Current Commentary

Refusals by Pharmacists to Dispense Emergency Contraception

A Critique

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Over the past several months, numerous instances have been reported in the United States media of pharmacists refusing to fill prescriptions written for emergency postcoital contraceptives. These pharmacists have asserted a "professional right of conscience" not to participate in what they interpret as an immoral act. In this commentary, we examine this assertion and conclude that it is not justifiable, for the following reasons: 1) postcoital contraception does not interfere with an implanted pregnancy and, therefore, does not cause an abortion; 2) because pharmacists do not control the therapeutic decision to prescribe medication but only exercise supervisory control over its dispensation, they do not posses the "professional right" to refuse to fill a legitimate prescription; 3) even if one were to grant pharmacists the "professional right" not to dispense prescriptions based on their own personal values and opinions, pharmacists "at the counter" lack the fundamental prerequisites necessary for making clinically sound ethical decisions, that is, they do not have access to the patient's complete medical background or the patient's own ethical preferences, have not discussed relevant quality-of-life issues with the patient, and do not understand the context in which the patient's clinical problem is occurring. We conclude that a policy that allows pharmacists to dispense or not dispense medications to patients on the basis of their personal values and opinions is inimical to the public welfare and should not be permitted.

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A 14-year-old girl from St. Louis presented to her gynecologist with an acute vaginal hemorrhage from perimenarchal anovulatory uterine bleeding. After evaluating this patient, her gynecologist prescribed a management regimen using a high-dose hormonal taper of oral contraceptive pills to control the bleeding. She wrote a prescription that included explicit instructions as to how the birth control pills were to be taken. The girl and her mother took the prescription to a local drug store. Instead of filling the prescription, the pharmacist berated them, accused them of "trying to produce an abortion," and refused to dispense the medication. This disturbing (but true) story of abusive behavior by a pharmacist raises the important question of whether or not pharmacists should be permitted to refuse to fill prescriptions on the basis of their personal values and opinions. We contend that such behavior is disruptive to effective medical care and should not be permitted.

Pharmacists who refuse to fill prescriptions because of their personal values and opinions often claim they are professionals and should be given the same kind of discretion routinely exercised by doctors, lawyers, and the clergy in carrying out their professional duties. Pharmacists do possess specialized knowledge, undergo an extensive period of academic training, espouse commitments to the greater social good, and are granted special, formal recognition by society in the form of professional licensure. However, pharmacy also suffers from a significant limitation. Unlike physicians, pharmacists do not exercise full autonomous control and authority over their area of expertise.[1] For this reason sociologists have used pharmacy as a classic example of "incomplete professionalization."[2] Although acknowledged as experts in the nature and action of drugs, pharmacists do not control the use of prescription medications. Pharmacists exercise only technical supervision over the dispensation of medications that are prescribed by physicians.[1,2] Because pharmacists can dispense but not prescribe medications, their activities are constrained in major ways by the

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medical profession. Physicians send their patients to the pharmacy to have prescriptions filled, and they retain responsibility for the care of these patients. They do not transfer their care to the pharmacist. The pharmacists who fill such prescriptions (particularly in the commercial retail setting) typically have only the most cursory knowledge of the clinical circumstances in which any given patient's prescription has been written. The pharmacist's knowledge of the patient's condition is usually obtained only by deduction: "Mrs. Smith has presented me with a prescription for amlodipine. Therefore, I deduce that she has hypertension." The person who presents the prescription at the counter is the pharmacist's *customer*, but remains the physician's *patient*. Customers who go to a drug store do not expect to have a professional encounter similar to what transpires between physician and patient, priest and congregant, or lawyer and client. Pharmacists do not take comprehensive medical histories, perform physical examinations, or evaluate laboratory results when they fill prescriptions. Indeed, pharmacists in general (and commercial retail pharmacists in particular) usually have more in common with corporate managers, retailers, and the general business community than they do with members of the traditional learned professions.

Physicians expect pharmacists to fill the prescriptions they have written correctly and in a timely manner. Physicians expect pharmacists to exercise due diligence in their work and to exercise appropriate technical pharmacological judgment in so doing. They do not expect pharmacists to fill prescriptions that contain obvious dosing errors or that pose a dangerous risk of interacting with other drugs, about which the prescribing physician might not be aware. They do not expect pharmacists to fill forged or obviously fraudulent prescriptions. If there are technical questions surrounding a prescription, physicians expect pharmacists to resolve these questions by contacting them in a timely manner and in a professional way.

