymond, supra note 64, at E-181 (calling mechanisms of action of a variety of forms of emergency contraceptives, including Plan B, "not well understood").
93 Kahlenborn, supra note 60, at 468.
94 Id. at 467.
95 Id.
97 Id.
98 American Academy of Pediatrics, supra note 52, at 1028-29.
99 Davidoff & Trussell, supra note 60, at 1777.
100 E.g., Grimes & Raymond, supra note 64, at E-182. (conceding that studies show post-fertilization effects in both pre- and post-intercourse oral contraceptives).
101 This information comes from the packaging of Plan B as approved by the FDA. Carton Text, supra note 66.
102 This information comes from the Frequently Asked Questions on the NorLevo website, http://norlevo.com/general_english/Faq.htm (last accessed on Jul. 14, 2007). How seriously it should be taken is unclear. For example, the FAQs also state that there is no "safe period" in a woman's monthly cycle. In fact, most of a woman's cycle is "safe." A woman cannot conceive except when an egg and a sperm are in close proximity, approximately six days, depending on the time of intercourse, which fertility awareness experts increase to ten to create an even greater comfort zone for those using natural family planning to avoid pregnancy. Toni Weschler, Taking Charge of Your Fertility 50-51, 111 (1995). The problem is that unless a woman is engaged in a regular pre-intercourse temperature-
fertilization, more difficult. When NorLevo was introduced in Italy, its supporters told Vatican officials that the drug was not an abortifacient because it had only "anti-implantation [read: potentially post-fertilization] effects," hardly the most politically astute response if the drug had only pre-fertilization effects.

Unfortunately, it is difficult if not impossible to measure Plan B's post-fertilization effect directly, because methods to measure the loss of zygotes prior to implantation are still in their infancy. Nevertheless, while a better understanding of the first moments after conception might change some pharmacists' legal and ethical calculus when assessing whether to distribute Plan B, some would still refuse on other grounds. Disagreements about pre- and post-fertilization effects are important to understanding pharmacists' scruples, and while they may not change legal duties, they cannot do so if judges do not understand them.

Distribution of Emergency Contraception: Pharmacists on the Front Lines

Though pharmacists' legal duties to customers remain constricted, courts' views of whether pharmacists have a duty to dispense or sell emergency contraception over time will turn on three variables. The first is a profound shift still ongoing in the pharmacy profession away from serving merely as dispensers of drugs, never questioning a physician's directions and exercising as little discretion as possible, to that of "pharmaceutical care," wherein pharmacists take a lead role in planning and administering patients' drug therapy as well as substantial responsibility for the results. More responsibility and discretion will inevitably affect courts' assessment of pharmacists' duties.

The second variable is the Food and Drug Administration's recent decision to make Plan B available without a prescription but only from "behind-the-counter." Pharmacists' duties to customers related to non-prescription, behind-the-counter drugs are still unexplored. Most cases defining pharmacists' duties address their taking and cervical fluid monitoring regime, she will not know after sex if she could have conceived. Id. at 113-23. NorLevo explains the facts in a way that is technically correct but ideally suited to encourage sales. That alone should raise the possibility that the post-fertilization effect is greater than the company suggests.

104 See Kahlenborn, supra note 60.
105 See Pontifical Academy for Life, Statement on the So-called "Morning-After Pill" (Oct. 31, 2000).
106 Larimore, supra note 97, at 127.
107 Ashley, et. al, supra note 62, at 85.
109 See, e.g., Pittman v. Upjohn Co., 890 S.W.2d 425, 434-35 (Tenn. 1994) (discussing ideals of pharmacy care from regulations and ethics experts in process of finding duty to warn).
110 Memorandum from Steven Galson to NDA 21-045, S-011 file, re: "Plan B" (Aug. 24, 2006), at 1-2 (hereinafter "Galson Memo").
111 The other well-known "behind-the-counter" drugs are ephedrine and pseudoephedrine, ingredients in cold medications such as Sudafed and also methamphetamine. See 21 U.S.C. § 830.
role as dispensers of prescription drugs, and to the extent they are not wholly distinguishable, the few addressing pharmacists' duties as to over-the-counter drug purchasers are not encouraging.\footnote{E.g., Krueger v. Knutson, 111 N.W.2d 526 (Minn. 1961).}

Finally, whether a pharmacist's conduct when refusing to sell emergency contraception is more analogous to conscientious objection rather than civil disobedience will inevitably inform the legal response to refusing pharmacists. The law tends to punish civil disobedience while it protects conscientious objection. Moreover, professional regulations sanctioning conduct such as obstructing customers seeking emergency contraception\footnote{Cal. Bus. & Prof. Code \S 733(a).}; refusing to return prescriptions for contraception\footnote{E.g., Cal. Bus. & Prof. Code \S 733(b)(2)(C); Okla. Stat. tit. 8, \S 354(A).} or lecturing customers about the morality of using the drugs\footnote{E.g., Wash. Admin. Code \S 246-869-010(4)(e).} have already appeared on the books, and courts often look to these types of regulations to identify the public policies that drive duty analysis.\footnote{E.g., Presto v. Sandoz Pharm. Corp., 487 S.E.2d 70, 74 (Ga. Ct. App. 1997).} This section explains the nature of these variables and their implications for duty analysis of the future.


The pharmacy profession's primary role in the modern American health care system remains serving as the gatekeeper to drugs deemed unsafe or ineffective for use without physician care.\footnote{David B. Brushwood, *From Confrontation to Collaboration: Collegiality Accountability and the Expanding Role of Pharmacists in the Management of Chronic Pain*, 29 J. L. MED. & ETHICS 9 (2001) (hereinafter Brushwood, Chronic Pain).} The pharmacy profession can trace its origins at least to the second millenium B.C. when a select group of professionals separate from physicians prepared medications and sometimes administered them accompanied by prayers and other incantations.\footnote{Id.; Brushwood, “Can” Imply “Ought”? supra note 108, at 456.} Early modern apothecaries wore the hat of both physician and pharmacist, but eventually the number and complexity of medications grew so much that the two professions split apart.\footnote{Peter Dwyer, *Pharmacists and Pharmaceutical Manufacturers: Some Ethical Considerations*, 24 MED. & L. 437, 440 (2005).}

Pharmacy changed dramatically in the twentieth century.\footnote{I am indebted for the summary of federal drug regulation to the excellent article of Matthew Seamon, a pharmacist and lawyer. Matthew Seamon, *Plan B for the FDA: A Need for a Third Class of Drug Regulation in the United States Involving a “Pharmacist-Only” Class of Drugs*, 12 WM. & MARY J. WOMEN & L. 521, 535 (2006).} The first watershed was federal entry into drug regulation. Early regulations simply required accurate drug labeling, but soon afterwards Congress limited the sale of habit-forming drugs to licensed doctors and pharmacies. The Food, Drug, and Cosmetic Act of 1938...
followed, requiring for the first time that drugs be proved "safe" and that manufacturers submit "New Drug Applications" before marketing.

The next major watershed occurred in 1951, when Congress formally set aside a large category of drugs that would only be available from a pharmacist with a doctor's prescription. Approximately a decade later, Congress beefed up the Food and Drug Administration's powers and required that drugs not only be shown to be "safe" but also "effective." In 1972, the FDA also established procedures to evaluate applications for non-prescription drugs.

These regulatory changes had a profound effect on the practice of pharmacy. As late as the mid-1920s, more than 80 percent of prescriptions required "compounding" by a pharmacist while two decades later, only about a quarter required such work. Yet in the wake of "prescription-only" regulations, the "product," not the "process," became central to pharmacy practice, and the pharmacist's role evolved from compounder to society's prescription drug distributors.

Finally, the 1960s ushered in the clinical pharmacy movement. Many pharmacists shifted their energies from compounding and dispensing and toward provision of sophisticated services. As many pharmacists explored their "newfound autonomy" in a more clinical, patient-oriented practice, their careers became "more exciting, more fulfilling, and more challenging than ever before."

The pharmacy profession's current aspiration is to provide "pharmaceutical care," a concept linked to new statutory, common law and administrative duties to customers. The American Pharmaceutical Association's vision of pharmaceutical care is "patient-centered, outcomes-oriented, pharmacy practice." In practical terms, pharmaceutical care means that "pharmacists work with patients as well as with physicians and other health-care providers" to promote drug therapy that contributes to a patient's well-being. Some states extend limited prescrib-

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123 Dwyer, supra note 120, at 440, 449-50, 456.
124 Cacciatore, supra note 122, at 104.
130 Brushwood, Chronic Pain, supra note 118, at 71.
Pharmacists and the "Duty" To Dispense Emergency Contraceptives

ing privileges to pharmacists, and the sum total of federal and state regulation has created a "third class" of drugs differentiated from the "prescription-only" and "over-the-counter" categories and available only from a pharmacist.

Though the ideals of pharmaceutical care are most obviously importable to a hospital setting, community pharmacy is also adding value in patient care. The federal government gave the pharmaceutical care movement a huge push when it enacted the Pharmaceutical Access and Prudent Purchasing Act of 1990. The Act requires that as a condition of receiving federal Medicaid matching funds, states must pass legislation or adopt regulations requiring pharmacists to engage in a "drug utilization review" process when serving Medicaid patients, in order to improve health outcomes and cut costs. The "prospective DUR" requires the following prior to dispensing a drug: screening for over-utilization or under-utilization, therapeutic duplication, drug interactions, incorrect dosing or duration of treatment, drug-allergy interactions, and clinical abuse/misuse. It also requires pharmacists to offer to counsel patients about their prescribed medications and to make a reasonable effort to obtain and maintain patient profiles that include disease history, known drug allergies and drug reactions, a comprehensive list of medications and additional comments. Many state statutes have expanded the substantive scope of these duties and made them required for all customers. These statutory duties are almost a community pharmacy version of pharmaceutical care.

To accommodate changes in pharmacists' aspirational goals and legal duties, pharmacy schools have reshaped their curricula. In 1990, the American Association of Colleges of Pharmacy (AACP) mandated that the "Doctor of Pharmacy" degree (Pharm.D.), as opposed to a traditional B.S. degree, should be the entry-level professional degree in pharmacy. Pharmacy schools now place heavy emphasis on patient-oriented, clinical practice, including a full year of experiential education.

134 Holleran, supra note 131, at 78-79; Richard Hight Gastineau, Drug Therapy Counseling: Whose Duty to Warn, 2 J. PHARMACY & L. 293, 312-14 (1994) (explaining that legislators identified patient noncompliance as a key reason for increased costs and unnecessary hospitalizations).
135 42 U.S.C. § 1369r-8(g)(2)(A)(ii); Cacciatore, supra note 122, at 110; Gonzales, supra note 128 (quoting Model Rules for Pharm., § 3 (G), Prospective Drug Review).
138 Pharmacist Scope of Practice, supra note 129, at 79.
140 Grussing, supra note 139, at 486.
Modern Pharm.D. graduates have spent huge portions of their schooling “reviewing drug interactions, contraindications, suboptimal therapy, missed opportunities, side effects,” and improving communication skills. Pharmacists are clearly better educated than ever and will continue to be more so.

Nevertheless, the pharmacy profession's aspirations are not yet reality for community pharmacists whose professional lives center on the traditional roles of dispensing prescription drugs and occasionally counseling customers. Community pharmacists spend as much as two-thirds of their in-store time performing tasks such as processing orders and prescriptions they could delegate to pharmacy technicians or other non-licensed staff. The workload has become so intense that customers probably can no longer assume pharmacists are double-checking their prescriptions for accuracy prior to dispensing. Tasks limited to licensed pharmacists such as reviewing and interpreting prescriptions, assessing patients' drug therapy, and clarifying prescriptions are probably out the window in many cases. As for another key duty everyone from policymakers, customers and pharmacists themselves would like to see prioritized, the reality is very different: “With the way working conditions are for pharmacists today, the idea of counseling is a joke.”

The disconnect between the promise and reality of community pharmacy practice could have profound effects on pharmacists’ legal duties to women seeking emergency contraception. Courts have been careful to protect the integrity of the medical profession or physicians' moral and ethical autonomy with respect to their professional privileges and obligations, partly because they must exercise immense expert discretion in their practices to fulfill “their part of the covenant with society and with individual patients” that they make from their first days in medical school. The rise of pharmaceutical care and the extension of more discretionary

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141 Gallagher, supra note 125, at 80.
142 Cacciatoire, supra note 122, at 104.
143 David S. Walker & Stephen G. Hoag, Symposium on the Evolving Pharmacy Jurisprudence: Changing the Law for a Changing Profession – Forward, 44 Drake L. Rev. i, ii (1996). Statistics show retail pharmacists may be making little progress toward the pharmaceutical care ideal. A decade ago, the number of prescriptions filled per day in a small retail pharmacy employing one pharmacist was approximately 133, up from 92 ten years prior to that, a 45 percent increase. Huang, supra note 137, at 420; Smith, supra note 24, at 226. Chain pharmacies, though employing more staff, filled as many as 165 during the same period. Id.
144 Carmichael & Cichowlas, supra note 128, at 185; Smearman, supra note 17, at 518-19.
145 Huang, supra note 137, at 420. A recent student comment ties workload issues to pharmacist inaccuracy very effectively. Smith, supra note 24, at 223-38.
146 Carmichael & Cichowlas, supra note 128, at 185.
147 Smith, supra note 24, at 232 & n.347 (from author's telephone interview with CVS pharmacist Janice W. Smith).
148 The United States Supreme Court has held on numerous occasions that the state has a legitimate interest in the integrity and ethics of the medical profession. See, e.g., Gonzales v. Carhart, 127 S. Ct. 1610, 1633 (2007); Washington v. Glucksberg, 521 U.S. 702, 731 (1997); Barsky v. Board of Regents of Univ. of N.Y., 347 U.S. 442, 451 (1954).
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decisionmaking in a pharmacist’s work support a conclusion that their moral and ethical principles deserve analogous respect and legal protection. On the other hand, if pharmacy work is not actually keeping up with the pharmaceutical care ideal, the analogy with doctors’ autonomy loses steam, because pharmacists lack the requisite professional discretion in fact.

Cases confirm that a court’s image of a pharmacist’s actual discretion under the circumstances influences the legal responsibility it imposes. Where pharmacists assume the duty to warn of contraindications from computerized patient medication histories, courts impose such duties. Despite courts’ traditional hesitance to create legal obligations for pharmacists that might interfere with the physician-patient relationship, they recognize a duty to refuse to dispense in cases of apparent prescription error or serious danger to the patient. Nevertheless, the dispensary role is not dead in courts’ minds. This latter view of pharmacy practice has tended to protect pharmacists from any duties other than filling prescriptions accurately. Therefore, to the extent that pharmacy practice is seen to live up to its aspirations, it will open itself up to ever more legal duties.

Pharmacists and the Distribution of Plan B

In 2000, the Food and Drug Administration approved Plan B for prescription use, and in 2006 made the drug available without a prescription. Plan B did not magically become as available as cough syrup overnight, however. The FDA borrowed for Plan B the “behind-the-counter” model used to distribute ephedrine and pseudoephedrine, the active ingredients in cold medications such as Sudafed and the illegal drug, methamphetamine. Women eighteen and older would not

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150 Compare Pellegrino, Patient and Physician Autonomy, supra note 149, at 59 (arguing that patient claims and society’s indulgence of “a right to any procedures they wish” challenges a conscientious physician’s integrity as a professional, thereby deprecating her expertise, reducing her discretionary latitude in decisionmaking and rendering her a “technical instrument of another person’s wishes”) with Brushwood, “Can” Imply “Ought?” supra note 108 (arguing that pharmacists have a legal duty and moral obligation to take greater responsibility for drug therapy outcomes given their increasing expertise, the imbalance of knowledge between themselves and patients, and the profession’s movement away from a mere dispensary function to the discretionary decisionmaking “pharmaceutical care” implies).


155 E.g., Hooks SuperX, Inc. v. McLaughlin, 642 N.E.2d 514 (Ind. 1994).


158 Galson Memo, supra note 110, at 3.

159 Fine & McClelland, supra note 50, at 1015.
have to present a prescription for Plan B, but they could only purchase the drug from a pharmacist or other health care professional licensed to distribute prescription drugs. The pitched battle between pro-choice and pro-life advocates over Plan B’s “hybrid” or “behind-the-counter” status pushed refusing pharmacists to the front lines where they quickly got caught in the crossfire.

