

Cold Comfort Pharmacy: Pharmacist Tort Liability for Conscientious Refusals to Dispense Emergency Contraception

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Abstract: The past several years have seen an increasing number of pharmacists refuse to dispense emergency contraception, an effective, post-coital form of contraception, on the grounds that the drug violates their personal beliefs. This Article addresses the impact of those pharmacist refusals under existing principles of tort law. The Article draws on existing pharmacy case law, state-specific refusal clauses, and ethics statements promulgated by professional pharmacy associations to investigate whether pharmacists have a legal duty to dispense emergency contraception, notwithstanding religious or ethical objections. Concluding that in most states, such a legal duty does exist, the Article develops a “wrongful conception” theory of tort liability for refusing pharmacists and argues that by refusing to dispense emergency contraception, pharmacists subject themselves and their employers to potential civil liability, including significant compensatory and punitive damages.

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I first learned about emergency contraception as a first-year college student. Returning from the semester break just after New Year, a friend and I began comparing notes about our respective holidays. “It was awful,” she told me. “*You* try driving a crying girl around for hours, searching for a doctor’s office or a Planned Parenthood that would be open on New Years Day. Let me tell you, *no one* is open.”

My friend and her car had been pressed into service by her dear friend from high school, a young woman whose New Year festivities had been punctuated not with the dropping of the ball but with the breaking of a condom. My friend explained to me that when contraception fails or for whatever reason is not used, emergency contraception, or “EC” for short, provides a woman’s last, best hope for avoiding an unplanned pregnancy. The drug provides a high dose of hormones similar to those contained in regular birth control pills, and is up to 89% effective—but only if taken within 72 hours of unprotected sex, and the sooner the better.¹

New Years Day fell on a Friday that year, and clinic after clinic had already posted their “closed” signs for the weekend. This was at the beginning of 1999, one year after the U.S. Food and Drug Administration (“FDA”) first approved EC for prescription use under the brand name Preven,² but nearly eight years before the agency would approve the drug for limited over-the-

¹ Press Release, American College of Obstetricians and Gynecologists, ACOG Steps Up Efforts to Get Emergency Contraception to Women (May 8, 2006) (available at http://www.acog.org/from_home/publications/press_releases/nr05-08-06-1.cfm) (last visited Sept. 21, 2006) [hereinafter ACOG Press Release].

² Emergency contraception has been an established off-label use of traditional birth control pills since the 1960s. Charlotte Ellertson, *History and Efficacy of Emergency Contraception: Beyond Coca-Cola*, 22 INT’L FAM. PLAN. PERSP. 52 (1996). Despite widespread acceptance of the practice, pharmaceutical companies were reluctant to market their traditional birth control pills as off-label emergency contraception, citing concerns about potential liability and a limited potential for profit. Gina Kolata, *Morning-After Contraceptive to Be Marketed*, N.Y. TIMES, July 21, 1998 at A12. In February 1997, the FDA responded to a citizen petition from the Center for Reproductive Law and Policy by publishing an official notice in the Federal Register stating that the efficacy and safety of certain off-label emergency contraceptive regimens had already been demonstrated and that the agency would therefore not require expensive new drug trials for applications to market and distribute emergency contraception. Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610 (Feb. 25, 1997). Preven, which consists of both progestin and estrogen, was approved by the FDA in September 1998 as a prescription-only emergency contraception regimen, U.S. FOOD AND DRUG ADMINISTRATION,

counter availability under the brand name Plan B.³ The 72-hour window of opportunity was rapidly closing for my friend's charge, and without a standing EC prescription from her doctor or an over-the-counter option for obtaining the drug, membership in the anxious sorority of women who nervously counted and recounted the days to their next period was about to increase by one.

For a drug that has the power to obviate the fraught decision among abortion, adoption, and unprepared parenthood, there had to be a better way. For the last several years, pro-choice advocacy groups thought that "better way" was to increase public awareness about the drug's existence and to make EC available on an over-the-counter basis. They are succeeding on both counts. Since 1999, EC's profile has risen considerably. Women are becoming aware of the drug in increasing numbers, and the number of EC prescriptions filled nationwide doubled between 2004 and 2006.⁴ The American College of Obstetricians and Gynecologists initiated their "Ask Me" campaign in May 2006 to increase awareness of and access to EC by encouraging women to get just-in-case EC prescriptions from their gynecologists during their regular appointments so that should the patients later need a dose, they would not have to scramble for a prescription.⁵ And in August 2006, after a controversial, protracted, and

FDA APPROVES APPLICATION FOR PREVEN EMERGENCY CONTRACEPTION KIT, Sept. 2, 1998, at <http://www.fda.gov/bbs/topics/ANSWERS/ANS00892.html> (last accessed Aug. 31, 2006), but was withdrawn from the market in May 2004 because it had more side effects and was less effective as a method of EC than Plan B, which consists only of progestin. *And Then There Was One: Barr Withdraws Preven*, CONTRACEPTIVE TECHNOLOGY UPDATE, Sept. 1, 2004. Plan B is currently the only drug marketed as a post-coital contraceptive.

³ See U.S. Food and Drug Administration, FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older, Prescription Remains Required for Those 17 and Under, Aug. 24, 2006, at <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html> (last accessed Aug. 29, 2006) [hereinafter FDA Approval].

⁴ Jonathon D. Rockoff, *Plan B battle shifts to states; FDA's inaction on 'morning after' pill boosts momentum*, BALTIMORE SUN, Feb. 25, 2006, at 1A.