Physicians also expect pharmacists *not* to do certain things. They do not expect pharmacists to question the diagnosis for which the prescription was written. They do not expect pharmacists to recommend alternative treatments to their patients. Most emphatically, physicians do not expect pharmacists to pass judgment about the moral propriety of the prescribed treatment regimen. In our opening case, the pharmacist violated almost every expectation of appropriate professional behavior. Not only did he refuse to honor a legitimate prescription written for a common clinical problem, but this refusal was based on erroneous information about the pharmacologic actions of the medication prescribed, on a misunderstanding of the indications for which the prescription was written, and on unfounded presuppositions about the patient's situation.

Once personal values and opinions become the criteria by which prescriptions are dispensed or not dispensed, the door is open to a wide range of abuses.

Consider the following hypothetical (but conceivable) case. Betty Jones is a 25-year-old married female who has never been pregnant. She has pulmonary hypertension from Eisenmenger's syndrome. Her gynecologist has advised her that this medical condition would pose a grave threat to her life if she becomes pregnant, with a 40–50% chance of death.[3] Ms. Jones and her husband have used condoms for contraception for the past 2 years, but the last time they had intercourse (at midcycle) the condom broke. She is terrified of becoming pregnant. Her gynecologist had previously given her a prescription for an emergency postcoital contraceptive, Plan B (Barr Laboratories, Pomona, NY), in case such an eventuality arose. The day after the unprotected intercourse, she takes this prescription to her local pharmacy to get it filled. The pharmacist refuses to dispense the medication due to his moral objections to emergency contraception. Before abruptly turning away from her, the pharmacist tells her that emergency contraception induces an abortion and that he will not participate in such an action.

Are pharmacists ethically justified in refusing to fill prescriptions for emergency postcoital contraceptives such as Plan B?

Pharmacists, as pharmacists, have an obligation to use standard medical terminology according to established usage so as not to mislead or confuse patients who come to them to have prescriptions filled. Pharmacists are not entitled to act like Humpty Dumpty who, in Lewis Carroll's *Through the Looking Glass,* said to Alice (in rather a scornful tone), "When *I* use a word it means just what I choose it to mean–neither more nor less." When pharmacists talk about hypertension or diabetes, for example, they have an obligation to use such terms in accord with established medical definitions. The use of an idiosyncratic personal defini-

tion is never justified. According to the internationally accepted obstetric definition, a human pregnancy begins with the implantation of the blastocyst.[4,5] This definition is even enshrined in federal law in the regulations that govern the protection of human subjects in research.[6] Because emergency contraceptives such as Plan B neither disrupt implantation nor have an effect on the implanted blastocyst, they do not cause an abortion. Pharmacists who describe these medications as abortifacients are either scientifically uninformed or are deliberately misusing standard medical terminology to promote a personal moral or political agenda.

There is abundant clinical evidence that the main mechanism of action of emergency contraception involves disruption of the physiology of ovulation, probably by interfering with the luteinizing hormone surge. The fact that pregnancy rates are much lower the earlier after intercourse the medications are taken[7] strongly suggests that emergency contraception operates through prefertilization mechanisms rather than through postfertilization effects. Early studies that suggested emergency contraception inhibits implantation have not been supported by more recent studies.[8] If the mechanisms of action included interference with implantation (which occurs approximately 7 days after fertilization), later administration of these drugs should be as effective as earlier administration, which is not the case.[9] Although statistical modeling has suggested that emergency contraception may also work in part through other mechanisms, such as by impairing sperm transport or penetration or by interfering with the corpus luteum, there is no direct clinical evidence that postfertilization mechanisms play any significant role in how emergency contraceptives work, and they will not cause congenital malformations should a pregnancy occur in spite of their use.[8–10] If, therefore, a prescription for postcoital contraception is presented to the pharmacist within 72 hours of the act of intercourse, a pregnancy cannot yet exist because implantation will not have occurred. Furthermore, it will be impossible to know if a pregnancy will result from the particular act of intercourse in question when the prescription is presented to a pharmacist because production of human chorionic gonadotropin from the conceptus will not be detectable clinically until at least a week after fertilization.[11]