Many researchers and contraceptive rights advocates had long believed Plan B should be an over-the-counter drug. Divorced from moral qualms about Plan B’s post-fertilization effect, many of those activists’ arguments were superficially persuasive. Most were rooted in Plan B’s 72-hour effectiveness window. Making the drug available without a prescription would speed up the process of obtaining it.

Blunting the “time imperative” is very meaningful to many women seeking the drug. If a woman has unprotected sexual intercourse on a Friday or Saturday, seeing a doctor to obtain a prescription and then getting to a pharmacy to fill it may take longer than the 72-hour window. Women who live in rural areas where neither doctors nor the drug are readily available often have to travel long distances to obtain it while the hours tick away. Studies show African-American and Latina women experience delays obtaining Plan B compared to white women, and both low-income and uninsured women face more general challenges in accessing the health care system.

The Plan B story is definitely one with two sides, however. Those opposed to wide availability in the early 2000s had a more complex and subtle story to tell, but it had considerable merit. This story undermines the oft-cited public policy rationale for a duty to dispense.

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160 Galson Memo, supra note 110, at 3.
161 Id.
162 Leslie C. Griffin, Conscience and Emergency Contraception, 6 Hous. J. Health L. & Pol’y 299, 307 (2006) ("[t]he easiest way to make emergency contraception available to consumers without delay is to sell it over-the-counter, without a prescription").
167 Dries-Daffner, supra note 165, at 94.
168 Iris F. Litt, Placing Emergency Contraception in the Hands of Women, 293 JAMA 98, 98 (2005); Fogel & Rivera, supra note 17, at 725, 733-34.
The arguments in favor of over-the-counter availability are not as strong as they appear at first glance. A study of women from four clinics in California indicates that enhanced access to emergency contraception does not increase its rate of use, decrease pregnancy rates or cut abortion rates.\textsuperscript{169} Studies from overseas show mixed results as to the effect of broad access to emergency contraception on abortion\textsuperscript{170} and pregnancy rates.\textsuperscript{171} The efficacy window for the drug may actually be longer than FDA labeling suggests: Plan B may prevent or terminate pregnancy up to five days after sexual intercourse and is sometimes used that way.\textsuperscript{172} Moreover, regulators had at their fingertips far less sweeping means of increasing access to Plan B: for example, by the mid-2000s, many states had authorized "pharmacy prescribers" and implemented other innovative programs to take advantage of pharmacists' increasing professional competency for the purpose of making a number of drugs more widely available.\textsuperscript{173} From a cost-benefit perspective, over-the-counter access is hardly worth imposing on a few dissenting pharmacists.\textsuperscript{174}

The costs of broad access reach beyond the moral dilemmas Plan B creates. The "conventional wisdom" is that Plan B is "safe,"\textsuperscript{175} and therefore prescription-only status is not warranted under FDA standards.\textsuperscript{176} On the other hand, while the label "safe" permits over-the-counter sale according to a formalistic reading of current law, a more functional analysis shows that "safety" alone does not mean removing doctors from the Plan B provision process is necessarily wise public policy.\textsuperscript{177} For

\textsuperscript{169} Tina R. Raine, et al., Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs, 293 JAMA 54 (2005) (measuring the effect of direct access to emergency contraception through pharmacies and advance provision).

\textsuperscript{170} E.g., X. Hu, L. Cheng & A. Glasier, Advanced Provision of Emergency Contraception to Postnatal Women in China Makes No Difference in Abortion Rates: A Randomized Controlled Trial, 72(2) CONTRACEPTION 111 (2005).


\textsuperscript{172} Dries-Daffner, supra note 165, at 98.

\textsuperscript{173} See generally Field, supra note 39, at 141. These programs are also called "Pharmacy Access," and as of earlier this year, nine states had such arrangements. Dries-Daffner, supra note 165, at 96.

\textsuperscript{174} E.g., Grimes & Raymond, supra note 64, at 186.

\textsuperscript{175} One immediate problem with this assumption is that "[i]t is generally accepted that no drug can be declared absolutely safe and that all drugs could be described as inherently unsafe." Peter Dwyer, supra note 120, at 441.

\textsuperscript{176} E.g., Grimes & Raymond, supra note 64, at 186.

\textsuperscript{177} In general, a drug may be approved for over-the-counter use if it can be adequately labeled for safe and effective use without medical supervision. 42 U.S.C. § 353(b)(1). A decision by a physician that a drug is safe and effective for an individual patient does not justify making it available over-the-counter to the entire population. David Brushwood, The Pharmacist's Duty Under OBRA-90 Standards, 18 J. LEGAL MED. 475, 480 (1997) (hereinafter OBRA-90).
example, both private health insurance companies\textsuperscript{178} and the Medicaid program\textsuperscript{179} require a prescription to ensure coverage. Adolescent women may require additional assistance for safe and effective use.\textsuperscript{180}

The benefits of counseling and a “learned intermediary” between women and the manufacturer also support prescription-only access to the drug.\textsuperscript{181} Physician involvement with the provision of even a “safe” drug is not always a bad thing.\textsuperscript{182} Evidence suggests off-label use would improve efficacy rates,\textsuperscript{183} but women would need personalized direction from a physician to do so.\textsuperscript{184} The privacy of a physician’s examination room is a preferable setting for such a consultation than a sometimes crowded, public pharmacy.

Studies do indicate that some doctors do not perform their informed consent obligations or other counseling responsibilities when prescribing contraceptives with potential abortifacient effects, blunting the practical impact of physician involvement.\textsuperscript{185} As a result, women who might be dissuaded from using such drugs will never hear the facts. Removing the physician from the Plan B provision process, however, only means women will be even less well informed.\textsuperscript{186} As discussed earlier, most pharmacists are barely able to perform their legally mandated counseling role for prescription-drug customers; they cannot devote substantial time to over-the-counter product purchasers.\textsuperscript{187}


\textsuperscript{179} See Smearman, supra note 17, at 519.

\textsuperscript{180} See, e.g., Galson Memo, supra note 110, at 1; Tummino v. Von Eschenbach, 427 F Supp. 2d 212, 220 (S.D. N.Y. 2006) (citing statements of Dr. Janet Woodcock and Dr. William Galson, Acting Director of CDER, as indicating concern that approval of the “switch application” “could potentially lead to ‘extreme promiscuous behaviors’ . . . [and] ‘lead adolescents to form sex based cults centered around the use of Plan B’”) & 221-22 (discussing senior FDA staff efforts to convince the agency’s management that Plan B did not adversely affect adolescent sexual behavior).

\textsuperscript{181} See Dwyer, supra note 120, at 446 (discussing the challenging aspects of ethical behavior where counseling about categories of drugs available only without a prescription but only at a pharmacy, such as pseudoephedrine).

\textsuperscript{182} See Larimore & Stanford, supra note 97, at 130.

\textsuperscript{183} Brushwood, OBRA-90, supra note 177, at 480.

\textsuperscript{184} It is perfectly acceptable for a doctor to direct a patient to use a drug differently from the FDA-approved labeling and happens often. FDA Guidance, supra note 51. The Yuzpe method of emergency contraception is an “off-label” method of using daily oral contraceptives. See supra text and note at 72.

\textsuperscript{185} Kahlenbom, et al., supra note 60, at 468.

\textsuperscript{186} Some argue that emphasizing possible postfertilization effects of emergency contraception, for example, might dissuade women from using the drug and thereby increase the incidence of unplanned pregnancies. See supra text and note at 72.

\textsuperscript{187} See Smearman, supra note 17, at 519.
As the primary distributors of Plan B, pharmacists ended up in the eye of an over-the-counter approval storm between 2000 and 2006. Some characterized the FDAs attention to politics and moral scruples as inappropriate without explaining why, but access, not science, motivated proponents of over-the-counter access. As one academic pharmacist observed, “the battle to approve Plan B [was] predominantly political and minimally scientific.” Inevitably, pharmacists’ own religious conduct would come under scrutiny as they tried to choose between faith and profession.

The story of the fight over several requests to “switch” Plan B from prescription to non-prescription status is a tour de force lined with allegations of intrigue, conspiracy, and lawlessness on the part of the Food and Drug Administration. In 2001, seventy-eight organizations submitted a citizens’ petition requesting that the FDA make Plan B and other forms of emergency contraception available without a prescription. On April 16, 2003, the then-owner of the rights to market Plan B sought over-the-counter status for the drug. When Barr Pharmaceuticals purchased those rights, it continued to pursue the switch application. In December 2003, two key committees of expert FDA advisors voted 23-4 in favor of non-prescription status, and FDA review staff agreed. Nevertheless, the acting director of the Center for Drug Evaluation and Review issued a “not-approvable” letter to Barr. At the request of influential legislators led by Hillary Clinton, the General Accounting Office investigated the FDAs proceedings and found them to be “unusual compared to the agency’s regular review process.”

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188 E.g., Tummino v. Von Eschenbach, 427 F. Supp. 2d 212, 227-28 (S.D. N.Y. 2006) (quoting Dr. Susan Wood, then-Director of the Office of Women’s Health at the FDA and Dr. Frank Davidoff, member of the Nonprescription Drugs Advisory Committee, both of whom claimed the Plan B process was motivated more by politics than science).

189 See, e.g., Griffin, supra note 162, at 307-08 (quoting statements of Plan B proponents).

190 See Seamon, supra note 121, at 550. While the argument that Americans should generally enjoy open access to medications absent good reasons to regulate them is compelling, the good reasons are not only the “scientific” ones. Id. at 549-50.

191 Id. at 549.

192 A “switch application” can be either a petition from “any interested party,” or a supplement to a new drug application, requesting that the Food and Drug Administration exempt the drug from prescription-dispensing requirements of federal statute. 21 C.F.R. § 310.200(b).

193 See Fifth Amended Complaint, Tummino v. Von Eschenbach, No. CV-05-0366 (E.D. N.Y., Oct. 10, 2006), 2006 WL 3634550 (hereinafter “Tummino Complaint”). Documentation does accompany many of the allegations of the Tummino complaint, but the FDA denied many of those allegations and discovery is proceeding. Id. at 229-30. This article does not attempt any independent assessment of the consistency of the FDA’s actions with its regulations.

194 Grimes & Raymond, supra note 64, at 186.

195 Id.


197 Id.

198 Id. at 5-6, 17.

199 Id. at 23; see also Seamon, supra note 121, at 549.
Almost immediately after receiving the “not approvable” letter, Barr submitted another switch application proposing to market Plan B over-the-counter to women sixteen years of age and older, while retaining prescription-only status for those younger than sixteen. But now different controversies emerged. FDA staff strongly opposed this age-based hybrid status on both public health and precedential grounds. The agency had simply never faced the notion of either a drug's status being determined by the age of those purchasing it or prescription and over-the-counter versions of the same active ingredient being marketed in the same package. The FDA doubted the enforceability of the proposed age restriction.

The FDA issued a letter to Barr Pharmaceuticals on August 26, 2005 expressing these concerns, stating that the FDA intended to request public comment on whether it should initiate a rulemaking process to codify the agency's interpretation of section 503(b) of the Federal Food, Drug, and Cosmetic Act regarding when an active ingredient can be simultaneously marketed in both prescription-drug and over-the-counter products. The letter provoked the resignations of one senior FDA official and a member of the Nonprescription Drugs Advisory Committee. Already in early 2005, a group of contraception access advocates and other individuals filed a lawsuit in the Eastern District of New York, challenging the legality of the FDA's administrative response to the Barr Pharmaceuticals' switch applications and the citizens' petition.

After studying the public comments, the FDA began to move on Plan B's approval status. It formally denied the citizens' petition, but decided to forego rulemaking and move quickly to evaluate Barr's pending “switch application” instead. On August 24, 2006, the FDA gave Plan B a hybrid status: available by prescription only to women less than eighteen years of age and without a prescription to women eighteen and older.

The practical implications of hybrid status for Plan B have important consequences for pharmacists and their potential legal duties arising out of their role in the drug's provision:

- The drug's packaging will comply with both prescription-only and over-the-counter requirements.
- Because the packaging and approval also includes a prescription-only

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200 Tummino, 427 F. Supp., at 223.
201 GAO, supra note 196, at 6.
203 Id.
204 Id., see also Galson Memo, supra note 110 at 2.
206 Galson Memo, supra note 110, at 2.
209 Galson Memo, supra note 110, at 3.
210 Id.
component, Plan B is available only from pharmacies and other healthcare providers authorized to dispense prescription drugs. In pharmacies, the drug must be stored “behind-the-counter.”  

- Purchasers must present either a prescription or government-issued proof of age before sale of Plan B.  
- Barr Pharmaceuticals must engage in its own investigations, including sending “anonymous shoppers” into pharmacies, to assess compliance with the FDA’s age restriction for Plan B, and it must report pharmacists who repeatedly violate the restrictions to the relevant state boards of pharmacy.  
- Barr will also make education programs available to consumers and state boards of pharmacy.

Despite raised eyebrows and irritation in the contraceptive rights community about Plan B’s hybrid status, it pushes the factual envelope a bit too far to argue that “Plan B is the only nonprescription drug required by the FDA to be kept behind the pharmacy counter.”  

The combination of the federal “Comprehensive Methamphetamine Control Act of 1996” and the “Combat Methamphetamine Epidemic Act of 2005,” albeit not products of FDA rulemaking, mandate that cold medications containing ephedrine, pseudoephedrine, or phenylpropanolamine be stocked “behind-the-counter” and that the seller even maintain records of identification information from customers purchasing more than a single sales package, defined as one containing no more than 60 milligrams of pseudoephedrine.  

The reason for these restrictions has little to do with “science” or “health” and much to do with public policy: the restrictions are designed to serve as roadblocks to methamphetamine lab operators who previously could obtain these key ingredients in bulk simply by purchasing cases of common over-the-counter drugs such as Sudafed.

Heightened controls on methamphetamine ingredients that are otherwise “safe” when used as labeled are hardly new: many states have rigorously regulated

\[\text{\footnotesize \textit{Id.} at 4.}\]
\[\text{\footnotesize \textit{Id.}}\]
\[\text{\footnotesize \textit{Id.} at 6.}\]
\[\text{\footnotesize \textit{Id.} at 6-7.}\]
\[\text{\footnotesize \textit{Cf. Tummino Complaint, supra note 193, at ¶ 132.}}\]
\[\text{\footnotesize \textit{Cf. Tummino Complaint, supra note 193, at ¶ 125 (alleging that “[i]there are no scientific or health related reasons for choosing 18 as a cutoff age” for sale of Plan B over the counter).}}\]
their sale for years. Most states that regulate the sale of pseudoephedrine require a purchaser to be either sixteen or eighteen years old. Plan B’s hybrid status fits well with the infrastructure that already exists for sale of tobacco, alcohol, pseudoephedrine and ephedrine products.

Little prior precedent provides meaningful cues as to the effect of switching Plan B’s status on pharmacists’ duties to dispense it, and yet the new status will inevitably affect pharmacists’ legal position. For example, the “learned intermediary doctrine” usually protects pharmacists from liability for failure to warn in personal injury cases on the theory that between the manufacturer, physician and pharmacist, the physician is in the best position to warn the patient of any side effects or contraindications. One court held that the learned intermediary doctrine relieved pharmacists from a duty to warn of dangers in prescription drugs on the basis that “pharmacists, as suppliers, do not freely choose which ‘products’ they will make available to consumers in any given instance and patients as consumers, do not freely choose which ‘product’ to buy.” As the exclusive purveyors of prescription-only products, pharmacists can be expected to carry a “normal” range of drugs including emergency and daily oral contraceptives.

All of this calculus changes when the pharmacist is selling over-the-counter drugs, however. The pharmacist becomes exposed to liability for torts such as negligent failure to warn, but the implicit assumption that she will stock all medications no longer applies. “Behind the counter” status muddies these legal waters, however. In the absence of a doctor’s prescription, a pharmacist risks liability for failure to warn, for example, but most apropos, only a pharmacist may sell Plan B, so the expectation that a pharmacist will stock Plan B is reasonable. Expectations matter in recognizing duties. Therefore FDA’s switch decision may have left pharmacists seeking to avoid a duty to dispense with all the legal disadvantages of prescription-only status, but few if any of the compensating advantages of over-the-counter status.