⁵ ACOG Press Release, *supra* note 1.

according to critics, unscientific and politicized, FDA review, that agency approved Plan B for over-the-counter availability for women age 18 and older.⁶

But this increasing awareness about EC among the public has not always been accompanied by improved access to the drug. Some pharmacists who believe life begins at conception—the moment of fertilization—equate EC, and in some cases even traditional birth control pills, with abortion because they fear it could interfere with the implantation of a fertilized egg in the uterus. Although there is no scientific evidence of EC ever preventing a fertilized egg from implanting, it is impossible to prove a negative—no one can demonstrate, logically or scientifically, that EC could never inhibit implantation.⁷ These pharmacists therefore refuse to fill prescriptions for such drugs on the grounds that to do so would be to facilitate abortion in violation of their moral or religious beliefs.⁸ “Advocates on both sides say the refusals appear to be spreading, often surfacing only in the rare instances when women file complaints” against the refusing pharmacists.⁹ Although the frequency with which pharmacists refuse to fill prescriptions for EC and traditional contraceptives can be assessed only on an anecdotal basis, such cases have been reported around the United States.¹⁰ In addition to

⁶ Women 17 or younger would still need a prescription for EC. Under the terms of the FDA approval, the drug would continue to be stocked behind the pharmacy counter, and pharmacy clients would be required to present either a valid prescription or proof of age before the pharmacist on duty could dispense the drug. FDA Approval, *supra* note 3.

⁷ Judy Peres & Jeremy Manier, *‘Morning-after pill’ not abortion, scientists say*, CHI. TRIB., June 20, 2005 at 1A.

⁸ See, e.g., Todd C. Frankel, *I’m sorry, I won’t fill that prescription*, ST. LOUIS POST-DISPATCH, Dec. 4, 2005, at B1; Charisse Jones, *Druggists refuse to give out pill, say their religion forbids the use of contraceptives*, USA TODAY, Nov. 9, 2004, at 3A.

⁹ Rob Stein, *Pharmacists’ Rights at Front of New Debate*, WASH. POST, Mar. 28, 2005, at A1.

¹⁰ See *id.* (refusals to dispense have been reported in California, Washington, Georgia, Illinois, Louisiana, Massachusetts, Texas, New Hampshire, Ohio, and North Carolina). Other refusals have been reported in Arizona, Calrla McClain, *Rape victim: ‘Morning after’ pill denied*, AZ. DAILY STAR, Oct. 23, 2005; and Missouri, Frankel, *supra* note 8.

refusing to dispense EC or traditional contraceptives to women bearing valid prescriptions, some pharmacists have refused to return those prescription slips to their clients or to transfer the prescription elsewhere, making it difficult or impossible for the clients to obtain the drugs.¹¹ Still other pharmacists have publicly berated and humiliated women seeking contraception or emergency contraception, inquiring into their sexual practices,¹² and calling them murderers and baby killers.¹³

“More and more pharmacists are becoming aware of their right to conscientiously refuse to pass objectionable medications across the counter,” explains a representative of the Christian Legal Society’s Center for Law and Religious Freedom. “We are on the very front edge of a wave that’s going to break not too far down the line.”¹⁴ How large that wave is, and when it might break, is anybody’s guess.

With the FDA’s limited approval of an over-the-counter option for EC, the frequency of such refusals to dispense seems likely to increase. Although women over 18 will no longer need a prescription to obtain EC, the drug will still be stocked behind pharmacy counters so the pharmacist on duty can examine the client’s proof of age and can further inspect the prescription clients 17 or younger must present. This policy of stocking the drug behind the pharmacy

¹¹ See Jo Mannies, *‘Pill’ dispute here costs pharmacist her job*, ST. LOUIS POST-DISPATCH, Jan. 27, 2006, at A1. Karen L. Brauer, of Pharmacists for Life, International, likens returning a client’s prescription to offering to call a hit man: “That’s like saying, ‘I don’t kill people myself but let me tell you about the guy down the street who does.’ What’s that saying? ‘I will not off your husband, but I know a buddy who will?’ It’s the same thing.” Stein, *supra* note 9.

¹² In re Disciplinary Proceedings Against Neil T. Noesen, R. Ph., Case File No. 01 PHM 080, Proposed Final Decision and Order (Wis. Pharm. Exam. Bd., Div. Enforcement, Feb. 28, 2005, at ¶¶ 26-28 (pharmacist asked whether client would use birth control pill for contraception purposes, and when she said yes, he refused to assist her further or transfer her prescription elsewhere) [hereinafter In re Noesen].

¹³ Roger J. Limoges, *Prescriptions denied: pharmacy refusal clauses have become the latest battleground in the provision of safe and legal medical services*, CONSCIENCE, Sept. 22, 2005, at 36; Betty Cuniberti, *In rural Missouri, pharmacists emerge as pastor, governor and Surgeon General*, ST. LOUIS POST-DISPATCH, May 1, 2005, at E1;

¹⁴ Stein, *supra* note 9.

counter makes the pharmacist EC's "primary gatekeeper."¹⁵ At pharmacies with larger staffs, pharmacy technicians may be empowered to dispense EC to women over 18, but even so, the universe of people empowered with this gatekeeper role remains quite small. Because the effectiveness of EC decreases so dramatically over a relatively short period of time, a single pharmacist's refusal to dispense the drug may mean the difference between an unplanned pregnancy and a sigh of relief. Even in an urban area with multiple pharmacists, finding one who both stocks EC and is willing to dispense it can take days,¹⁶ and this at a time when anxiety, trauma, or embarrassment may most impede a woman's ability to undertake a diligent search for EC in the face of repeated refusals. The pharmacist's gatekeeper role means not only can he or she refuse to dispense the medication, but also has a unique ability to harass or insult women who seek it, or to prevent underage women from getting it at all by refusing to return or transfer their prescription elsewhere.