In the hypothetical Betty Jones case, not only is the pharmacist factually in error about the nature of the medication being denied, but he also lacks the basic prerequisites for making an adequate, acceptable ethical judgment. Jonsen et al[12] propose that every clinical scenario in which an ethical problem arises should be analyzed by examining 4 salient features of the case: "1) medical indications, 2) patient preferences, 3) quality of life, and 4) contextual features, defined as the social, economic, legal, and administrative context in which the case occurs." In the hypothetical Betty Jones case, the medical indications for which the prescription had been written are unambiguous. The patient has a cardiopulmonary condition that will likely cause her death if she becomes pregnant. The patient's preferences are also unambiguous. She has known about her condition for years, is intelligent and well educated, and understands the probable consequences of pregnancy for her. Neither she nor her husband wants her to become pregnant. She has carefully considered the fact that she might someday require a therapeutic abortion because of her medical condition. However, given her religious and philosophical background, she would prefer to avoid the need for an abortion by using postcoital emergency contraception, which she clearly understands is *not* an abortifacient. The pharmacist at the counter, lacking the critical information necessary to analyze Ms. Jones' situation, cannot make a competent ethical decision regarding her prescription for Plan B. His refusal is based on a poorly informed a priori judgment about emergency postcoital contraception.

In light of the time constraints she faces, Ms. Jones may well feel compelled to argue with the pharmacist about his refusal to fill her prescription. But there are other customers crowding the counter, and there is no truly private consultation area in which she can make her appeal. Should she be forced to recite her whole medical history in public to a pharmacist who has never met her before, has never examined her, has no access to any of her laboratory or clinical records, and has been actively hostile toward her from the beginning? Should she be forced to outline her menstrual and sexual history in front of a store full of customers? Not only would this be illegal under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, but it would subject her to grotesque procedural injustice as well. Lacking an appropriate clinical understanding of this patient's circumstances, it is unethical for this pharmacist to refuse to fill her prescription solely on the basis of his own preconceptions.

Rawls[13] has defined justice as basic fairness. A fundamental function of "justice as fairness" is to protect individuals in the marketplace from arbitrary discrimination based on unjustifiable prejudice. The retail pharmacist presented with a legiti-

mate prescription is in very much the same position as a realtor who must abide by the fair housing laws that prohibit racial discrimination in the housing market. Certain acts of prejudice are simply not tolerated in an open democratic society. Allowing pharmacists carte blanche to refuse to fill legitimate prescriptions for purported "reasons of conscience" introduces an unjust and unacceptable level of arbitrariness into the health care system. Once personal values and opinions become the criteria by which prescriptions are dispensed or not dispensed, the door is open to a wide range of abuses. Would we sustain the moral objections of homophobic pharmacists who refuse to dispense antiretroviral drugs to an acquired immunodeficiency syndrome (AIDS) patient (perhaps a hemophiliac who acquired the infection through a blood transfusion or an innocent married woman who acquired the disease as the result of her faithful relationship to a philandering spouse) because they view AIDS as "God's punishment" for sodomy? Would we allow pharmacists to refuse to dispense insulin or oral hypoglycemic agents to obese diabetics because their sense of moral outrage is triggered by their assumption that such patients are just "lazy gluttons" who ought to exercise more and eat less to control their blood sugar? Access to legitimately prescribed medications should not be dependent upon one's race, religious convictions, private behavior, or political affiliations. In the hypothetical Betty Jones case, the purpose of the pharmacist's objection appears to be not only to keep his conscience clean, but also to intimidate a patient (who desperately needs access to a properly prescribed medication) to advance his own personal agenda. Such actions exploit patients by using them as means to another goal rather than treating their clinical problems as the end to which a therapeutic relationship should be directed.[14] This kind of behavior should be vigorously opposed by all health care professionals.

Pharmacists should never be in jeopardy for filling prescriptions they believe to be legitimate or for refusing to fill prescriptions they have reason to suspect have been written illegally (eg, in an attempt to obtain narcotics). Pharmacists should never be in jeopardy for refusing to fill a prescription that appears to have been written in error (eg, for the wrong dosage or the wrong drug) or for refusing to fill a prescription they feel may cause a potentially fatal drug interaction. In these cases, the pharmacist has a fiduciary duty to contact the prescribing physician in a timely fashion to address the perceived problem. But pharmacists who refuse to fill legitimate prescriptions for medications because of their personal values and opinions should be held accountable for their actions. Such violations should be reportable to state boards of pharmacy, and pharmacists who engage in such activities should be liable for sanctions, including the loss of their licenses, and employers should be able to use such behavior by pharmacists as legitimate grounds for terminating their employment. We cannot allow access to legitimately prescribed medications to be hijacked for other purposes.

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