Such restrictions included sale only by a pharmacist, behind-the-counter storage, retrieval from a locked display case only by a store employee, packaging in limited amounts, packaging only in blister packs, and a range of limitations on the quantity that could be purchased at one time. See generally Stanley, supra note 221, at 393-96.

See Fine & McClelland, supra note 50, at 1015; Stanley, supra note 221, at 393. The same is true of ephedrine, a generic drug used “on label” as a diet aid and off label as a methamphetamine ingredient. Harper, supra note 165, at 230

See Harper, supra note 165, at 230,


See, e.g., N.D. Admin. Code 61-04-04-01(14) (“[t]he definition of ‘unprofessional conduct’ . . . for disciplinary purposes includes, but it not limited to, the following . . . [refusing to compound and dispense prescriptions that may reasonably be expected to be compounded or dispensed in pharmacies by a pharmacist”).


See infra text and notes at 363-365.
**Pharmacists and Conscience Versus Civil Disobedience**

The final theme likely to inform the development of a pharmacist's duties as to Plan B is the distinction between "civil disobedience" and "conscientious objection." Judges are "women in the streets" as well. Stories of pharmacists calling women "murderer[s]" or refusing to return prescriptions for emergency or daily oral contraceptives not only disturb, but can even repel. Commentators have attempted to frame the debate over a pharmacist's duty to dispense as being about a pharmacist's using her profession as a soapbox for pro-life activism, which if accepted in the judiciary would leave more pharmacists open to liability, because the law tends to punish such "civil disobedience." Therefore, to the extent that a pharmacist passively refuses to sell as opposed to actively attempts to change a woman's behavior, that pharmacist is less likely to face civil liability.

The law imposes different consequences for passive refusal to engage in immoral behavior and activism. Some observers describe pharmacists who refuse to sell emergency contraception as engaging in civil disobedience that should not relieve a pharmacist of her legal duties, because "acts of conscience are usually accompanied by a willingness to pay some price." "Civil disobedience" is more than an act of conscience, however. One useful definition focuses on public, deliberately unlawful, public protest:

Civil disobedience is an act of protest, deliberately unlawful, consciously and publicly performed. It may have as its object the laws or policies of some governmental body, or those of some private corporate body whose decisions have serious public consequences; but in either case the disobedient protest is almost invariably nonviolent in character.

This definition of "civil disobedience" is not applicable to most pharmacists refusing to sell contraception. Their conduct cannot be "deliberately unlawful" if

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230 E.g., Chandrasekhar, supra note 14, at 55.
231 E.g., White, supra note 39, at 1611-12.
232 Evangelium Vitae speaks in terms of the mercy and love individuals and society as a whole should show women facing abortion. Evangelium Vitae, supra note 50, at ¶ 58-59 & 99. The encyclical emphasizes that the woman's support network and the wider community too often fail her in making choices about abortion for others to make definitive judgments about her conduct. Id. at ¶ 58.
233 See, e.g., Collins, supra note 10, at 58 (referring to an objecting pharmacist as a "zealot" who engages in "obstruction for the sake of obstruction"); Katherine James, Conflicts of Conscience, 45 Washburn L.J. 415, 421 (2006).
234 See Gast, supra note 18, at 174.
235 Id.; R. Alta Charo, The Celestial Fire of Conscience—Refusing to Deliver Medical Care, 352 N. Eng. J. Med. 2471, 2471 (2005) (quoting Dr. Martin Luther King, Jr.).
what the law requires is not even clear.  

Conscientious objection is something else. The Catholic Church calls for health care professionals to engage in conscientious objection: “[t]o refuse to take part in committing an injustice”  

According to Edmund Pellegrino, Professor Emeritus of Medicine and Medical Ethics at the Center for Clinical Bioethics at Georgetown University Medical Center, “[c]onscienctious objection implies the physician’s right not to participate in what she thinks morally wrong, even if the patient demands it. It does not presume the right to impose her will or conception of the good on the patient.”  

This latter form of conduct would be civil disobedience.

The distinction between passive adherence to “conscience” and “active” attempts to influence others is one the law can and does draw. Taking active steps to stop another's conduct is substantively different from passively not taking action oneself. The combination of the United States Supreme Court's privacy jurisprudence and statutory protections tend to stop one person from “coopting another” private individual from participating in the exercise of her rights. This principle runs both ways in both health and bioethics. Patients do not have a generalized, legally protected right to “demand” care from doctors and hospitals. Catholic bioethicists question whether there exists “the right to impose [a health care professional’s] will or conception of the good on the patient.” There are differences to split: providing notice of what services a health care professional will or will not provide, for example, so that customers may make advance arrangements, and the pharmacist may not be forced into a crisis of conviction.

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239 Evangelium Vitae, supra note 50, at ¶ 74.


242 Cf. Gast, supra note 18, at 173-74.

243 Kent Greenawalt notes this difference when he distinguishes between refusal clauses that protect health care professionals on religious bases where the patient has alternate options to obtain service and knows where to find them and where refusal is an effective denial of all service. Kent Greenawalt, Objections in Conscience to Medical Procedures: Does Religion Make a Difference? 2006 U. Ill. L. Rev. 799, 823 (2006).


246 Pellegrino, Physician’s Conscience, supra note 241, at 242.

247 See id.; Jacqueline Gilbert, When Rights Collide: In a Battle Between Pharmacists’ Right of Free Exercise and Patients’ Right to Access Contraception, Who Wins? A Possible Solution for Nevada, 7 Nev. L.J. 212, 236 (2006); see generally infra text and notes at 486-490. This is a fundamentally differ-
To the extent a pharmacist can assuage the demands of conscience with less intrusive and more passive conduct—such as a vanilla flavored refusal to dispense unadorned with an active lecture or refusal to return a prescription—the less likely that conduct will run afoul of common law duties. Cases evaluating pharmacist conduct in less morally charged but otherwise analogous settings concur that the active/passive distinction could drive duty analysis. One court has held that refusing to sell a drug was not an “affirmative act” that creates a duty to act for the benefit of others.\textsuperscript{248} The general common law rule is that in the face of a physician’s prescription decision a pharmacist should simply dispense, despite her doubts about the propriety of that particular drug therapy.\textsuperscript{249} On the other hand, where a pharmacist actively gave advice inconsistent with a doctor’s about an appropriate medication, the pharmacist was liable for damages to the customer.\textsuperscript{250} The distinction is partly the garden-variety assumption of a duty principle.\textsuperscript{251}

The active/passive distinction applies to conduct even more analogous to that most controversial to emergency contraceptive activists, refusal to return an emergency contraception prescription. In holding that pharmacist could not refuse to return a prescription and in effect, keep it as collateral for payment of past debts, the Mississippi Supreme Court stated that to do otherwise “would be to place the sick largely at the mercy of the apothecary, and to cause suffering and maybe death, to the poor.”\textsuperscript{252} These were also issues of concern in the Plan B approval debate. Therefore, to the extent a pharmacist can limit herself to passive conscientious objection as opposed to active civil disobedience, a court is less likely to find that she has violated a duty of care.\textsuperscript{253}

Clearing Away The Brush: The Exciting Law of Constitutional Moment That Does Not Support a Duty to Dispense

Many exciting issues of “constitutional moment” and bioethics swirl around the refusing-pharmacists-versus-Plan-B conundrum. Commentators\textsuperscript{254} have

\textsuperscript{248} Williams v. Albertson’s, Inc., 82 F.3d 415, 1996 WL 167215, at *2 (5th Cir. 1996).
\textsuperscript{249} The leading case stating the majority rule remains McKee v. American Home Products Corp., 782 F.2d 1045, 1049-52 (Wash. 1989).
\textsuperscript{250} Fuhs v. Barber, 36 P.2d 962 (Kan. 1934).
\textsuperscript{252} White v. McComb City Drug Co., 38 So. 739, 740-41 (Miss. 1905).
\textsuperscript{253} Happel, 766 N.E.2d at 1123-24.
latched onto such factually related cases such as a pharmacist's liability for wrongful conception; health care professionals' conscientious objection to participation in termination of life support; and state requirements that hospitals provide abortion services, in the hope of finding a basis for a duty to sell emergency contraception: *Troppi v. Scarf*, 255 *Brownfield v. Daniel Marina Hospital*, 256 *In re Jobes* 257 a triptych of cases arising from *Brophy v. New England Sinai Hospital* 258 and *Valley Hospital Ass'n v. Mat-Su Coalition for Choice*. 259 Ironically for those looking for constitutional duties to dispense, however, careful examination of these cases' precise facts and holdings reveals that they provide almost no foundation for a quasi-constitutional duty to dispense. If anything they are more effective swords in the hands of pharmacists, not contraception activists. 260

*Troppi v. Scarf* 261 is a wrongful conception/pregnancy case with a pharmacist defendant. Mrs. Troppi took her doctor's prescription for oral contraceptives to pharmacist Frank Scarf. Instead of giving her the drug in the prescription, Scarf negligently filled the prescription with a tranquilizer instead. Not surprisingly, Mrs. Troppi became pregnant soon afterwards and eventually delivered a healthy baby boy.

Most of the *Troppi* opinion concerns computation of damages, a point on which it was later overruled in *Rouse v. Wesley*. 262 The duty issue, however, was a virtual jurisprudential no-brainer: "As early as 1882, the Michigan Supreme Court recog-

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259 948 P2d 963 (1997).
260 Most of the legal principles discussed in this Part are not actually constitutional law per se, but they are grounded in what I loosely call here, matters of "constitutional moment"—abortion, contraception, death and dying, privacy and ethics—that one might expect to encounter in a constitutional law or constitutional theory text. I suspect that constitutional law's "excitement factor" explains why so many of my student and academic colleagues focus their energy on legal issues very tangential to tort duties and construction of statutory conscience protections. Two notable exceptions are Gast, *supra* note 18 (tort duties) and Karissa Eide, *Can a Pharmacist Refuse to Fill Birth Control Prescriptions on Moral or Religious Grounds?* 42 Cal. W. L. Rev. 121 (2005). I construe many conscience clauses elsewhere. Spreng, *Conscientious Objections*, *supra* note 20.
261 187 N.W2d 511.
nized that a pharmacist's negligence in providing the wrong drug is actionable.\footnote{263} The \textit{Troppi} court is plainly referring here to the well-established duty to dispense accurately, and lacking another connection not present in the case, it does not support a more generalized duty to dispense. All \textit{Troppi} holds is that "a pharmacist is held to a very high standard of care in filling prescriptions";\footnote{264} it does not address whether the pharmacist had a duty to dispense in the first place.

The oft-cited emergency contraception case, \textit{Brownfield v. Daniel Freeman Marina Hospital},\footnote{265} is no more helpful in extrapolating pharmacist duties to dispense. \textit{Brownfield} holds as follows:

[W]hen a rape victim can allege: that a skilled practitioner of good standing would have provided her with information concerning and access to estrogen pregnancy prophylaxis under similar circumstances; that if such information had been provided to her she would have elected such treatment; and that damages have proximately resulted from the failure to provide her with information concerning this treatment option, said rape victim can state a cause of action for damages for medical malpractice.\footnote{266} \textit{Brownfield} fails as precedent for the existence or substance of a duty from any professional group to Kathleen Brownfield, because it does not actually address duty! The hospital did not dispute that it had a duty of care to Ms. Brownfield. Instead, the hospital asserted a statutory conscience defense protecting doctors from participating in abortions.\footnote{267} A litigation "mistake" proved fatal to that defense, however: the hospital conceded that the "morning-after pill" at issue was "'pregnancy prevention' treatment," not abortion, and the court jumped on the admission to avoid deciding whether emergency contraception was an abortifacient.\footnote{268} All the case really holds is that once a hospital decides to treat a rape victim, the standard of care requires that it inform her about emergency contraception.\footnote{269}

In another case oft-cited to support a pharmacist's duty to dispense, \textit{Brophy v. New England Sinai Hospital, Inc.},\footnote{270} the Massachusetts Supreme Judicial Court established that a hospital could in some circumstances protect its conscience-based scruples and refuse to comply with a patient's request to turn off life support. The court did hold that such a hospital must accept the substituted judgment of the wife of a man in a persistent vegetative state as to whether artificial maintenance of

\footnote{263} \textit{Troppi}, 187 N.W.2d at 513.\footnote{264} \textit{Id.} (emphasis added).\footnote{265} 256 Cal. Rptr. 240 (1989). Though the case could serve to develop an argument in favor of finding a duty on the part of a pharmacist, it does not hold that a physician has a duty to establish a physician-patient relationship with a rape victim. \textit{Cf.} Knestout, supra note 236, at 377-78.\footnote{266} \textit{Brownfield}, 256 Cal. Rptr. at 245.\footnote{267} \textit{Id.} at 244.\footnote{268} \textit{Id.} at 245.\footnote{269} \textit{Id.}\footnote{270} 497 N.E.2d 626, 626 (1986).
his food and water should continue.\textsuperscript{271} Like a woman who might be seeking either contraception or abortion, the patient had a right to control his health care through the substituted judgment of another.\textsuperscript{272}

The patient's right did not create a correlative duty on the part of the providers, however. The court did not hold that hospital personnel were required to remove the tube in violation of their own perceptions of their ethical duties to their patients or to take any other affirmative steps contrary to their consciences.\textsuperscript{273} Because the Board of Directors was not opposed to transferring the patient elsewhere so that the tube could be removed there, the court authorized that process.\textsuperscript{274} To the extent \textit{Brophy} might even apply in a pharmacist case, the analogous analysis would be that as long as a pharmacist did not impede a potential customer from going to another pharmacy, the pharmacist would have no additional duty to that customer.

\textit{Brophy}'s authoritative brawn was weakened, however, in light of two New Jersey cases handed down soon afterwards. In \textit{In re Requena},\textsuperscript{275} New Jersey Superior Court held that a Catholic hospital could be compelled to withhold artificial feeding and fluids from a competent woman losing the ability to swallow.\textsuperscript{276} The Appellate Division upheld the decision.\textsuperscript{277} The hospital proposed to transfer the woman to another institution of equal quality only seventeen miles away, but Mrs. Requena refused to move, and neither court required that she do so to have her right to refuse care vindicated.\textsuperscript{278}

According to Professor J. David Bleich, "it would be extremely naïve to assume [\textit{Brophy} and \textit{Requena}] do not fundamentally disagree."\textsuperscript{279} The court in \textit{Requena} either ignored or refused to credit the defendants' conscience-related objections to withdrawing nutrition and hydration which rose to constitutional magnitude,\textsuperscript{280} while the \textit{Brophy} court took the defendants' concerns seriously. As the New Jersey Appellate Division put it, the trial court simply "balanced the equities" of the two parties' positions,\textsuperscript{281} an approach not consistent with established religious liberties jurisprudence of the time. But the real clash was between the hospital's and its personnel's religious liberties and Ms. Requena's potentially extreme emotional trauma from the move.\textsuperscript{282} Mrs. Requena's situation was certainly pathetic, but it

\begin{itemize}
\item\textsuperscript{271} \textit{Id.}
\item\textsuperscript{272} \textit{Id.} 632-34.
\item\textsuperscript{273} Professor Bleich argues that perhaps the ethics of the medical profession at large played an equal if not greater role. Bleich, \textit{supra} note 149, at 253-54.
\item\textsuperscript{274} \textit{Brophy}, 497 N.E.2d at 632, 639-40.
\item\textsuperscript{275} \textit{In re Requena}, 517 A.2d 886 (N.J. Ct. Super. 1986).
\item\textsuperscript{276} \textit{Id.}
\item\textsuperscript{278} \textit{Id.} at 889.
\item\textsuperscript{279} Bleich, \textit{supra} note 149, at 225.
\item\textsuperscript{280} \textit{Id.}
\item\textsuperscript{281} \textit{Requena}, 517 A.2d at 870.
\item\textsuperscript{282} \textit{Id.}
\end{itemize}
Pharmacists and the "Duty" To Dispense Emergency Contraceptives

did not create a constitutional claim, while the hospitals' did. Moreover, if either court had been truly convinced that the hospitals' position had no constitutional merit, Requena should have been an easy case: the right to refuse care was well established.