Pharmacists on the whole are adamant that they have the ethical and legal right to refuse to dispense medications they find objectionable.¹⁷ Whether or not this is true has been the subject of debate.¹⁸ Very little scholarship exists analyzing how courts would likely construe

¹⁵ *Id.*

¹⁶ In Tuscon, a rape victim spent three days searching dozens of pharmacies for one that both had EC in stock and that had a pharmacist on duty who would dispense it to her. McClain, *supra* note 10.

¹⁷ Sixty-nine percent of pharmacists believe they should have the right to refuse to dispense drugs they find objectionable, HCD Research, *Pharmacists Believe They Should Have Authority to Refuse emergency Contraception Prescriptions*, Dec. 6, 2005, available at <http://www.hcdi.net/News/PressRelease.cfm?ID=103> (last visited Oct. 20, 2006) and two major professional pharmacy associations have issued ethics statements in support of a pharmacist's right to refuse, *see infra* note 40.

¹⁸ *See e.g.*, Julie Cantor & Ken Baum, *The Limits of Conscientious Objection*, 351 NEW ENG. J. MED. 2008, 2011 (Nov. 4, 2004) (concluding that "pharmacists who object should, as a matter of ethics and law, provide alternatives for patients" to obtain EC but need not dispense the drug themselves); Sarah J. Vokes, *Just Fill the Prescription: Why Illinois' Emergency Rule Appropriately Resolves the Tension Between Religion and Contraception in the Pharmacy Context*, 25 L. & INEQUALITY 399 (2006) (arguing that pharmacists have a legal duty to dispense EC); Charu A. Chanrasekhar, *Rx for Drugstore Discrimination: Challenging Pharmacy Refusals to Dispense Prescription Contraceptives Under State Public Accommodation Laws*, 64 ALBANY L. REV. 101 (2006) (developing a claim that refusals to dispense contraceptives, including EC, may be litigated as unlawful sex

pharmacists' duty of care in the context of EC—whether, in the absence of a medical justification for refusal, they must dispense the drug or whether they may act in accord with the dictates of their conscience without being subject to liability.¹⁹ Ultimately, this legal issue may be settled on a state-by-state basis as legislatures and licensing boards resolve the debate by either allowing pharmacists to refuse or requiring them to dispense EC. But in the meantime, what duty of care does a pharmacist owe to a woman seeking EC? What recourse, if any, does a woman have when a pharmacist's conscientious objection threatens to moot her right of access?

This article develops a framework for assessing pharmacists' duty of care with respect to dispensing prescription and nonprescription, pharmacy-only drugs, both in a general sense and in the specific context of EC, concluding that absent a medical justification for refusing to dispense, pharmacists have a legal duty to dispense EC, whether by prescription or by non-prescription request (Section I.A.). The article then analyzes the impact various states' refusal clauses may have on that generally applicable duty (Section I.B.), concluding that in most states a refusal to dispense EC is best described as an act of civil disobedience, the nature of which does not insulate pharmacists from tort liability (Section I.C.). Finally, the article sketches a claim of wrongful conception as an example of how pharmacists' breach of their duty to dispense EC might result in civil liability (Section II.).

I. DO PHARMACISTS HAVE A DUTY TO DISPENSE EC?

discrimination in a place of public accommodation and further concluding that Title VII, which prohibits religious discrimination in employment, does not guarantee pharmacists a right of refusal); Claire A. Smearman, *Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 *Az. L. Rev.* 469, 512 (2006) (arguing that “[b]y limiting the reasons pharmacists may refuse to fill prescriptions to valid medical and legal concerns, state pharmacy laws implicitly prohibit refusals for other reasons, including religious, personal, or moral beliefs.”).

¹⁹ Although many of the considerations discussed in this Article may also apply in the context of traditional birth control, this Article focuses specifically on pharmacists' duty to dispense EC because of the unique challenges posed by that drug's limited over-the-counter status and the need for quick access by women in order to maximize efficacy.

A. Establishing the Baseline

A direct analogy to the duty analysis in other medical malpractice negligence cases, and in particular the wrongful conception cases discussed below,²⁰ is complicated somewhat by the question of precisely when a duty arises. The traditional medical malpractice case involves a medical professional who has affirmatively undertaken care of the patient-plaintiff and then performed his or her undertaken duty negligently, whereas the pharmacist who refuses to dispense EC arguably has not assumed the role of healthcare provider, and has in fact actively refused to step into such a role with respect to that client's request for that drug.

The question of whether pharmacists have a legal duty to dispense all safe, validly prescribed drugs or whether they may refuse for non-medical reasons to fill such a prescription is a murky one. Pharmacists have simply never before argued that they have a right of conscientious objection to aspects of their job, at least not in a courtroom setting. In the dearth of directly applicable case law, commentators who have addressed what duties pharmacists possess with respect to EC have largely ignored the existing body of common law, assuming as a starting point either that a duty does or does not exist, and have proceeded with their analysis based on that initial assumption.²¹ This Article takes a somewhat different tack, arguing that based on how courts have construed pharmacists' duties in other contexts, and the rationales that controlled in those decisions, a compelling legal argument exists that absent a medical

²⁰ See discussion in text, *infra* at II.A.