The New Jersey courts found a loophole: the hospital's failure to provide Mrs. Requena with notice of its standing policy against withdrawing nutrition and fluids when she was admitted as a patient. If that “failure of notice” distinction comes off as a bit of a “dodge,” the New Jersey Supreme Court made clear it was not in In re Jobes. In this case, almost a repeat of Requena, the New Jersey Supreme Court indicated in dicta that it might very well have ordered that Jobes be moved had the hospital provided her with notice of a policy on the subject.

The Brophy-Requena-Jobes triptych reveal a doctrinal means to avoid pharmacist liability, not a basis for imposing it. First, the Brophy court placed considerable weight on professional standards. In Brophy, the Massachusetts Supreme Court observed that “a patient's right to refuse medical treatment does not warrant such an unnecessary intrusion upon the hospital's ethical integrity in this case,” as to require that the hospital and its staff remove the feeding/hydration tube, and the court specifically endorsed the hospital's position that it had no constitutional, statutory or common law duty to remove the feeding tube. The court also relied on profession-wide ethical standards against removing feeding tubes in Mr. Brophy's situation. While the pharmacy profession does not take the view that pharmacists should not dispense emergency contraception, it does support conscience protections for pharmacists who do. Brophy might therefore be a compelling response to grounding a duty to dispense in some states' Board of Pharmacy standards that a pharmacist should dispense all prescription medications.

Brophy's holding also expresses concern for the ethical integrity of the medical profession. The United States Supreme Court recently reiterated the importance

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283 See Bleich, supra note 149, at 258-60.
284 Id. at 255.
285 The fact that notice was so important in Requena should remind pharmacists that one proactive step they can take to avoid liability is to be clear to customers ahead of time about what drugs they will and will not supply. See infra text and notes at 487-491.
287 Id. at 450.
288 Brophy, 497 N.E.2d at 440. The case uses the word "right" instead of "duty," but in context, it is clear it must mean the latter.
289 See Bleich, supra note 149, at 253-54.
290 See infra text and notes, at 458-462 (discussing positions of national pharmacists' professional associations).
293 Brophy, 497 N.E.2d at 634.
of this state interest in the partial-birth abortion case, Gonzales v. Carhart.\footnote{Gonzales v. Carhart, 127 S. Ct., at 1633.} As Professor Bleich argues, "[p]hysicians can best protect society if [conscientious] conduct is in the nature of a Pavlovian response by intuitively and instinctively seeking to actively prolong the life of a patient."\footnote{Bleich, \textit{supra} note 149, at 257; \textit{see also} Lin, \textit{supra} note 39, at 117-20.} Another commentator wonders: "What guides a physician's decision when a patient is physically ready but emotionally unready to receive an optional procedure? (Hopefully, not blind faith in the dogma of medicine.)."\footnote{Lin, \textit{supra} note 39, at 119.}

Whether the pharmacy profession is entitled to similar concern is disputed. Proponents of a duty to dispense argue that the pharmacy profession lacks the discretionary decisionmaking privilege that marks medicine, and therefore should follow the physician's orders in otherwise legal prescriptions.\footnote{Gast, \textit{supra} note 18, at 157-58; Miller, \textit{supra} note 244, at 265-68; Smearman, \textit{supra} note 17, at 523-24; Varughese, \textit{supra} note 151, at 683-88; Weisser, \textit{supra} note 18, at 882-83.} Even when their role was solely to serve as the gatekeeper to the nation's drug supply, pharmacists did exercise some discretion while filling prescriptions.\footnote{Nelson, \textit{supra} note 254, at 157.} Now, the "pharmaceutical care" aspiration and new regulatory standards are infusing the profession with discretionary decisionmaking ability and power. As pharmacists' role in drug therapy decisions expands, society's interest in protecting the profession's ethical integrity will continue to approach its analogous interest as to physicians.\footnote{See, \textit{e.g.}, Brushwood, \textit{Chronic Pain} \textit{supra} note 118, at 69-75; Brushwood, "Can" Imply "Ought"? \textit{supra} note 108, at 455-61.}

The three cases also provide guidance for avoiding litigation all together. The Brophy court's willingness to allow the hospital to transfer Mr. Brophy to another facility\footnote{The \textit{Requena} court even labeled its defendant hospital's proposed transfer as "the ideal solution," but Ms. Requena did not want to move and the court honored that position. \textit{Requena}, 517 A.2d at 890. In \textit{Jobes}, no alternate facility was available. \textit{Jobes}, 529 A.2d 451.} is a strong basis for arguing that if a pharmacist and customer are willing and an alternate pharmacy is available, perhaps the worst a court might impose on an objecting pharmacist would be a duty to transfer a prescription.\footnote{Further, the \textit{Requena} case turned on the fact that Beverly Requena was likely to experience intense emotional trauma from a move. \textit{Requena}, 517 A.2d at 890. It is possible to imagine a similar effect on a woman seeking Plan B—she has been turned away several times; she is particularly sensitive; the pharmacist is rude; time is running out—but this is not likely in most situations.} Referring a potential customer or transferring a prescription will often violate a pharmacist's conscience, but if the pharmacist can do either, the reasoning in \textit{Brophy} read in light of \textit{Requena} and \textit{Jobes} should insulate the pharmacist from liability.\footnote{This is exactly what the American Pharmacists' Association recommends. American Pharmacists Association, \textit{Action of the APhA House of Delegates}, Seattle, WA, Mar. 26-30, 2004. Unfortunately, this "compromise" is not available to all pharmacists. Nelson, \textit{supra} note 254, at 166.} Moreover, \textit{Requena} shows that if an objecting health care professional provides clear notice of what services she will or will not provide, the chance of liability is substantially
reduced. The three cases confirm that a duty to dispense is not pharmacists' destiny.

The final act in foundational cases said to suggest a pharmacist's duty to dispense emergency contraception is Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice. Valley Hospital Association holds that a "quasi-public hospital" in Alaska may not refuse to allow its facilities to be used to perform abortions. Significant to the decision is the fact that Alaska interprets a woman's right to an abortion under state law to be much broader than that protected under the United States Constitution—perhaps, the decision seems to speculate, because the right to privacy is express in the Alaska Constitution while it is only implicit in the penumbras of the U.S. Bill of Rights. The challenges of Alaska's geography mean that what might elsewhere be clearly private institutions become infused with a public interest such that the Alaska Supreme Court was quicker to find that a hospital is a quasi-public institution where privacy rights trump religious rights. But nowhere does the Alaska Supreme Court suggest that a more clearly private institution would have the same obligation to perform abortions as Valley Hospital, and therefore, the case would not apply to most pharmacists' situations.

303 Not surprisingly in light of cases such as Requena, government institutions have caught on to this potential means of protecting all parties. Gilbert, supra note 247, at 236.
304 948 P2d 963 (1997).
305 Id. at 971.
306 Id. at 969 (indicating the breadth of the Alaska right to abortion is similar to that announced in Roe v. Wade, but not adopting "the narrower definition of that right promulgated in the plurality opinion in Casey").
307 Id. at 967-68.
308 Id. at 970.
309 In particular, most of the factual findings that supported the conclusion that Valley Hospital is "quasi-public" would not apply to the average retail pharmacy: (1) Valley was the only hospital serving the community; (2) the construction of the hospital was funded in significant part by State and federal grants; and (3) over twenty-five percent of the funds received for hospital services came from governmental sources. Valley Hospital Association, 948 P2d at 679-70. Given the widespread use of Medicare and Medicaid funds for prescription drugs and the comparative paucity of pharmacies in rural areas, it is not inconceivable that criteria (1) and (3) could be satisfied even for many retail pharmacies. Seed money for at least some retail pharmacies could come from government grant programs or certainly from Small Business Administration loans (which are not quite the same thing), so it is possible that with a stretch a court could even find criterion (2) satisfied for a retail pharmacy. Valley Hospital Association relies on Storrs v. Lutheran Hosps. and Homes Soc'y of Am., Inc., 609 P2d 24 (Alaska 1980), which found a religious hospital to be "quasi-public," certainly a counterintuitive holding, and indicative of how far the Alaska Supreme Court was willing to stretch to protect rights, perhaps because the fact that these hospitals were the only ones serving geographically very large communities in a uniquely frontier landscape. See Valley Hosp. Ass'n, 948 P2d, at 970 (noting that Alaska's certificate of need program "creates in VHA a type of health care monopoly. Indeed, VHA is the only hospital serving the Mat-Su Valley, just as the hospital in Storrs was the only hospital serving the Fairbanks area. The public need for medical facilities makes this sort of regulation essential"). This is the beginning of where the analogy would break down, however. Only in rare cases would an otherwise private, retail pharmacy be funded by the government, because it would be the only drug supplier in town. Few if any would be situated on land donated by a government institution for
Buried within the overlay of the constitutional moment in all these cases, however, is that all these cases turn on relationships—pharmacist-customer, physician-patient, hospital-patient, and public institution-members of the local community—and the implications of those relationships on the legal duties of the parties: to fill prescriptions accurately, to provide crucial medical information, to vindicate constitutionally protected rights and to provide notice of institutional policies. They are not authority—not even very foundational authority—for a generalized duty to dispense contraceptives in common law. They do, however, provide key illustrations of the circumstances that give rise to legal duties, all of which are grounded in the nature and implications of a relationship between one person and another.

**Pharmacists’ Common Law Duties: Do They Have A Duty to Dispense?**

Many sources speculate that women who experience a pharmacist’s refusal to sell Plan B may have a cause of action for a common law prenatal tort such as wrongful conception, pregnancy, birth or life. One state has already held a pharmacist liable for a prenatal tort for breaching his duty to fill an oral contraceptive prescription accurately. Until recently, courts relied on pharmacists’ role as “purvey[ors] of a product” to limit their legal duties to customers. This remains the majority that purpose. See id. at 695 (Valley Hospital built on five acres donated by City of Palmer). Nor are many retail pharmacies membership associations any local adult can join by paying a minimal fee, thereby also obtaining the privilege of voting for management. Cf. id. The Storrs and Valley Hospital Association courts chose to focus on only a handful of particularly compelling factors, and all the facts together indicate that the hospitals in those cases did indeed “smell” public. Only the rarest retail pharmacies would be similarly situated, however.

310 E.g., Gast, supra note 18; Weisser, supra note 18, at 891-908; see also Afif, supra note 254, at 260-63 (extrapolating a duty to dispense from a duty to dispense accurately and a pharmacist’s responsibility to put a patient’s care first); Cantor & Baum, supra note 69, at 2009 (arguing that a pharmacist’s fiduciary duties and professional ethics standards imply a duty to dispense); Cicconi, supra note 254, at 724 (describing the position of the New York American Civil Liberties Union in a disciplinary case where it took the position that a refusal to fill violated the duty to fill accurately and extrapolating this to common law torts); Herbe, supra note 254, at 90-92 (suggesting the possibility that a duty to fill accurately might be analogous to a duty to fill); Smearman, supra note 17, at 510-17 (finding a duty to dispense in “the various regulations promulgated by state legislatures and pharmacy boards”); Dennis Rambaud, Prescription Contraceptives and the Pharmacist’s Right to Refuse: Examining the Efficacy of Conscience Laws, 4 CARDOZO PUB. L. POL’Y & Ethics J. 195, 220-25 (2006) (extrapolating a duty to dispense from professionalism regulations).

311 Troppi v. Scarf, 187 N.W2d 511 (Mich. Ct. App. 1971). Troppi also points out that many other issues determine whether a woman will have a cause of action for failing to dispense emergency contraception, such as whether the pharmacist’s refusal to dispense is the proximate cause of her pregnancy or whether a pregnancy is truly “damage.” Id.

view. Nevertheless, with an eye to pharmacists’ new professional roles, the trend is otherwise. Whether duty analysis grounded in prescription-only drug cases will apply to failure to sell from behind-the-counter remains unexplored. Embedded among established tort theories, the conscientious objection versus civil disobedience distinction will provide a strong philosophical basis to limit the impositions on pharmacists to duties to refer, transfer, or give notice of services the pharmacist will not provide. Most importantly, pharmacists who do not wish to dispense emergency or daily oral contraception at all will also have additional legal basis to add from that gleaned in the prior section to insulate themselves from all but the most minimal duties with careful advance preparation.

A pharmacist has no generalized duty to act for a woman’s benefit, but pharmacists do have duties to act for the benefit of particular women in the following situations:

1. The defendant has created risks or already caused harm to the plaintiff;
2. The defendant is in a special relationship to the plaintiff that is deemed to create a duty of affirmative action;
3. The defendant takes affirmative action that is either cut short or performed negligently; and,
4. The defendant has assumed a duty of care.

The more pharmacist-specific duties courts have recognized are extrapolations of these basic principles:

1. Duty to accurately and properly fill prescriptions, which is a contextualized restatement of the duty to perform affirmative action without negligence.

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\[\text{313}\] Myrhn, supra note 139, at 62.
\[\text{315}\] Myrhn, supra note 139, at 60-69.
\[\text{316}\] See supra text and notes at 225-229.
\[\text{317}\] See supra text and notes at 248-253.
\[\text{318}\] See infra text and notes at 250-261.
\[\text{319}\] DAN B. DOBBS, THE LAW OF TORTS § 314 (2000); RESTATEMENT OF TORTS, § 314 (1965); Hamilton v. Beretta U.S.A. Corp., 750 N.E.2d 1055, 1061 (N.Y. Ct. App. 2001) (duty is not owed to members of the community at large, but to a particular plaintiff); see also Kirk, 513 N.E.2d at 399. In a particularly extreme example, the Restatement (Second) of Torts states that even if a defendant sees a blind person about to step in front of a car and even the slightest warning or motion on the defendant’s part may save the blind person, the defendant does not have a duty to act. Id. (discussing Restatement (Second) of Torts, § 314, Illus. 1).
\[\text{320}\] Id. at §§ 314-20.
\[\text{321}\] The duties in this section have been gleaned from the extremely useful publication by Frank M. McClellan, et al., Litigating Medical Malpractice Claims: Tort Law and the Pharmacist, SK072 ALI-ABA 159 (Mar. 3-5, 2005).
2. Duty to warn under certain circumstances:
   (a) where the pharmacist has discovered a wrongly filled prescription;
   (b) the pharmacist has actual knowledge that the prescription will cause harm to a particular patient;
   (c) the prescription is clearly written incorrectly; and,
   (d) the pharmacist has advertised or held herself out as one that will warn patients of side effects or other dangers;

3. Duty to warn where the drug is sold over the counter;

4. Duty to consult with the prescribing physician where a reasonable pharmacist would find the prescription erroneous or unusual; and

5. Duties based on statute or other law, such as the duty to counsel patients under the Omnibus Budget Reconciliation Act of 1990.

Nothing about a pharmacist's work has thus far resulted in "creative" duty analysis outside the mainstream of tort law.

Duties run to particular persons with whom a defendant has a relevant relationship. Neither the law nor professional ethics requires professionals with the

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323 For the most part, where prescription drugs are concerned, a pharmacist is protected from a duty to warn by the learned intermediary doctrine which protects manufacturers from the duty to warn ultimate consumers by placing that burden on the prescribing doctor. E.g., Cottam v. CVS Pharmacy, 764 N.E.2d 814, 819-20 (Mass. 2002); McKee v. American Home Products Corp., 782 F.2d 1045 (Wash. 1989). On the other hand, some jurisdictions are not quite so quick to assume no duty to warn. Cf. Lasley v. Shrake's Country Club Pharmacy, 880 F.2d 1129 (Az. Ct. App. 1994) (permitting plaintiff to submit expert testimony and relying on local professional rules of conduct to refute defendant pharmacist's evidence of local standard of care). Further, all bets are off when over-the-counter products are at issue. See Morales v. American Home Products, 214 F. Supp. 2d 723, 726 (S.D. Tex. 2002) (where cause of action is for failure to warn of dangers in over-the-counter drug, there is no learned intermediary, and pharmacist may have duty).

324 McClure v. Walgreen, 613 N.W.2d 335 (Iowa 2000). This duty arises from the principle that where a pharmacist has created risks or caused harm to the specific plaintiff, the pharmacist has a duty to warn of the problem.

325 Happel v. Wal-Mart Stores, Inc., 766 N.E.2d 1118 (Ill. 2002). This is an application of the "special relationship" rule.


328 Morales v. American Home Products, 214 F. Supp. 2d 723, 726 (S.D. Tex. 2002) (where cause of action is for failure to warn of dangers in over-the-counter drug, there is no learned intermediary, and pharmacist may have duty).

329 Horner v. Spalitto, 1 S.W.3d 519 (Mo. Ct. App. 1999). This is another assumption of duty principle.


331 See generally Hepplewhite, supra note 132.

332 McKenzie v. Hawai'i Permanente Medical Group, Inc., 47 P.3d 1209, 1214 (Hawai'i 2002); Kirk v. Michael Reese Hospital and Medical Center, 513 N.E.2d 387, 396 (Ill. 1987).
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discretionary authority pharmacists increasingly exercise in their practices, such as doctors, nurses and lawyers, to accept all comers as patients, clients or customers. Physicians who decline to enter into a professional relationship with a patient are not liable for medical malpractice. In a pharmacist negligence case, the Fifth Circuit failed to find “a case where a series of transactions . . . created a duty on the part of a vendor of products or services to enter into future transactions.”

No reported case appears even to have implied a generalized duty to dispense a drug. Like businesspeople and landowners, pharmacists do not have duties to members of the community at large, but rather to particular persons: those with whom the defendant has the sort of relationship that places the defendant in the best position to protect against the risk of harm to the plaintiff without opening her up to unlimited liability to a huge, undefined group. Doctors most often have the relevant relationship with patients. For pharmacists, the analogous persons are customers.

Therefore, the soundest factual basis for “no duty” is if a pharmacist refuses to serve a person she has never served before and no other extenuating circumstances exist. A physician would make this argument with success. As to pharmacists, the argument is also almost certain to be a winner under established tort principles, but it is not quite so cut-and-dried.

A functional analysis of the relationship between pharmacists and those who walk in off the streets shows that no analogy to physicians is ever dispositive enough for comfort. Pharmacies more closely resemble places of public accommodation

333 American Medical Association, Code of Medical Ethics § E-9.12 (“both the physician and the patient are free to enter into or decline the relationship”).

334 See, e.g., American Nurses Association, Code of Ethics for Nurses ¶ 2.2 (addressing conflicts of interest) & ¶ 5.3 (endorsing “an authentic expression of one’s own moral view in practice”).

335 See, e.g., Model Rules of Professional Conduct, Rule 1.7.

336 St. John v. Pope, 901 S.W.2d 420 (Tex. 1995).

337 Williams v. Albertson’s, Inc., 82 F.3d 415, 1996 WL 167215, at *1 (5th Cir. 1996). On the other hand, simply because one court failed to find authority holding a duty to dispense exists does not mean another court might not recognize such a duty in the future. A federal court is unlikely to make such a jurisprudential departure in common law.

338 Id. at *1-2. A few states recently enacted statutes and regulations that could support a negligence per se cause of action or a recognition of a duty based on public policy. See infra text and notes at 393-446.


340 For example, the Illinois Supreme Court held that a hospital and doctor might have a duty to warn a patient of the risks of driving after ingesting a particular medication with alcohol, but that duty did not extend to protect a third-party passenger injured when the patient drove without having received the warning. Kirk, 513 N.E.2d 387. In that case, the court held that “[t]he negligence count against the hospital failed to state a cause of action because it lacks the first essential element in a negligence claim: a recognized duty of care owed by the defendant to the particular plaintiff.” Id. at 397.


342 E.g., St. John v. Pope, 901 S.W.2d 420 (Tex. 1995).
A pharmacist does have a "gatekeeper" relationship even with those she has not served before, because a pharmacist controls access to prescription drugs. By virtue of becoming a pharmacist and taking on this role, the pharmacist indicates a willingness to be "open" to the public in a way a physician does not. Melding these theories of "relationship" and "assumption of duty" together provides a basis for finding a duty to dispense even in the absence of a contractual relationship.

Though tenuous, this analysis could be a potential minefield for pharmacists. The gatekeeper/seeker-of-entry relationship that provides its foundation will not change even as the dispensary model of pharmacy shifts to pharmaceutical care. The intuitive notion of a pharmacist's availability that gives rise to an assumed duty will evaporate if pharmacists actually shift into more of a drug therapy practice, thereby offsetting the impact gatekeeper/seeker-of-entry relationship, but not until long into the future. The likelihood that a court would adopt such a theory is low, but if it did, the results could be devastating to pharmacists' duties to dispense prescription drugs.

The good news for refusing pharmacists is that the same "public accommodation" reasoning works against finding a duty to dispense Plan B as a behind-the-counter drug. Where over-the-counter drugs are concerned, pharmacies are hardly distinguishable from other retail stores. Only rarely are pharmacies required to stock particular products, for example. Behind-the-counter status requires little more inconvenience than does asking a clerk to open a locked display case to obtain access to DVD sets or computer software. Providing proof of age is irritating and offends some sensibilities of privacy, but customers accept it when purchasing tobacco or alcohol. Most retail stores offer a "normal" range of products, but salespeople routinely say, "we do not stock that brand" or "we do not have that in your size," without expending substantial effort to obtain the item. Menus at seafood restaurants need not include steak, no matter how much a patron may want Surf 'n Turf.

What constitutes a place of public accommodation is often a matter of state statute, but under various definitions, most pharmacies probably qualify. See Blackman, supra note 163, at 78-79; Chandrasekhar, supra note 14, at 70-77. Though states could take the next step and mandate by statute or as an extrapolation from case law that failure to sell contraceptives violates law prohibiting discrimination on the basis of gender in public accommodations, the United States Supreme Court's reading of what constitutes discrimination "on the basis of sex" does not permit such an interpretation. See Geduldig v. Aiello, 417 U.S. 484 (1974).

Plan B does remain a prescription drug as to women aged seventeen and under. Only Washington state has a duty-to-distribute requirement that includes "drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies." Wash. Admin. Code § 246-869-010(1). This regulation came into effect approximately a year after the FDA approved Barr Pharmaceuticals' switch application for Plan B. The state's drug stocking requirements could apply to both prescription and "behind-the-counter," non-prescription drugs. See Wash. Admin. Code § 246-869-150(1).

A customer's "expectations" also plays a role in determining whether a duty exists. See infra text and notes at 364-365.
The pharmacist might have other duties even if no sale occurs. These would include treating the customer with respect; referring the customer or transferring the prescription if the drug is not in stock — but these would not be duties to sell. Most other duties are derivative of the decision to sell: providing direction and warnings, taking due care in checking the purchaser's identification for proof of age, and dispensing the drug accurately. The duty to sell, however, only arises if the woman and pharmacist have established the requisite relationship or the pharmacist has voluntarily accepted the duty.

The view that a pharmacist has no duty to dispense to a person to whom she has never sold anything becomes almost unassailable in light of other indicators of duty. Tightening the relationship between a pharmacist and a customer even in the smallest ways unleashes an infinite set of variables into the duty analysis, particularly the following:

- The frequency with which the pharmacist filled prescriptions for the customer;
- Any representations made to the customer;
- The pharmacist's access to historical data about the customer; and,
- The manner in which the prescription was tendered to the pharmacist.

What these variables show is whether the characteristics of the parties' relationship are such that the pharmacist should carry the burden of liability, focusing on assumption of duty and foreseeability of injury. All undermine the possibility that a pharmacist would have a duty to a person who had never purchased anything. On the other hand, they also reveal just how fact-sensitive duty analysis really is.

Hooks SuperX v. McLaughlin illustrates several of these factors at work in a "duty not to dispense" situation. Mr. McLaughlin had presented Hooks SuperX...
pharmacy with “dozens” of prescriptions for two habit-forming drugs filled over a nineteen-month period, while consuming the medications sometimes more than twice as quickly as the prescriptions indicated he should have done.\textsuperscript{356} As a result, he suffered mental injuries, and the court held that under the circumstances, the pharmacist had a duty to stop filling the prescriptions based on “a practical recognition of the relationship between pharmacist and customer.”\textsuperscript{357}

If Mr. McLaughlin had walked into Hooks SuperX only once and requested that his prescription be filled, the pharmacist would have had no liability for doing so.\textsuperscript{358} Instead, the duty arose from a key aspect of the relationship: its length, which meant the pharmacy had Mr. McLaughlin’s long prescription record and made Mr. McLaughlin’s injury foreseeable to the pharmacy staff.\textsuperscript{359} Further, the law may not have required Hooks SuperX to retain Mr. McLaughlin’s prescription record, but once it did, the argument that it assumed a duty improved.\textsuperscript{360} Hooks SuperX does not foreclose the possibility that certain duties may exist as a result of only one contractual relationship\textsuperscript{361}—one purchase or one prescription filled\textsuperscript{362}—but others arise only after a longer-term relationship, especially if it renders the injury foreseeable.

\textsuperscript{356} Id. at 516.
\textsuperscript{357} Id. The court relied primarily on privity of contract, which forms the basis for tort liability in a wide range of other circumstances, such as insurer/insured, physician/patient, contractor/customer, and landlord/tenant. Id. at 517.
\textsuperscript{358} This does not mean to imply that a pharmacist has no legal duties to one-time customers. Numerous cases confirm that a solitary purchase may be the relevant relationship. See, e.g., Riff v. Morgan Pharmacy, 508 A.2d 1247, 1251-52 (Pa. Super. Ct. 1986). The nature of the duty defines the nature of the relationship needed to create it, however. A duty to read and recognize errors in a prescription arises out of one purchase, id., while a duty to cut a customer off after filling prescriptions at an excessively fast rate obviously only arises after many purchases. Hooks SuperX, 642 N.E.2d 514.
\textsuperscript{359} See 642 N.E.2d. at 517-19.
\textsuperscript{360} Cf. Happel, 766 N.E.2d at 188-89 (“We do not disapprove of pharmacies’ collecting allergy information and recording it in their computers. However, if a pharmacy chooses to engage in such a practice, it must also warn of known contraindications.”).
\textsuperscript{361} Bear in mind that a pharmacist, as a business owner, does have duties to business invitees, though these would not necessarily be the same as her duties to a customer, because the relationship is different. Translated into a pharmacist’s circumstances, this could mean that a pharmacist has some duty to a potential customer requesting Plan B to avoid conceiving, which could occur as she stands in the pharmacy. See Lasley, 880 P.2d at 1132 (explaining that duty arises from the relationship between the plaintiff and defendant and the duty is always the same, to conform to a standard of care which is whatever conduct is necessary to satisfy the duty). I think this theory is far-fetched, because like other business owners who would have no more than a duty to “summon care,” few landowners would be expected to have a large stock of medical supplies on hand. The opposite is true of pharmacists.
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The Hooks SuperX story translated into Plan B-speak might sound something like the following. Imagine a woman who regularly has her prescriptions for occasional or routine medications filled at a neighborhood pharmacy. Over time that pharmacy has developed a customer profile on the woman so that it has become a real player in her health care; she may be on a first-name basis with the pharmacist; she relies on the pharmacist for health care advice, especially in minor emergencies; and she purchases a number of other personal care items off the shelf at that store.\(^3\) One might say this pharmacy is providing the woman with street-corner “pharmaceutical care,” implying enhanced legal duties. Then after unprotected sexual intercourse, she comes in seeking Plan B.

The pharmacist would be under considerable legal pressure to do something for this customer: sell the drug or find another source. Through the relationship the pharmacist has cultivated between herself and the customer—to the benefit of the customer's health and the pharmacist's profit margin—she has created in the customer almost a reliance interest in her assistance that a court will almost inevitably protect.\(^4\) The woman not only expects help, but she has tangible reasons for believing it will be given.\(^5\) Further, the risk and foreseeability of injury is greater, because in light of her reliance on the pharmacist's help, the woman may not have acted to obtain Plan B immediately after discovering she was at risk of pregnancy. Finally, given the relationship between them, the woman is more likely to have told the pharmacist that time is of the essence or provided information over time that magnifies the foreseeability of injury.\(^6\)

\(^3\) Admittedly, this is a somewhat rarified hypothetical, creating what might be dubbed the "best case" for a duty to dispense. This culture of pharmacy, where pharmacists and customers knew each others' names and pharmacists had time to counsel customers about appropriate over-the-counter medications, is a thing of the past. Smith, supra note 24, at 224.

\(^4\) Courts routinely protect "reasonable reliance interests" in a wide variety of contexts where they are found and other strongly competing interests do not interfere. See, e.g., ExxonMobil Oil Corp. v. E.E.R.C., 487 F3d 945, 968 (D.C. Cir. 2007); Bridges v. Dept. of State Police, 441 F3d 197, 210 (4th Cir. 2006); In re Continental Airlines, 91 F3d 553, 572 (3d. Cir. 1996); Hernandez v. City of Hanford, 59 Cal. Rptr. 3d 442, 458 (Cal. 2007); Yourik v. Mallonee, 921 A.2d 869, 874 (Md. Ct. Spec. App. 2007). I am not arguing here that courts should do so in the case of refusing pharmacists; my "policy" view is otherwise. As a practical matter, however, I am hard pressed to think that a court would not take very seriously an argument that a pharmacist had a duty to do "something" where a woman needing emergency contraception relied on their established relationship.

\(^5\) Professor David Brushwood cautions against imposing duties on pharmacists based on consumer expectations. Brushwood, Duty to Warn, supra note 312, at 55-57. The course of conduct in this hypothetical, however, not only suggests the woman's expectation is reasonable but also that the pharmacist cultivated and received a market benefit from that expectation.

\(^6\) Cf. Kirk, 513 N.E.2d at 396 (injury to patient or patient's passenger not reasonably foreseeable for hospital where doctor should have warned patient about drug interactions); see supra note 340 (discussing Kirk). The Kirk court's holding might not have been different, but the analysis would have been, if the patient had said to a knowledgeable hospital health care provider prior to leaving, "now, is there anything I need to know about this medication?" Moreover, the Kirk court's analysis leaves open the possibility that where it was "very" foreseeable that an injury would occur, a more attenuated relationship would still permit a finding of duty. Id. at 396.
A pharmacist may glean much from other circumstances about the foreseeability of pregnancy, but they require careful scrutiny, because circumstances can deceive. Several facts in particular can make a difference: whether the woman is seeking emergency contraception after unprotected sex; if so, when the woman had sex during the “72-hour period”; and where she is in her monthly cycle. Circumstances can deceive, however, and the foreseeability of a pregnancy even when the woman is seeking emergency contraception deserves scrutiny. Most of the time a woman is not fertile, and therefore, no pregnancy is possible, whether “foreseeable” or not. The assumption that a woman purchasing emergency contraception is doing so during the seventy-two-hour window implies “archaic and stereotypic notions” about women. Women are responsible; they do take precautions, and they are increasingly being taught to do so with “emergency” contraception. Moreover, a woman’s age or race bears on when and under what circumstances the woman may seek emergency contraception. Even a woman attempting to purchase Plan B at 2:00 a.m. may not be doing so after sexual intercourse. After all, if you wanted to avoid your next door neighbor, would you nip down to the corner Walgreens at its busiest time of day or would you go after most people were asleep? 

_Happel v. Wal-Mart Stores, Inc._ shows by analogy how a court could juggle numerous circumstances and find that a pharmacist had obligations to a woman seeking Plan B. In _Happel_, customers knew the Wal-Mart pharmacy collected information about allergies and other medical conditions that would reveal contraindications, and as a result, the Illinois Supreme Court held that it had a duty to warn a customer purchasing a contraindicated drug. The court held that the duty arose from the reasonable foreseeability, given the pharmacy’s knowledge of Happel’s allergy, that she would be injured from taking the contraindicated drug. 