²¹ Vokes, *supra* note 18 (based on Code of Ethics adopted by professional pharmacy association and pharmacists' monopoly on prescription drug distribution, pharmacists have a duty to dispense); Cantor & Baum, *supra* note 18 at 2011; Dennis Rambaud, Note, *Prescription Contraceptives and the Pharmacist's Right to Refuse: Examining the Efficacy of Conscience Laws*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 195 (2006) (based on ethics statements adopted by professional pharmacy associations and a single case construing a pharmacist's duty to dispense prescriptions, the pharmacist has satisfied his or her duty by refusing to dispense and referring the client elsewhere); Donald W. Herbe, Note, *The Right to Refuse: A Call for Adequate Protection of a Pharmacist's Right to Refuse Facilitation of Abortion and Emergency Contraception*, 17 J. L. & HEALTH 77 (2004) (based on ethics statements adopted by professional pharmacy associations, the pharmacist has satisfied his or her duty by refusing to dispense and referring the client elsewhere).

justification for refusal or an applicable state refusal clause, pharmacists already have a duty to dispense all validly prescribed drugs and all nonprescription drugs that are available only from a pharmacist.

Although case law provides some useful guidance for delineating the outer edge of a pharmacist's duty, most of this guidance exists in dicta, as virtually all cases construing the pharmacist's duty have arisen from plaintiffs' assertions that in affirmatively filling a prescription the pharmacist neglected some other duty, whether by filling the prescription inaccurately,²² by accurately filling an incorrectly prescribed lethal dose,²³ or by failing to warn of possible side effects²⁴ or of potential negative drug interactions.²⁵ The murkiness of this question—whether a duty to dispense EC exists—is further compounded by the fact that the terms of FDA's approval make EC an over-the-counter drug for women over 18 and a prescription-only drug for women 17 and younger. This difference in dispensing protocols could potentially result in a different standard of care with respect to minors and to women 18 and older because a legal duty to dispense a safe, validly prescribed prescription drug might not necessarily translate to a duty to dispense nonprescription drugs such as EC, or vice versa.

²² See, e.g., Troppe v. Scarf, 187 N.W.2d 51 (Mich. Ct. App. 1971) (pharmacist incorrectly dispensed tranquilizers instead of prescribed birth control pills)

²³ See Horner v. Spalitto, 1 S.W.3d 519, 523-24 (Mo. Ct. App. 1999) (pharmacy found negligent when pharmacist filled a prescription for what he knew was a lethal dose).

²⁴ See e.g. Allberry v. Parkmore Drug, 834 N.E.2d 199 (Ct. App. Ind. 2005) (pharmacist had no duty to warn client of need to seek medical attention if after using drug client had erection lasting more than four hours); Cottam v. CVS Pharmacy, 764 N.E.2d 814 (pharmacist had no duty to warn of possible side effect of permanent impotence); Coyle v. Richardson-Merrell, Inc., 584 A.2d 1383 (Pa. 1989) (pharmacist did not have duty to warn of potential for prescription drug to cause birth defects).

²⁵ See Lasley v. Shrake's Country Club Pharmacy, Inc., 880 P.2d 1129, 1132 (Ct. App. Az. 1994) (pharmacist has duty to warn patient when two prescriptions negatively interact with one another); Hand v. Krakowski, 89 A.D.2d 650, 651 (N.Y. 1982) (pharmacist had duty to warn client of negative interactions of prescription with alcohol where pharmacist knew client to be an alcoholic).

Case law is scarce on the question of whether a pharmacist has discretion to refuse to dispense safe, validly prescribed drugs.²⁶ Moreover, no cases have construed whether a pharmacist has a legal duty to dispense a nonprescription drug available exclusively from behind the pharmacy counter, either in the context of EC or similarly limited-access drugs, such as cold medicines containing pseudoephedrine. In this vacuum of directly applicable case law, therefore, any analysis of how courts would likely analyze a pharmacist's duty with respect to EC is necessarily inferential. Nevertheless, a woman facing an unplanned pregnancy as a result of her pharmacist's refusal must, before bringing a tort action against her pharmacist, assess how a court would likely define a pharmacist's duty with respect to dispensing EC. Furthermore, a rigorous attempt to delineate that duty can assist pharmacists to define more precisely what they may be risking should they refuse to dispense as an act of conscience. It is in light of this utility that I offer the following framework for analyzing the pharmacist's duty with respect to dispensing EC.

It is undisputed that pharmacists owe a duty of care to their clients. Though the question of what standard of care the pharmacist must adhere to with respect to any given client is a question for the fact-finder,²⁷ practitioners of skilled professions such as pharmacists "have a

²⁶ One case upholding disciplinary action against a pharmacist who refused to fill or transfer a client's birth control prescription specifically declined to address whether Wisconsin imposes such a duty on pharmacists, deciding on other grounds the issue of what sanctions, if any, were appropriate. *In re Noesen*, *supra* note 12. One Saturday in 2002, pharmacist Neil Noesen refused to either fill or transfer a client's prescription for birth control pills. *Id.* at ¶¶ 26, 28-33. The next day, the client returned with two police officers and Noesen again refused to transfer or to fill the client's prescription. *Id.* at ¶ 39. Two days after her initial attempt to fill her birth control prescription, and after Noesen's two-day shift was over, the client was able to fill her prescription. *Id.* at ¶ 43. The Administrative Law Judge found that due to the delay she incurred as a result of Noesen's refusal to dispense, and the resultant missed dose, she had to use a backup form of contraception for the next month and was subject to physical and emotional harm from anxiety about an unplanned pregnancy. *Id.* at ¶ 42, 50. The Administrative Law Judge framed the central issue as "whether by refusing to transfer the patient's prescription on the basis of his conscientious objection, Respondent [Noesen] departed from a standard of care ordinarily exercised by a pharmacist and which harmed or could have harmed the patient." *Id.* at *8. The issue of whether Noesen had an affirmative duty to dispense the prescription was not before the tribunal. *Id.* at *9.

²⁷ *Horner v. Spalitto*, 1 S.W.3d 519, 522 (Mo. Ct. App. 1999).

duty of care to conform to the generally recognized and accepted practices in their profession.”²⁸ Because the FDA’s approval sets up a two-tiered distribution system for EC based on the age of the woman seeking it, the duty of care a pharmacist owes a client seeking EC must be analyzed first with respect to those bearing a prescription, and then with respect to those to whom the drug is available without a prescription.

1. Duty to Dispense Emergency Contraception As Prescription Drug

Case law supports the proposition that the pharmacist, as the possessor of a legal monopoly on the dispensing of prescription drugs, may not exercise nonmedical discretion by refusing to dispense prescriptions he or she finds objectionable, but rather must accurately fill all safe, valid prescriptions presented by a client.²⁹ The circumstances under which a pharmacist may depart from a physician’s prescription are limited to those instances where a departure is essential to ensure the client’s health and safety—unless the prescription would medically endanger the client, the pharmacist has no discretion as to whether to fill it.³⁰ So pervasive is the belief that pharmacists should not meddle in the doctor-patient relationship that most courts have declined to require pharmacists even to warn clients when dispensing drugs with such serious possible side effects as addiction,³¹ birth defects,³² or impotence.³³ Even in these high-stakes

²⁸ Evans v. Rite Aid Corp., 478 S.E.2d 846 (S.C. 1996).

²⁹ See Coyle v. Richardson-Merrell, Inc., 584 A.2d 1383, 1386 (Pa. 1989) (recognizing that prescription drugs are unlike other products because their distribution system is “highly restricted,” and pharmacists, therefore lack discretion as to which products they will make available to consumers); Heredia v. Johnson, 827 F. Supp. 1522, 1525 (D. Nev. 1993) (“At a minimum, a pharmacist must be held to a duty to fill prescriptions as prescribed and properly label them (include the proper warnings) and be alert for plain error.” Id.).

³⁰ Nev. State Bd. of Pharmacy v. Garrigus, 496 P.2d 748 (Nev. 1972) (“It is not for the pharmacist to second guess a licensed physician unless in such circumstances that would be obviously fatal.” Id.). See also France v. State, 506 N.Y.S.2d 254 (N.Y. Ct. Cl. 1986) (finding pharmacist negligent for failing to dispense inmate’s skin medication, and construing the pharmacist’s duty as “mix[ing] and dispens[ing] the salve as prescribed by claimant’s doctor.” Id. at 255).

³¹ Morgan v. Wal-Mart Stores, Inc., 30 S.W.3d 455 (Tx. Ct. App. 2001)

contexts, most courts have held that no duty to warn exists, reasoning that the imposition of such a duty on pharmacists “would place the pharmacist between the physician—who knows the patient’s physical condition—and the patient and could lead to harmful interference in the patient-physician relationship.”³⁴

Such interference has the potential for harm where it might upset the balance between risk and benefit already struck by the doctor, presumably in consultation with the patient, and might lead the client-patient to forgo medical treatment deemed appropriate or necessary by the doctor. Courts, concerned that a pharmacist not adversely affect a client’s ability to pursue a course of treatment determined by his or her doctor to be most appropriate, have held that “[t]he pharmacist does not have discretion to alter or refuse to fill a prescription because the risks and benefits of that prescription for that particular patient have already been weighed by the physician.”³⁵

In the duty-to-warn scenario, the potential for interference in the doctor-patient relationship is relatively mild because the pharmacist’s clients still have the option of consuming the medication prescribed by their doctor, notwithstanding the pharmacist’s warnings. If courts have been concerned even by this relatively mild risk of interference, they are unlikely to permit the pharmacist to interfere more concretely and conclusively by refusing altogether to dispense the drug that the physician, in his or her considered professional opinion, has prescribed. Absent some medical necessity, such as preventing the client from taking a mistakenly prescribed lethal

³² Coyle, 548 A.2d 1383.

³³ Cottam v. CVS Pharmacy, 764 N.E.2d 814 (Mass. 2002).

³⁴ Allberry v. Parkmor Drug, 834 N.E.2d 199, 202 (Ind. Ct. App. 2005).

³⁵ Cottam, 764 N.E.2d at 821, *citing* Coyle, 584 A.2d 1383.

dose, the role of the pharmacist is simply to supply the drug as prescribed. In construing the pharmacist's duty of care, the Pennsylvania Supreme Court reasoned that:

Unlike the marketing system for most other products, the distribution system for prescription drugs is highly restricted. 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. Physicians exercising sound medical judgment act as intermediaries in the chain of distribution, preempting, as it were, the exercise of discretion by the supplier-pharmacist, and, within limits, by the patient-consumer.³⁶

Furthermore, even in jurisdictions where pharmacists may be empowered to refuse to dispense a valid prescription, the only circumstances where such an act has been recognized as permissible involve those necessary to safeguard the client's health and safety.³⁷

Some commentators have suggested that formally adopted ethics statements, because they are adopted by professional associations and therefore indicate the "generally recognized and accepted practices in [the] profession,"³⁸ constitute the final word on the pharmacist's standard of care.³⁹ The two main professional pharmacy organizations have adopted ethics statements in support of pharmacists' right to conscientiously object to providing any drug they

³⁶ Coyle, 548 A.2d at 1386.