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356 The chance of conception, after all, is not high, only eight percent. Murphy, _supra_ note 67.
358 Professor Lynne Marie Kohm notes the error in judgment of what many think is an inherent inconsistency of “planning for ‘an emergency,’” which leads them to conclude that Plan B should be available in pharmacies at a woman’s convenience. Kohm, _supra_ note 63, at 802. In fact, people plan for emergencies all the time.
359 Some college health departments are encouraging young women to “be prepared” with emergency contraception. See Katherine D. Spitz, _Sex, Drugs, and Federalism’s Role: Regulation of the Morning After Pill on Public College and University Campuses_, 33 J. C. & U.L. 191, 191 (2006). Moreover, though studies that provide women with Plan B prior to sexual intercourse do not show decreases in abortion rates, they are themselves evidence of efforts in the family planning community to encourage “preparation.” E.g., Glasier, et al., _supra_ note 171; Hu, et al., _supra_ note 170; Raine, et al., _supra_ note 169; see also Cicely Marston, et al., _Impact on Contraceptive Practice of Making Emergency Hormonal Contraception Available Over The Counter in Great Britain: Repeated Cross Section Surveys_, Brit. Med. J. On-Line First, available at www.bmj.com
360 See Dries-Daffner, _supra_ note 165, at 94 (citing evidence that African American, Latina and adolescent women experience delays in obtaining emergency contraception than white women).
361 _Happel_, 766 N.E.2d at 1125.
362 766 N.E.2d 1118 (Ill. 2002); see also _Baker v. Arbor Drugs, Inc._, 544 N.W.2d 727 (Mich. Ct. App. 1997) (if pharmacy advertises that it uses computer system to check for contraindications and if it fails to warn it has breached duty to customer).
363 _Id._
The pharmacy had no duty to collect the allergy information; the court probably would have found that requirement too burdensome had Wal-Mart not already been doing it. But Happel had filled prescriptions at Wal-Mart six times and the pharmacy's staff testified that they did know about both the allergy and the drug's contraindications. They just made a mistake.

The Happel court recognizes duties arising from the established customer-pharmacist relationship, the affirmative involvement in the customer's health, and most importantly, the customer's reasonable reliance on the pharmacist's care based on the pharmacist's knowledge of the customer's circumstances and medical history. Similarly, the longstanding pharmacist-customer relationship; the woman's confession about her "emergency", and information in the pharmacist's files implying the viability of the Yuzpe method or other forms of emergency contraception would justify the woman's reliance on the pharmacist to help her, and as in Happel, constitute a voluntary assumption of a duty.

But not necessarily a duty to dispense. Courts do consider the magnitude of the burden they are imposing on a pharmacist when finding duties, and in Happel, that burden was minimal: after all, Wal-Mart was already collecting the information, and under normal circumstances, provided it. Even Wal-Mart admitted that

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375 "[T]he magnitude of the burden of guarding against such injury" and "the consequences of placing [the] burden on the defendant" are factors commonly employed in elucidating duties along with foreseeability of injury and the likelihood of injury, and all were considered in Happel, 766 N.E.2d at 1123-25.

376 Happel, 766 N.E.2d at 1121.

377 The Happel court both notes the six times Happel had been to Wal-Mart to have prescriptions filled and necessarily relies on the relationship this created, because Wal-Mart took the prescription over the phone, and no evidence indicated that Happel provided her allergy information that day. Id. at 1121. Further, the description of the override system indicates that Happel's allergy information was already recorded, though this is not absolutely clear. Id.

378 Id. at 1125. This turns out to be the primary basis for the opinion.

379 The court goes so far as to state that the injury was not simply "reasonably foreseeable," but that "the likelihood and the reasonable foreseeability of injury were great" from the contraindicated drug being ingested given Happel's allergy. Id. at 1124.

380 The reliance interest is paramount: "By asking customers about their drug allergies, the pharmacy is engendering reliance in the customer that the pharmacy will take steps to ensure that the customer does not receive a drug to which the customer is allergic." Id.

381 Id.; compare Cottom v. CVS Pharmacy, 764 N.E.2d 814, 822-23 (Mass. 2002) (holding that where a pharmacist provided a long list of side effects of a medication to a customer, the pharmacist had voluntarily assumed a duty to provide a complete list) with Frye v. Medicare-Glaser Corp., 605 N.E.2d 557, 560-61 (1992) (holding that a pharmacy did not assume a duty to warn where it simply labeled a medication bottle and included a single warning stating that the drug might cause drowsiness). The differences between Cottom and Frye indicate that where a pharmacist engages in substantive conduct on which it is reasonable for a customer to rely for the integrity of the substance, the pharmacist has voluntarily accepted a duty to vindicate the integrity of that substance.


383 As the Illinois Supreme Court noted:

The burden on defendant of imposing this duty is minimal. All that is required is that the pharmacist telephone the physician and inform him or her of the contraindication.
the pharmacist on duty who filled Happel’s prescription just made a mistake. For a refusing pharmacist, a duty to dispense would impose a substantial conscience-related burden, but also a laundry list of others individually less severe, but still quite serious: training and continuing education,\textsuperscript{384} checking identification to prove age,\textsuperscript{385} giving advice in the absence of another learned intermediary,\textsuperscript{386} storage space,\textsuperscript{387} and community disapproval.\textsuperscript{388} Courts have been hesitant to recognize duties imposing burdens as minimal as requiring pharmacies to keep extra copies of a package insert in stock in order to warn customers of dangers in the medication.\textsuperscript{389} It is difficult to believe a court would go so much farther.

Alternatively, the pharmacist could provide the same information to the patient. Since this burden of warning about a contraindication is extremely small, this factor also favors the imposition of a duty here.

[D]efendant is not being asked to learn the customer’s condition, nor is defendant being required to render a medical judgment or interject itself into the doctor-patient relationship. Instead, Wal-Mart need only pass along to the customer or physician the information it already possesses about the contraindication for this specific customer. Such a practice apparently was already being followed at the Wal-Mart pharmacy in McHenry. Bowser [the dispensing pharmacist] testified in her deposition that prior to August 1993 she had had occasion "once, twice a month" to notify a physician about a patient’s drug allergies. In these circumstances, the recognition of a duty to warn would simply require Wal-Mart to continue with a practice it was already engaged in.\textsuperscript{Id. at 1124.}

\textsuperscript{384} See Letter to Joseph A. Carrado from Steven Galson, Director, Center for Drug Evaluation and Research, Food and Drug Administration, NDA no. 21-045/S-011, at 3 (hereinafter Carrado letter) (stating that the manufacturer of Plan B “will conduct an education campaign that will focus initially on healthcare professionals (including prescribers and pharmacists) to raise awareness and knowledge levels about emergency contraception . . . . The campaign will include continuing education by certified professionals . . . .”).

\textsuperscript{385} Id. at 2. The letter indicates that the manufacturer will conduct extensive research, including surveys and a “Point-of-Purchase Monitoring Program” which will send anonymous shoppers into pharmacies, to determine if sellers are complying with the requirement that Plan B not be distributed over-the-counter to those younger than age eighteen. The manufacturer is initially to report what it learns to the Food and Drug Administration, and then latter it is to report “repeat violators” to state boards of pharmacy. \textit{Id.} at 2-3.

\textsuperscript{386} See \textit{supra} text and notes at 225-229.

\textsuperscript{387} Plan B must be kept in precious “behind-the-counter” space, because of the age requirement for non-prescription purchase. Carrado Letter, \textit{supra} note 384, at 3; cf. \textit{Leesley}, 518 N.E.2d at 763 (noting the burden of having to "retain" warning material on prescription drugs).

\textsuperscript{388} Cf. \textit{Where to Get RU-486, supra} note 85 (noting that at least some doctors prefer not to prescribe and use RU-486 because of concern about violence or protest).

\textsuperscript{389} Walker v. Jack Eckerd Corporation, 434 S.E.2d 63, 67, 69 (Ga. Ct. App. 1993) (holding no duty to warn exists even where pharmacist was provided with package insert warning of potential adverse effects if certain drug dosages exceeded); \textit{Leesley} v. \textit{West}, 518 N.E.2d 758, 762-63 (Ill. Ct. App. 1988) (calling a requirement that a pharmacy duplicate cautionary information received from a manufacturer “very burdensome” and labeling it an “oppressive burden of retaining and cataloguing every document received to be certain each is distributed with the appropriate drug”). The \textit{Leesley} court states that the requirement is inconsistent with the learned intermediary doctrine, which would not apply in the case of over-the-counter drugs. It may not be irrelevant, however, that these cases came down prior to a jurisprudential shift after which many more courts found duties to warn. See generally \textit{Myrhn}, supra note 139, at 33-69.
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Statutes, Regulations and Professional Standards: Potential Risks and Rewards for Pharmacists

All that has been said above pales against the handful of what are essentially statutory and regulatory requirements that pharmacists fill prescriptions, even if doing so violates the pharmacist’s religious beliefs. In other states, “conscience clauses” serve as affirmative defenses for pharmacists facing civil liability arising out of failure to dispense contraceptives, suggesting a different state policy and indicating local rejection of a duty to fill. Though in most states, regulatory statutes and administrative rules will not give rise to duties or otherwise create private causes of action against a pharmacist, they also inform a court’s analysis of whether a duty exists. As the statutes and regulations in a state go—either evincing a policy of respect or disdain for pharmacists’ conscientious scruples—so may their courts in assigning duties.

Must-fill Requirements

In response to concerns that some pharmacists may refuse to dispense Plan B, Illinois and Washington state recently promulgated strict regulations that require pharmacists to dispense Plan B, and at the end of 2007, the New Jersey legislature passed a broad must-fill statute. Policymakers and commentators are calling for such requirements in other states. These statutes will substantially

391 E.g., Miss. Code § 41-107-5(2).
392 Cf. Stanley v. Wyeth, Inc., 2006 WL 2588147, at 3-4 (E.D. La. 2006) (holding that where the FDA requires that a pharmacist provide a patient insert when dispensing a drug, and the manufacturer provides the insert or the insert requires the pharmacist to give more warnings if asked, plaintiff could state a claim for failure to warn); Pharmacare Oklahoma, Inc. v. State Health Care Authority, 152 P3d 267 (Okla. Ct. Civ. App. Div. 2 2006) (relying on numerous state statutes and regulations to fix the duties of various parties as to Medicaid billing).
393 See, e.g., Horner v. Spalitto, 1 S.W.3d 519, 523 (Mo. Ct. App. 1999) (relying on Missouri statute defining duty to warn as well as statutory definition of pharmacy); Powers v. Thohbani, 903 So. 2d 275, 279 (Fl. Ct. App. 4 Dist. 2005); Walker v. Jack Eckerd Corporation, 434 S.E.2d 63, 67 (Ga. Ct. App. 1993) (suggesting that statutory authority imposing a duty to warn would create a duty the court would recognize); Johnson v. Walgreen Co., 675 So. 2d 1036, 1038 (Fla. Ct. App. 1996) (Florida Pharmacy Act imposing pharmaceutical-care-type practice standards not intended as a private right of action but just a regulation, finding only a duty to dispense accurately); Pittman v. Upjohn Co., 890 S.W.2d 425, 434-35 (Tenn. 1994) (discussing the statutory definition of “the practice of pharmacy” as well as numerous other regulations as a guide to the substance of common law duties, but ultimately finding no duty to warn on another basis) (citing liberally Dooley v. Everett, 805 S.W.2d 380 (1990)); Ramirez v. Richardson-Merrill, Inc., 628 F. Supp. 85 (E.O. Penn. 1986) (considering “Standards of Practice for Professional Pharmacy,” but holding other authority establishes that pharmacists do not have generalized duty to warn).
394 Ill. Admin. Code tit. 68 § 1330.91(j).
397 See NCSL, PHARMACIST CONSCIENCE CLAUSES, supra note 12 (listing pending bills in state legislatures that would impose must-fill requirements).
burden pharmacists' professional activities and religious freedom, but courts should not find them fertile soil for creative duty analysis.

The legal implications of a "must-fill" statute or regulation depends on three factors. The first is the person or entity being regulated. If a statute or regulation requires that a pharmacy provide emergency contraception rather than an individual pharmacist, the provision does not impose a duty on a particular individual and entities can avoid liability as long as at least one employee can sell the product.\footnote{See Peres, supra note 5, at 1. Focusing on pharmacies as opposed to pharmacists does not help individual owner-operators or small pharmacies, but it does limit the number of refusing pharmacists who could face exposure as a result of the rule.}

The second is whether the provision requires only that a pharmacist fill prescriptions or whether it reaches non-prescription drugs. If the former type of provision came into effect after the FDA switched Plan B's status, a court could make no inference that the regulation reflected a state policy that pharmacists should dispense non-prescription Plan B. On the other hand, if the state had a must-fill regulation prior to August 2006 that it has not amended since, its policy could be construed to favor the access of women with prescriptions\footnote{The purpose of must-fill regulations is to enhance access, and therefore, to limit that enhanced access to holders of prescriptions seems counterproductive to federal efforts to enhance access by making Plan B available without a prescription. But there are many reasons to favor prescription holders. The purchase arises from highly respected physician-patient relationship. Ostensibly, the physician has made a professional decision about the woman's condition with which the law discourages interference. Many of the risks to the pharmacist, such as the lack of the learned intermediary shield and other liability exposure, decline when a physician writes a prescription. These policies are of quintessential state concern.} or more functionally to favor broad access generally by imposing a duty to sell the drug however a customer requests it. The final factor is the facial neutrality and general applicability of the provision. If the must-fill requirement targets religious believers or applies only to contraceptives, it may run afoul of the Free Exercise Clause of the United States Constitution\footnote{See generally Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520 (1993).} or other state religious liberties protections.\footnote{See Morr-Fitz, Inc. v. Blagojevich, 867 N.E.2d 1164, 1171-72 (Ill. App. Ct. 2007) (Turner, J. dissenting) (analyzing the Illinois Health Care Right of Conscience Act and the state's Religious Freedom Restoration Act).}

On November 2, 2007, the Governor of New Jersey signed a "must-fill" statute into law, but that statute has several infirmities as a basis for common law liability. The statute states as follows:

1. a. 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.

b. If a pharmacy practice site does not have in stock a prescription drug or device that it carries, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer:

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\footnote{See Peres, supra note 5, at 1. Focusing on pharmacies as opposed to pharmacists does not help individual owner-operators or small pharmacies, but it does limit the number of refusing pharmacists who could face exposure as a result of the rule.}

\footnote{The purpose of must-fill regulations is to enhance access, and therefore, to limit that enhanced access to holders of prescriptions seems counterproductive to federal efforts to enhance access by making Plan B available without a prescription. But there are many reasons to favor prescription holders. The purchase arises from highly respected physician-patient relationship. Ostensibly, the physician has made a professional decision about the woman's condition with which the law discourages interference. Many of the risks to the pharmacist, such as the lack of the learned intermediary shield and other liability exposure, decline when a physician writes a prescription. These policies are of quintessential state concern.}

\footnote{See generally Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520 (1993).}

(1) to obtain the drug or device under its standard expedited ordering procedures; or

(2) to locate a pharmacy that is reasonably accessible to the patient and has the drug or device in stock, and transfer the prescription there in accordance with the pharmacy practice site's standard procedures.

The pharmacy practice site shall perform the patient's chosen option without delay. If the patient so requests, the pharmacist shall return an unfilled prescription to the patient.

c. If a pharmacy practice site does not carry a prescription drug or device, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer to locate a pharmacy that is reasonably accessible to the patient and has the drug or device in stock.  

Characteristic of must-fill rules are the alternatives to dispensing Plan B, such as transferring a prescription or referring the customer to another pharmacy that will sell the product. These supposed alternatives are really no alternatives at all for many pharmacists, however, because they are “direct participation in an act against human life” instead of a passive refusal to sell a product.

The New Jersey legislature clearly intended to increase access to Plan B despite interference from pharmacists' religious or moral scruples, but the statute is not a sufficient basis in which to ground a duty to sell a non-prescription drug. The statute's primary purpose is to make sure a pharmacy otherwise in the business of selling a drug such as Plan B does not allow religious scruples of its employees to get in the way of access to the drug. Were it otherwise, the statute would include a stocking requirement instead of the option to transfer the prescription or refer the customer. Then, the plain language of the statute refers only to “prescription[s]” even though it was enacted more than a year after the FDA's action. Subsections

405 Evangelium Vitae, supra note 50, at 74.
409 The main sponsor had already introduced the original bill when the FDA changed Plan B's status. Prial & Groves, supra note 406.
(b) and (c) so clearly apply only if "a patient presents a prescription" that the failure to take non-prescription status into account can hardly be an accident. The statute also creates no private right of action against a pharmacist for violating it, and an individual pharmacist cannot violate it. The law is also not facially neutral; its plain language targets religion and religious believers and therefore may turn out to be unconstitutional anyway. Whatever merits the New Jersey statute may have as such, it is not an appropriate source for a common law duty or negligence per se.

Washington state's July 2007 regulation is how lawmakers would write a provision if they wanted to require pharmacies to sell both prescription and non-prescription Plan B regardless of religious or moral convictions, and it further illustrates the limits in the New Jersey statute described above. The Washington regulation states:

Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies, or provide a therapeutically equivalent drug or device in a timely manner consistent with reasonable expectations for filling the prescription, except for the following or substantially similar circumstances.

Instead referring to "prescriptions," as does the New Jersey law, the Washington regulation creates a duty to deliver drugs "approved . . . for restricted distribution by pharmacies," which includes Plan B sold even on a non-prescription basis. Refusing pharmacists cannot wriggle away in Washington as easily as in New Jersey.

The New Jersey regulation contains loopholes that would allow a careful pharmacist to get out of the business of selling Plan B at all, but must-stock provisions in Washington law mean pharmacists cannot simply claim bare shelves every time a woman requests Plan B. Washington pharmacies must "maintain at all times a representative assortment of drugs in order to meet the pharmaceutical needs of its patients." Not having a drug in stock is an exception to the regulatory duty to dispense only if the pharmacist has complied in "good faith" with the "must stock" regulation. If the pharmacy is complying in good faith and a drug is still out of stock, the pharmacist must either obtain the drug, contact the prescriber for further instructions, return the prescription, or transfer the prescription to .

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410 There is no apparent intent to create such a right. Lee & Lindell, supra note 341, at § 3:41.
411 Wash. Admin. Code § 246-869-150(1)(c). The section does not imply that "drugs" refers solely to prescription drugs, and when read in light of the must-fill regulation, should not be interpreted as such at least for purposes of complying with the latter provision.
415 Id. at (3)(a).
416 Id. at (3)(b).
a pharmacist who can fill it timely. No refusing pharmacist could comply with these regulations.

Yet the regulation still does not amount to a duty to dispense nor does it state a public policy that is an appropriate foundation for a common law duty. Washington's legislature had already provided conscience protection to health care providers before the state's board of pharmacy promulgated the regulation, recognizing both patients' and health care providers' religious liberties and obscuring in advance a more foundational policy message from the regulation. Further, on July 25, 2007, a group of Washington pharmacists filed a legal challenge to the regulation on federal religious liberties grounds. The district court issued a preliminary injunction on the basis that "the regulations appear to impose a Hobson's choice for the majority of pharmacists who object to Plan B . . . . The evolution of these regulations . . . convinces the Court that these regulations targeted the religious practices of some citizens and are therefore not neutral." Given these conflicting requirements and policies, the must-fill regulation is an inappropriate basis for a tort duty.

Illinois also has a vigorous must-fill regulation, promulgated on August 1, 2005, but it fares no better than Washington state's as a basis for a duty to dispense. It is both hostile toward pharmacy professionals and condescending to religious believers. According to the provision:

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419 Id. at (3)(c).

420 For one thing, violation of an administrative regulation may be evidence of negligence, but its significance pales in comparison to violation of a statute. LEE & LINDELL, supra note 341, at § 3:45.

421 Wash. Code §§ 48.43.065(1) & 70.47.160(1); Stormans, Inc. v. Selecky, 524 F. Supp. 2d 1245, 1249 (W.D. Wash. 2007). The statutory religious liberties protection states:

No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion.

Wash. Code §§ 48.43.065(2) & 70.47.160(2).


423 Stormans, 524 F. Supp. 2d at 1259.


425 For example, the regulation requires that pharmacies display a notice which states as follows:

IF YOU USE CONTRACEPTIVES KNOW YOUR RIGHTS.

If this pharmacy dispenses prescription contraceptives, then you have the following rights under Illinois law:

The pharmacy must dispense your prescribed contraceptives without delay, consistent with the normal timeframe for filling any other prescription.
Upon receipt of a valid, lawful prescription for a contraceptive, a pharmacy must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient's agent without delay, consistent with the normal timeframe for filling any other prescription. If the contraceptive, or a suitable alternative, is not in stock, the pharmacy must obtain the contraceptive under the pharmacy's standard procedures for ordering contraceptive drugs not in stock, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. However, if the patient prefers, the prescription must be transferred to a local pharmacy of the patient's choice under the pharmacy's standard procedures for transferring prescriptions for contraceptive drugs, including the procedures of any entity that is affiliated with, owns or franchises the pharmacy. Under any circumstances an unfilled prescription for contraceptive drugs must be returned to the patient if the patient so directs.\textsuperscript{426}

The regulation puts all the power in the hands of the customer, not only to demand the drug, but to determine how and from whom she will receive it.

The Illinois regulation’s flaws as a source of a duty are legion. It regulates a pharmacist’s conduct only as to prescription drugs, which Plan B now rarely is.\textsuperscript{427} Further, Illinois’ conscience protection for health care providers is even more comprehensive than Washington’s and facially protects against civil liability for refusing to dispense family planning products:

No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.\textsuperscript{428}

“Health care services” includes provision of family planning services,\textsuperscript{429} and “health care personnel” includes “any other person who furnishes, or assists in furnishing of, health care services.”\textsuperscript{430} The Illinois Court of Appeals recently indicated that

\begin{itemize}
  \item When your contraceptive is out of stock, you have the following options: the pharmacy must cooperate with your doctor to determine a suitable alternative, order the contraceptive, or transfer the prescription to another pharmacy of choice.
  \item You can instruct the pharmacy to return the prescription slip to you at any time prior to dispensing.
  \item You may file a complaint with the Department of Financial and Professional Regulation —Division of Professional Regulation through the Department’s website http://www.idfpr.com.
\end{itemize}

\textsuperscript{426} Ill. Admin. Code tit.68, §1330.91(k)(2).
\textsuperscript{427} Ill. Admin. Code tit.68, § 1330.91(j)(1).
\textsuperscript{428} Though normally silence in light of external developments is an imprecise indicator of a lawmaker’s intent, Illinois’ failure to amend the regulation since the FDA changed Plan B’s status creates an inference that it does not tend to do so. See supra note 399 and accompanying text.
\textsuperscript{429} 745 Ill. Comp. Stat. 70/4.
\textsuperscript{430} 745 Ill. Comp. Stat. 70/3(a).
\textsuperscript{430} 745 Ill. Comp. Stat. 70/3(c). “Health care facilities,” also covered under the act, includes “dispensary[ies].” 745 Ill. Comp. Stat. 70/3(c).
Pharmacists and the "Duty" To Dispense Emergency Contraceptives

in a justiciable case, future plaintiffs could state facts sufficient to overturn the regulation based on the Illinois Health Care Right of Conscience Act or the Illinois Religious Freedom Restoration Act. The Illinois must-fill requirement's focus on contraceptive and abortifacient drugs and Governor Blagojevich's statements against conscience-based refusals to dispense also provide strong evidence that it unconstitutionally targets religious believers. A regulation cannot constitute a public policy of a state if the regulation is illegal.

California comes almost as close to the must-fill regulation edge as possible without falling over, but its relevant statutes still provide no basis for extrapolating an individual pharmacist's duty in tort. The statute, enacted in 2005, starts as follows:

It is the intent of the Legislature that health care professionals dispense prescription drugs and devices in a timely way or provide appropriate referrals for patients to obtain the necessary prescription drugs and devices, despite the health care professional's objection to dispensing the drugs or devices on ethical, moral or religious grounds.

California does provide limited conscience protection, as long as it provides no "undue hardship" on an employer saddled with the ultimate responsibility of distributing the drug.

The rest of the statute gives voice to a version of the civil disobedience/conscientious objection distinction. The thrust of the statute is that a pharmacist may not "obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient." What the provision really means, however, is that a pharmacist must fill prescriptions unless doing so would be injurious to

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431 Morr-Fitz v. Blagojevich, 867 N.E.2d 1164, 1171 (Ill. App. Ct. 2007). The vigorous dissent was prepared to go right ahead, arguing that given the precise terms of the regulation, the plaintiffs "must choose either to violate the Rule or their consciences, a form of coercion expressly prohibited by the Right of Conscience Act" and the Illinois Religious Freedom Restoration Act. Id. at 1171–73.

432 Menges, 451 F. Supp. 2d at 1000-01. See also Morr-Fitz, 867 N.E.2d at 1171 (holding that plaintiffs have simply failed to plead facts establishing that they have a concrete injury or will suffer substantial hardship if not permitted to pursue their action; id. at 1172 (Turner, J., dissenting) (referring to the operation of the Act as "coercion" targeting religious conduct); Church of the Lukumi Babalu Aye v. City of Hialeah, 508 U.S. 520 (1993) (holding that a religious gerrymander may be discrimination against religious persons or religion actionable as a Free Exercise violation and reviewable with compelling interest analysis).


434 Cal Bus. & Prof. Code § 733(b)(3).

435 Cal. Bus. & Prof. Code §§ 733(a) ("[n]o licentiate shall obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient") & 733(b) ("a licentiate shall dispense drugs and devices . . . pursuant to a lawful order or prescription unless one of the following circumstances exists," such as the pharmacist's professional judgment that injury will occur to the patient or that the drug is not in stock, with additional measures then to be taken to assist the patient to obtain the drug).
the customer's health, or the drug is not in stock, or the pharmacist refuses on ethical, moral or religious grounds. Despite the statute having been amended in 2006, it makes no requirements as to non-prescription drugs.

The conscience exception is narrow, placing the burden of ensuring access on pharmacies. The pharmacist may refuse to dispense on this basis:

\[
\ldots \text{only if the licentiate has previously notified [her] employer, in writing, of the drug or class of drugs to which [she] objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection.}\]

The employer must also have "protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense."

The statute sweeps broadly, but its facial and implicit exceptions confirm that provides no basis for a duty to dispense in tort. Pharmacist refusals to dispense drugs such as Plan B inspired the 2005 law, but at that time the drug was available in California by prescription and directly from willing pharmacists via a state mandated protocol. The legislature then amended the statute in 2006 without mentioning behind-the-counter Plan B. Taken together, those facts indicate that the California legislature intended pharmacists to honor Plan B prescriptions and to make the drug available widely, but given that it had elsewhere created a voluntary, non-prescription means of distributing the drug through pharmacists, the statute does not indicate an intent to create an involuntary duty to sell behind-the-counter Plan B. Moreover, finding a tort duty to dispense from behind the counter in California based on a statute about prescription drugs would require a court to ignore the existing distinction in California law between prescription and non-prescription Plan B at the time the legislature passed the statute. Finally, the statute's primary focus is obstruction, so that the broader ill the statute targets is in the nature of civil disobedience, not the sort of conscientious objection that the law normally protects and that this statute actually does, albeit narrowly.

The reality, however, is that the California Supreme Court's decision in Catholic Charities of Sacramento, Inc. v. Superior Court, which held that the Women's Contraception Equity Act required employer Catholic Charities to provide health coverage for prescription contraceptives, throws cold water on this optimistic prediction of a California court's analysis of the statute. The Catholic Charities court reads a law that forces a Catholic organization to provide contraceptive coverage

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437 Cal. Bus. & Prof. Code § 733(b)(2). In this case, the pharmacist has a duty under the statute to obtain the drug, transfer the prescription or refer the customer. Id. at § 733(b)(2)(A) - (C).
439 Id.
442 85 P.3d 67 (Cal. 2004).
contrary to its religious foundations as a benefit to the Catholic Church.\textsuperscript{444} The court
denies the law's discriminatory purpose and effect, simply on the basis that Church
organizations requested and received a limited exemption, despite noting that no
other religious organizations appear to be subject to the law.\textsuperscript{445} The court questions
whether Catholic Charities' "obligation arising from the Gospel message of justice
and charity" to provide at least some prescription drug benefits for its employees is
truly one of religious belief as opposed to one of "philosophical choice."\textsuperscript{446} Finally,
the court holds that the contraceptive coverage requirement is necessary to achieve
"the compelling state interest of eliminating gender discrimination"\textsuperscript{447} despite the
statute's having an exemption for some religious employers.\textsuperscript{448} Pharmacists refusing
to sell Plan B in this hostile legal environment are unlikely to benefit from precise
readings of statutes or policy inferences in their favor.

\textit{Professionalism Standards}

Judge them as their own profession judges them: this is the superficially attrac-
tive justification for distilling common law duties from professionalism standards.\textsuperscript{449} Many states' ethics requirements do chide pharmacists for "[r]efusing to compound
and dispense prescriptions that may reasonably be expected to be compounded
or dispensed in pharmacies by a pharmacist,"\textsuperscript{450} a sobering standard for refusing
pharmacists. According to the leading authority in pharmacy malpractice, however,
extrapolating duties from professionalism standards is unwise, because:

- A "standard" may not be a standard at all, but rather an aspirational goal
  for the profession;
- Recognizing standards as legal duties might create a disincentive to setting
  clear professional goals and exercising professional discretion;
- It is more appropriate in setting legal duties to focus on patient rights as
  opposed to caregiver values; and,
- Indirectly allowing professional groups to define legal duties could result
  in collusion to avoid liability.\textsuperscript{451}

Moreover, professionalism standards often change quickly, while the nature of the
common law is that it develops slowly, one case at a time. Courts do honor profes-

\textsuperscript{444} Id. at 84-85 & n.9 (noting that a crabbed conscience exemption that relieves some Catholic
organizations from the coverage requirement only benefits them, because "no other religious group
opposed to prescription contraceptives has been identified").
\textsuperscript{445} Id.
\textsuperscript{446} Id. at 91-92.
\textsuperscript{447} Id. at 92.
\textsuperscript{448} See id. at 93-94.
\textsuperscript{449} Brushwood, \textit{Duty to Warn}, supra note 312, at 54.
\textsuperscript{450} E.g., N.D. Admin. Code § 61-04-04-01(14).
\textsuperscript{451} Brushwood, \textit{Duty to Warn}, supra note 312, at 54-55.
sionalism standards when defining pharmacists' duties, albeit mostly in the breach, but a review of professions relevant to a duty to dispense is a classic illustration of why it is better not.

Even the most vanilla professionalism rules are quicksand for duty seekers. North Dakota's Board of Pharmacy rule is an example: "The definition of 'unprofessional conduct' . . . includes, but is not limited to, . . . (14) [r]efusing to compound and dispense prescriptions that may reasonably be expected to be compounded or dispensed in pharmacies by a pharmacist." Non-prescription Plan B is by definition not a prescription drug, and given that Plan B is available (and likely will be sold) as a non-prescription drug, prescription Plan B is not a drug that "may reasonably be expected to be . . . dispensed in pharmacies." Taking Plan B's FDA status together with uncertainties about conscience rights, consumers are more reasonable to have few expectations either way about Plan B's availability. Though potentially amenable to define pharmacists' responsibilities as to Plan B, this provision is more appropriately applicable to stopping arbitrary and capricious pharmacist conduct. It says little or nothing about common law duties.

Explore more such standards and you will sink far, fast. Maine has a Board of Pharmacy regulation equivalent to North Dakota's, but Maine also has statutory conscience protection for health care professionals "refusing to provide family planning services when such refusal is based upon religious or conscientious objection." The statutory language can be read to reach pharmacists—"No private institution or physician or no agent or employee of such institution or physician"—but at minimum, the policies conflict in spirit. This is a thin reed on which to hang a common law duty.

Georgia is the regulatory mirror of Maine. Its professionalism code includes a clause stating: "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." On the other hand, Georgia's statutory conscience protection for

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451 E.g., Pittman v. UpJohn Co., 890 S.W.2d 425, 434-35 (Tenn. 1994) (discussing state statutes and regulations and quoting from a David Brushwood law review article describing "pharmaceutical care" in discussion of pharmacist duties, but holding on other grounds that no duty existed); Dooley v. Everett, 805 S.W.2d 380 (1990) (using APhA as a source of duty); McKee v. American Home Products, 782 P.2d 1045, 1051 (1989) (not finding duty from "definitional" and non-mandatory professionalism standards); Adkins v. Mong, 425 N.W.2d 151, 153 (Mich. Ct. App. 1988); Brophy, 497 N.E.2d at 639; see also Presto v. Sandoz Pharm. Corp., 487 S.E.2d 70, 74 (Ga. Ct. App. 1997) (leaving open the possibility that pharmacy board standards might assist in shaping duties by noting that they do not apply because they were promulgated prior to the claim arising).


453 See 02-392-30 Me. Code R. § 1(24)


455 Id. A pharmacy can be a "private institution" and a pharmacist an "agent or employee of such institution." To the extent that a hospital-employed pharmacist is at issue, the statute clearly provides protection.