³⁷ See Cohn v. Department of Professional Regulation, 477 So. 2d 1039 (Fla. Dist. Ct. App. 1985) (upholding Board of Pharmacy order declining to suspend, revoke, or take other disciplinary action against pharmacist who filled valid prescriptions for quaaludes). In Cohn, the hearing officer characterized petitioner's grounds for seeking disciplinary action as an assertion that the pharmacist "has a moral duty to make a determination of whether the doctor has prescribed a medication which is 'good' for the patient." Cohn, 477 So.2d at 1052. Finding no basis for the claim that pharmacists have a duty to make such a "moral" judgment, or even that they are empowered to do so as a matter of discretion, the hearing officer recommended levying no sanctions against the dispensing pharmacist. Id. at 1052-53. See also Hooks SuperX, Inc. v. McLaughlin, 642 N.E.2d 514 (Ind. 1994) (where client refilled addictive prescription medication at a rate much faster than prescribed, pharmacist had duty to refuse to dispense further refills).

³⁸ Evans v. Rite Aid Corp., 478 S.E.2d 846 (S.C. 1996).

³⁹ See e.g., Rambaud, *supra* note 21 at 200.

find ethically or morally problematic,⁴⁰ and these commentators have interpreted these statements to mean that pharmacists have no duty to fill prescriptions for EC.⁴¹ This nearly exclusive reliance on ethics statements in construing pharmacists' standard of care, however, is misplaced. Although ethics policies and standards of practice adopted by professional organizations "may be a potential source of guidance on a pharmacist's duty of care generally," they are not dispositive.⁴² Courts base their deference to the practices and standards developed within a profession on "the healthy respect which the courts have had for the learning of a fellow profession, and their reluctance to overburden it with liability based on uneducated judgment."⁴³ As discussed in more depth below, however, where the relevant standards are not based on particular professional expertise, such deference is inappropriate. Notwithstanding evidence to the contrary that a particular practice is generally recognized and accepted among practitioners, "when the jury are considered competent to do so, they are permitted to find that a practice generally followed by the medical profession is negligent."⁴⁴

Given the nature of the pharmacy ethics statements at issue, the fact finder is certainly competent to independently evaluate whether a pharmacist's refusal to dispense EC was

⁴⁰ See American Pharmacy Association, 2004 House of Delegates Report of the Policy Review Committee, available at http://www.aphanet.org/AM/Template.cfm?Section=Search§ion=About_APhA1&template=/CM/ContentDisplay.cfm&ContentFileID=224 (last visited Sept. 12, 2006) [hereinafter APhA Refusal Statement]; American Society of Health-System Pharmacists, Ethics Positions, available at http://www.ashp.org/bestpractices/ethics/Ethics_Positions.pdf (last visited Sept. 12, 2006) [hereinafter ASHSP Refusal Statement].

⁴¹ See e.g., Herb, *supra* note 21 (concluding, "When the pharmacist refuses to dispense and then refers, if he has given a good faith referral, she has probably satisfied reasonable care." *Id.* at 90); Accord Rambaud, *supra* note 21 at 221. It should be noted that even those commentators who have asserted that no duty to dispense exists have inferred from the ethics statements a duty to refer. Herb at 90; Rambaud at 221.

⁴² See *Evans*, 478 S.E.2d at 848 (involving the Code of Ethics promulgated by the American Pharmacy Association, *id.*)

⁴³ PROSSER AND KEETON ON TORTS, § 32, 189 (5th ed. 1984).

⁴⁴ *Id.*

negligent and should not treat ethics statements as dispositive. In 2004, the American Pharmacy Association (“APhA”) Policy Review Committee voted to retain language it first adopted in 1998, which reads, “APhA recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patient’s access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.”⁴⁵ In 2002, the American Society of Health-System Pharmacists (“ASHSP”) reviewed and retained its statement on conscientious objection, which reads, “ASHP recognizes a pharmacist’s right to conscientious objection to morally, religiously, or ethically troubling therapies and supports the establishment of systems that protect the patient’s right to obtain legally prescribed and medically indicated treatments while reasonably accommodating the pharmacist’s right of conscientious objection.”⁴⁶ The policy statements adopted by these two pharmacy associations do not involve scientific or technical competence or an evaluation of medical risk or benefit. They do not require an understanding of chemistry, physiology, or any of the other fields pharmacists must study in the course of their professional training. The issue of whether a pharmacist must fill all safe, valid prescriptions despite any ethical or moral objections he or she may have is fundamentally an ethical rather than a technical one. No specialized technical or professional expertise is required to address the issue competently, and pharmacists are in no better position than are laypeople in navigating its boundaries. Deferring to the ethical and policy statements of the APhA and the ASHSP would allow pharmacists to set the bounds of their professional duties to society in matters in which they have no professional expertise and in ways which are nonresponsive to

⁴⁵ APhA Refusal Statement, *supra* note 40.

⁴⁶ ASHSP Refusal Statement, *supra* note 40.

larger societal need or input.⁴⁷ Because the policy statements of the APhA and ASHSP are not embodiments of particularized professional expertise, because pharmacists are not uniquely able to competently assess how to navigate the ethical conflict inherent in the refusal-to-dispense scenario, and because pharmacists' preferences with respect to the delineation of their professional duty of care are, on the whole, contrary to those of larger society, the ethics statements should not be used as conclusive sources for defining the pharmacist's duty of care.