456 Ga. Comp. R. & Regs. § 480-5-.03(n).
pharmacists otherwise required to participate in abortion services says, "[n]othing in this subsection shall be construed to authorize a pharmacist to refuse to fill a prescription for birth control medication including any process, device, or method to prevent pregnancy . . . ."457 At minimum, a court could not confidently glean a firm public policy as to pharmacists' duties to sell emergency contraception from this pair of authorities.

Codes of ethics from professional associations are also riddled with equivalent imprecision, though as to Plan B, they ultimately degenerate into a rough civil-disobedience-versus-conscientious-objection framework. The American Pharmacists Association ethics code recognizes conscience rights458 within a patient-centered context.459 The organization's 2004 amended policy states:

The APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patients' access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.460 The theme is simple: assist the customer to the extent conscience permits and avoid crossing the line into obstruction. The American College of Clinical Pharmacy,461 American Society of Health-System Pharmacists and the Academy of Managed Care

457 Ga. Code Ann. § 16-12-142(b).
459 Perhaps the two most relevant are:

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.

A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.


460 Action, supra note 458.
461 The American College of Clinical Pharmacy is similar, and has also endorsed conscience rights, adding:

[T]he pharmacist has a concurrent professional and ethical responsibility to ensure that in situations where patients are seeking access to legally prescribed medications, devices, or services, such patients are referred to another pharmacist or other health care provider in an effective, professional, timely, confidential, and non-judgmental manner.
Pharmacists support these subtle lines in the sand.\textsuperscript{462}

Physicians would like to redraw those lines, but even they do not go so far as to advocate a true duty to dispense. The two professions have stumbled into a bitter squabble, with some physicians taking the view that pharmacists lack the professional characteristics that would entitle them to refuse to dispense.\textsuperscript{463} Nevertheless, even though the American Medical Association may talk tough—resolving that “our AMA support legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions”—ultimately, they demand only that refusing pharmacists “provide immediate referral to an appropriate alternative dispensing pharmacy.”\textsuperscript{464}

One danger of relying on the American Medical Association as a statement of doctors’ clinical view of how much decisional autonomy pharmacists should have in morally ambiguous situations is that doctors do not practice what they preach. According to a recent study published in the New England Journal of Medicine, 86 percent of all doctors believe they should present all treatment options to patients, even in morally ambiguous situations.\textsuperscript{465} On the other hand, the same study also shows that almost two-thirds of doctors believe it is acceptable to discuss their moral objections to a particular treatment, and only 71 percent think they are obligated to refer patients to a doctor who does not object to the procedure.\textsuperscript{466} Although the group of physicians surveyed included those of all specialities and not only gynecologists

\textit{American College of Clinical Pharmacy Board of Regents, Position Statement: Prerogative of a Pharmacist to Decline to Provide Professional Services Based on Conscience} (Aug. 2005). In its background to the policy statement, the ACCP adds:

> pharmacists should strive always to serve the legitimate health care needs and desires of their patients. In the very limited situations where those needs and desires are in conflict with a pharmacist’s values, the obligation of the pharmacist is to provide a referral for the patient to receive the care they desire—without any actions seeking to persuade, coerce, or otherwise impose on the patient any of the pharmacist’s values, beliefs or objections.

Id. at bkgrd.

\textsuperscript{462} Judith Cahill, et al., Pharmacist Critique Woefully Outdated and Uninformed (letter to the editor of Obstetrics and Gyneco\textit{\textsc{logy}} from leaders of professional pharmacists’ groups).

\textsuperscript{463} Compare L. Lewis Wall & Douglas Brown, Refusals by Pharmacists to Distribute Emergency Contraception: A Critique, 107 Obst. & Gyn. 1148 (2006), with Cahill, supra note 462. Admittedly, the Wall & Brown article has perhaps an excessively dismissive tone, claiming that since pharmacists are merely dispensers as opposed to meaningful players in therapeutic decisionmaking, they lack a “professional right” to refuse to dispense. The pharmacists’ associations did not miss this tone, characterizing it as “seek[ing] to transform pharmacists from thinking health care professionals into robots or automatons forbidden from having personal beliefs and from exercising their considerable professional judgment gained during years of education and practice.”

\textsuperscript{464} American Medical Association, Preserving Patients’ Ability to Have Legally Valid Prescriptions Filled (adopted June 2005) (hereinafter “AMA Policy”).


\textsuperscript{466} Id.
or obstetricians, 52 percent of respondents reported moral objections to emergency contraception. 467 The Christian Medical Association openly backs pharmacists' right to refuse to dispense. 468 Some physicians may harbor self-interested motives. 469 Therefore, interesting though this power struggle between health care professional groups may be to outsiders, the AMA's position should not be persuasive to a court defining pharmacist duties.

**Conclusion: What Is A Conscientious Pharmacist To Do?**

Though a common law "duty to dispense" Plan B is at best an aspirational goal for contraceptive rights activists, pharmacists do have some legal duties to even potential customers seeking the drug. Plan B's "behind-the-counter" status does mean pharmacists remain the "gatekeeper" for the drug. 470 As "pharmaceutical care" becomes a reality for more pharmacists, the increase in responsibility and discretion will imply more legal duties. 471 Finally, while American law values rights of conscience, especially among professionals coping with particularly sensitive issues, state statutes 472 and professionalism standards 473 discourage efforts to obstruct women seeking Plan B. Particularly where a pharmacist and a woman have a relationship providing a basis for a woman to believe she can rely on the pharmacist to provide Plan B, the pharmacist clearly is at significant risk of exposure. 474 Nevertheless, pharmacists are not simply unprotected victims of this legal state of nature.

State statutes and professionalism standards suggest compromises that will permit some pharmacists to navigate the waters between the Scylla of conscience violations and the Charybdis of civil liability. 475 As long as a pharmacist is willing to transfer a prescription, 476 refer a customer to a colleague, show the potential customer

467 Id.
469 For example, physicians also want privileges in certain cases to dispense medications to protect their patients' rights. AMA Policy, *supra* note 464 ("RESOLVED, That our AMA, in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty mile radius who is able and willing to dispense that medication").
471 Brushwood, "Can" Imply "Ought"? *supra* note 108, at 456-57 (arguing that pharmaceutical care means pharmacists accept responsibility for bad outcomes).
472 E.g., Cal. Bus. & Prof. Code § 733(a).
474 See *supra* text and notes at 362-365.
475 See *supra* text and notes 402-404 (discussing statutory transfer requirements).
476 "Transfer" of a prescription involves the pharmacist sending the prescription to a colleague, usually at the customer's request. Transfer, as opposed to referral, is not all that relevant for an over-the-counter drug, but some teenagers and those seeking insurance/Medicaid reimbursement will present Plan B prescriptions. See *supra* text and notes at 178-179, and 209.
some respect, and return the prescription,\textsuperscript{477} she will probably avoid legal liability for refusing to dispense contraception even in states with tough professionalism rules. Unfortunately, the referral or transfer compromise does not solve all objecting pharmacists’ problems, because for some, dispensing an abortifacient could constitute the sort of “direct participation . . . or sharing in the immoral intention”\textsuperscript{478} of a person engaged in an act against human life.\textsuperscript{479} As Karen Brauer, President of Pharmacists for Life explained it, referring a customer to a colleague who will sell Plan B “is like saying ‘I don’t kill people myself but let me tell you about the guy down the street who does.’”\textsuperscript{480}

A court might consider such a conscience burden too great to impose a duty to transfer or refer, for example,\textsuperscript{481} but the plight of a potential customer with a reasonable reliance interest in difficult circumstances could outweigh a court’s perception of that burden.\textsuperscript{482} Prescription transfer and referral do satisfy reliance interests to the extent that a customer has not herself exacerbated the risk by delay, for example, so that to the extent a pharmacist can transfer or refer, those actions will eliminate most if not all possible liability exposure.\textsuperscript{483} The “transfer-or-refer” compromise is what many state professionalism standards require\textsuperscript{484} and academic authorities’ encourage.\textsuperscript{485} After all, if another pharmacy is nearby, as one would be in the urban or suburban areas where most Americans now live, the woman would not lose much time going elsewhere as long as she knew where to go.\textsuperscript{486}

\textsuperscript{477} The Mississippi Supreme Court has held that not returning a prescription is actionable. See White v. McComb, 38 So. 739 (Miss. 1905). Many states’ statutes and professionalism standards now require prescription return if the pharmacist does not intend to fill. E.g., Cal. Bus. & Prof. Code § 733(b)(2)(C); Ill. Admin. Code tit. 68, § 1330.91(j)(1); Ok. Stat. Ann. § 354(A); Wash. Admin. Code § 246-869-010(4).

\textsuperscript{478} Evangelium Vitae, supra note 50, at 1 74.

\textsuperscript{479} Nelson, supra note 254, at 166.

\textsuperscript{480} Rowlands, supra note 441, at 171. In fact, transfer may not be a complete solution for anyone. One commentator notes that dissenting pharmacists may be dissatisfied given that transfer is only a tiny bit removed from dispensing the drug themselves, and some women may be displeased, because such a requirement seems discriminatory—whether actually so in law—because no men’s prescriptions must be transferred for similar reasons. Sarah Tomkowiak, Reconciling Principles and Prescriptions: Do Pharmacist Refusal Clauses Strike the Appropriate Balance Between Pharmacists’ and Patients’ Rights, 2007 U. Ill. L. Rev. 1329, 1348-49 (2007).

\textsuperscript{481} See supra text and notes at 382-389.

\textsuperscript{482} See supra text and note at 364.

\textsuperscript{483} Cf. Dries-Daffner, et al., supra note 165, at 94.


\textsuperscript{485} See, e.g., Cantor & Baum, supra note 69, at 2011; Lin, supra note 39, at 136-37; White, supra note 39, at 1646. But see Herbe, supra note 254, at 101 (arguing conscience clauses should protect even from the requirement to refer).

\textsuperscript{486} Cf. Lasley, 880 P2d at 588 (court should establish whether a duty to a particular person should exist, and if it does, the substance of the duty should depend on the relationship of the defendant and the plaintiff).
A prophylactic means of eliminating customer reliance entirely is to make clear from the beginning of the pharmacist’s relationship with the customer what the pharmacist will and will not sell. The Brophy-Requena-Jobes line of cases strongly infer that prior notice insulates a conscience refusal from collateral attack; after all, notice eliminates reasonable reliance. Providing notice is also ethical. The Ethical and Religious Directives for Catholic Health Care Services recommend that Catholic hospitals treating rape victims make sure they are fully advised of “the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures.” A community pharmacy might post signs stating that emergency contraception is not available in the store, and the strategy is more likely to be successful the fewer forms of contraception the pharmacy sells. Hopefully a court finding a duty to provide notice will be sensitive to a pharmacist’s scruples in the messages it requires.

Other “miscellaneous” duties are more troubling, which should caution against importing them into common law duties. Anti-“lecturing” rules are an example. What constitutes “lecturing” the customer depends very much on the beholder. Most of these fairly vague rules were adopted in the wake of incidents such as those in

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487 Professor Pellegrino recommends that physicians—and the same would apply to pharmacists—“should prepare a leaflet outlining what they can, and cannot, in good conscience, do,” because “[p]atients should know in advance of a crisis that what they desire and believe to be morally acceptable may not be acceptable to the physicians they may be engaging.” Pellegrino, Physician’s Conscience, supra note 241, at 242-43.

488 See supra text and notes at 285-287 and 303.

489 See United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services n.19 (June 15, 2001) (hereinafter “Ethical and Religious Directives”). The Ethical and Religious Directives apply in a hospital setting, which is not the primary factual setting this article addresses. The fact that they urge notice raises another question beyond the scope of this paper but worth considering in a tort action: whether a woman aware of a provider’s policy has comparative fault if she relies on the provider for drugs the provider does not prescribe or sell.

490 See Pellegrino, Physician’s Conscience, supra note 241, at 242-43; Selby, supra note 254, at 523. One of the intriguing developments in the academic literature is that those sympathizing with both the buyer and seller in the Plan B squabble lean toward compromises that rely on letting the market work, which implies, of course, full information. Compare White, supra note 39, at 1645 (arguing that pharmacies will be embarrassed to post notice that they will not fill prescriptions and therefore will resolve any conscience problems with so doing before customers show up) with Vischer, supra note 38, at 112 (arguing in favor of no regulation in the form of “duty-to-fill” statutes or conscience clauses but requiring that pharmacists be candid about what prescriptions they will or will not fill). Those who believe that free markets maximize utility can hardly be surprised at a result suggesting that the market will best protect everyone, but they do imply a duty to disclose what the pharmacist will or will not sell ahead of time.

491 For example, Cantor and Baum recommend notice that refers customers to Planned Parenthood or the emergency contraception website. Cantor & Baum, supra note 69, at 2011. The suggestion is simply unrealistic.

492 E.g., Wash. Admin. Code § 246-869-010(4)(e) (banning intimidation or harassment of customers).

493 See, e.g., OREGON BOARD OF PHARMACY, POSITION PAPER: CONSIDERING MORAL AND ETHICAL OBJECTIONS (Rev Jun. 7, 2006) (“the Board would consider it unprofessional conduct for a pharmacist to lecture a patient about the pharmacist’s moral or religious beliefs”).
which a woman seeking to fill an oral contraception prescription received a “full rant about [the] ‘murder of a baby’”, or in which another was told, “I will not help you kill this baby” when she presented an emergency contraception prescription.

These incidents make everyone wince, but the proposed “remedies” may be as bad as the disease. In the first place, they compromise a pharmacist’s ability to make sure a woman is sufficiently informed about the consequences of using Plan B. Compliance with regulations condemning what truly is “verbal abuse” does not raise moral or ethical issues, but to the extent true verbal abuse is not at issue, in the absence of a doctor’s advice and direction, a pharmacist may be the only health care professional left who can provide a customer with relevant information about the drug. Counseling customers is a hallmark of both statutorily mandated and aspirational notions of “pharmaceutical care.” Pharmacist duties to warn are well established and may imply a duty to counsel women in the behind-the-counter setting. If pharmacists have a legal, moral or ethical duty to counsel women about the potentially abortifacient effects of Plan B, they can hardly comply with both the regulation and the common law.

The underlying ethic of “informed consent” also implies some responsibility to help women make truly consensual decisions about Plan B. Even though the requirement does not arise in the over-the-counter setting, courts should be discomforted by depriving women of critical information needed to make informed decisions. To the extent that “anti-lecturing” regulations chill pharmacists’ ef-
forts to provide information, they also contradict the policies underlying warning requirements and counseling mandates.

In fact, pharmacists’ religious beliefs may require some effort to inform a patient fully about emergency contraception. The Catholic Church calls on health care professionals to do more than abstain from participating in morally illicit conduct; Catholic teaching should not “place at the service of death skills which were acquired for promoting life.” Counseling is such a skill, which for some pharmacists would create a moral duty to be honest with patients about the potential moral consequences of their conduct. At best, anti-lecturing rules seem counter-productive and at worst could violate both parties’ First Amendment rights.

These “intermediate duties” and “prophylactic strategies” aside, however, in the final analysis, a tort duty to dispense emergency contraception is both practically unwarranted and would be a radical departure from established common law duty analysis. There are better ways to protect women and split the differences a pluralistic society implies without trampling both individual rights and societal interests in professionals’ conscientious scruples. Both courts and other policymakers should explore them first.

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503 Evangelium Vitae, supra note 50, at ¶ 59.
504 Pontifical Academy for Life, Moral Reflections on Vaccines Prepared From Cells Derived From Aborted Human Foetuses 5 (promulgated June 9, 2005) (explaining that “omission of an act of denunciation or impediment of a sinful action carried out by another person” should be avoided except when “it would be greatly difficult to do so”). A pharmacist may be able to distinguish between customers who might and might not value such information in order to avoid discomfort when regular customers attempt to purchase Plan B. A regular customer who does not use daily oral contraceptives may be unaware of their potential abortifacient effect or may not use them because of her awareness. She may appreciate counseling about Plan B, even with moral implications, before making a decision to use the drug.
505 Cf. Planned Parenthood v. Casey, 505 U.S. 833, 883-84 (1992) (finding no First Amendment implications to informed consent rules that require doctors to provide information about fetal development to women prior to an abortion). This is especially true to the extent that they may be void for vagueness in some instances.