Further, the organizations' ethics statements are of limited utility in assessing the pharmacist's standard of care in the context of EC. In neither iteration is the pharmacist's ability to refuse absolute. Both policies stress the importance of balancing the pharmacist's interest in acting in accord with his or her ethical beliefs and the client's interest in obtaining the treatment he or she seeks. Though most commentators have focused on the pharmacist's interest to the exclusion of that of the woman seeking EC, the pharmacy associations' ethics statements do not support such tunnel vision. The importance of the client's interest is further underscored by the APhA's Code of Ethics, which states:

“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.”⁴⁸

⁴⁷ In fact, polls demonstrate that most Americans—78 percent—do not believe a pharmacist should be allowed to refuse to fill contraceptive prescriptions on religious or moral grounds; only 16 percent believe pharmacists should be able to so refuse. CBS News.com, *Religion at the Drugstore*, Nov. 23, 2004, available at <http://www.cbsnews.com/stories/2004/11/23/opinion/polls/main657413.shtml>, last visited Oct. 16, 2006.

⁴⁸ Am. Pharm. Ass'n, Code of Ethics for Pharmacists, Art. III, adopted by the American Pharmacists Association membership Oct. 27, 1994, available at <http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2809> (last accessed Sept. 7, 2006).

As discussed in more depth below, in any given situation these two competing sets of interests may be irreconcilable, leaving the fact finder with little guidance as to whether the pharmacist has satisfied the applicable duty of care. Moreover, the pharmacist is unlikely to know at the time of his or her referral whether the client will be able to fill her EC prescription elsewhere, and the pharmacist therefore has not engaged in the same sort of balancing activity contemplated in the ethics statements.⁴⁹

The time-sensitive nature of EC means that honoring the pharmacists' interest in refusing and safeguarding a woman's right of access may be mutually exclusive. Although allowing pharmacists to refuse and refer might be a reasonable compromise in other circumstances, adopting a refuse-and-refer protocol for EC requires a woman to enter a hall of mirrors in which she must go from referring pharmacist to referring pharmacist, looking for a pharmacy that stocks the drug *and* is willing to dispense it *and* that is open when she does not have to be at school or work *and* that she can locate and reach before EC's brief window of effectiveness closes. In some locales, this convergence of conditions may not pose a significant barrier to access, but other commentators have spoken to the considerable, potentially insurmountable obstacles a refuse-and-refer protocol would pose for women, especially those in rural areas where going to the next town may mean traveling miles without a reliable car or transit system, or in politically conservative areas where pharmacist after pharmacist either does not stock the drug or will not dispense it.⁵⁰ Because the policy statements adopted by pharmacy organizations

⁴⁹ Kelly Vyzral, the government affairs director for the Ohio Pharmacists Association, explains how the balancing must work in order to safeguard both the pharmacist's and the client's interests: "The thing we stress is that pharmacists provide the patient with access—either through another pharmacist on staff, or at another pharmacy." Stephanie Irwin, *Buying Plan B? You might need a backup plan*, DAYTON DAILY NEWS, Aug. 26, 2006, at A4. A bare refusal and referral, particularly when the referral is made offsite, cannot guarantee the client's access because the client may be refused at subsequent pharmacies.

⁵⁰ See Katie Fairbanks, *Waging a moral battle from behind the counter: Pharmacists' refusal to fill contraception prescriptions Prompts question of Whose choice is it to make?*, DALLAS MORNING NEWS, Apr. 24,

cannot in practice resolve the fundamental and in some cases irreconcilable conflict between the two interests they seek to balance, case law construing pharmacists' duty to dispense provides a far firmer basis on which to assess the pharmacist's duty of care.

In the context of prescription medications, then, case law strongly suggests that as a matter of law, pharmacists have a legal duty to fill all safe, valid prescriptions. Applying this rule to the EC controversy, pharmacists appear to have a legal duty to fill all valid EC prescriptions presented by women 17 and under. Refusing to fill such a prescription for undeniably nonmedical reasons impermissibly intrudes on the doctor-patient relationship, compromises the medical care of the client, and constitutes a breach of the pharmacist's duty to dispense.

2. *Duty To Dispense Emergency Contraception As Nonprescription, Pharmacy-Only Drug*

These twin emphases, first on the need to ensure the client's access to drugs already deemed safe by a skilled evaluator, and second, the pharmacist's unique position as the sole point of distribution for those drugs, also cut sharply in favor of extending the pharmacist's duty to dispense to include nonprescription as well as prescription drugs. Indeed, classification of EC as an over-the-counter drug indicates that little to no individualized medical oversight is required to ensure its safe use by consumers. Where the risks and benefits of EC have already been weighed not just by a single doctor but by the whole of the FDA, and where as a result of this analysis the drug has been found to be so safe that no prescription at all is required for any users

2005, at 1A (noting that Texas has 199 towns with only one drug store and that those towns frequently have only one pharmacist. A local Planned Parenthood official observed, "If someone wants to get emergency contraception filled and they go to the one pharmacy and are refused, she then has to go 30 to 50 miles to the next town, and just hope she can get the prescription filled in the time frame she has left."). This hall of mirrors meant that a rape victim in Tuscon had to spend three days trying to find an area pharmacy that even stocked EC, only to finally find it stocked at a pharmacy where the pharmacist refused to dispense it for religious and moral reasons. McClain, *supra* note 10.

over the age of majority, allowing a pharmacist to deny access to the drug for nonmedical reasons cannot advance public health. Absent any medical rationale for denying access to EC, the pharmacist's role as EC's gatekeeper and sole supplier should control disposition of the issue as it does in the prescription drug context.

Refusing pharmacists may argue that relegating the pharmacist to the role of mere supplier fails to recognize the pharmacist's specialized expertise and professional training and is not appropriate where no doctor is providing more individualized care. In the absence of physician oversight, the pharmacist, who deals directly with the client, may be better equipped than is the FDA, which has no such direct or personalized knowledge, to provide individualized care to a pharmacy client seeking information on or access to limited access, nonprescription drugs. At least insofar as that rationale is used to deny for nonmedical reasons access to safe, legal nonprescription drugs, however, that argument is unpersuasive because any individualized care the pharmacists seek to provide is not pharmaceutical or medical in nature, and is therefore incompatible with their role as the primary gatekeeper of EC. Though a pharmacist may have no duty to dispense a nonprescription drug where he or she has a medically based reason for denying such access (*e.g.*, it would negatively interact with other drugs the client is taking or would be unsafe or otherwise inappropriate for the client given allergies or other lifestyle considerations such as the client's willingness or ability to tolerate probable side effects), that rationale does not hold where pharmacists' refusals to dispense are not based on medical considerations but rather are ethically or religiously motivated.⁵¹ The idea that pregnancy begins

⁵¹ The belief among refusing pharmacists that pregnancy commences at the moment of fertilization is at root an ethical or religious belief, not a medical one. EC is classified by the FDA as a method of contraception (meaning that it prevents pregnancy), not as an abortifacient, (meaning that it does not terminate a pregnancy). Gardiner Harris, *F.D.A. Gains Accord on Wider Sales of Next-Day Pill*, N.Y. TIMES, Aug. 9, 2006. This classification is far from arbitrary. It is based jointly on the medical definition of when pregnancy begins and on the best available scientific evidence as to how EC works. The medical establishment defines pregnancy as commencing not at fertilization but several days later, when the fertilized egg successfully implants in the uterus. *See, e.g.*, 45 C.F.R.

at conception may have merit from a particular philosophical or theological perspective, but pharmacists are generally empowered to exercise professional discretion only on medical grounds, not on philosophical or theological ones.⁵²

Just as in the prescription drug context, there is neither a medical justification for refusing to dispense EC, nor an alternative point of distribution for women 18 and older who seek access to the drug. In light of the persuasive weight courts have afforded to these two factors in past decisions construing the pharmacist's duty, courts are likely to find that pharmacists have a legal duty to dispense EC, and that a refusal to dispense EC constitutes a breach of that duty.

B. Impact Of State Refusal Clauses On Duty To Dispense

Increasingly, states are looking to refusal clauses as one way to counteract this duty to dispense, attempting thereby to limit pharmacists' tort liability for refusing to provide EC.

46.202(f) (1978) ("Pregnancy encompasses the period of time from implantation until delivery."). There is no evidence that EC disrupts an implanted egg or even inhibits the implantation of a fertilized egg. In fact, EC generally works by inhibiting ovulation. Peres & Manier, *supra* note 7. EC has never been known to be effective after fertilization. *Id.* The F.D.A.'s statement that Plan B "may" work by inhibiting implantation of a fertilized egg is best understood as an example of the truism that one cannot definitely prove a negative. *Id.*

⁵² Even if, *arguendo*, pharmacists were permitted to dispense or withhold care on philosophical or religious (but at any rate, nonmedical) grounds, a pharmacist's personal beliefs as to when pregnancy begins should not trump a right of access to EC. The best available medical evidence is that EC does not work if taken after ovulation, does not interfere with implantation, and thus even by the refusing pharmacists' nonmedical definitions of the term, does not terminate a pregnancy. See Peres & Manier, *supra* note 7 (noting that evidence of the anti-implantation effects of both caffeine consumption and breastfeeding children is stronger than evidence that EC inhibits implantation of a fertilized egg. As one researcher explains, "We can't prove it, but a lot of inferences are strongly supportive that emergency contraception does not work after fertilization... Once [an egg] is fertilized, there's not an iota of evidence that says fertilization won't go forward." *Id.*). See also James Trussel et al., *The role of emergency contraception*, AM. J. OBSTETRICS & GYNEC. (2004) 190, S30-8 (noting that in light of EC opponents' belief that pregnancy begins at fertilization, not at implantation, "[t]o make an informed choice, women must know that [EC]—like all regular hormonal contraceptives such as the birth control pill, the patch Evra, the vaginal ring NuvaRing, the injectable Lunelle, the injectable Depo-Provera and even breastfeeding—may prevent pregnancy by delaying or inhibiting ovulation, inhibiting fertilization, or inhibiting implantation of a fertilized egg."); Mary K. Collins, *Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction?*, 15 ANN. HEALTH L. 37, 47 (2006) (noting that this claim of an anti-implantation effect is also baseless with respect to traditional oral contraceptives). Even at this most charitable interpretation, a refusal to dispense EC on the grounds that to do so could terminate a pregnancy by inhibiting implantation of a fertilized egg is unsupported speculation grounded upon a nonmedical definition of the word "pregnancy."

Refusal clauses, sometimes alternatively referred to as conscience clauses, provide a statutory or regulatory basis for health care workers of various stripes to refuse to participate in one or more health services they find morally, religiously, or ethically objectionable.⁵³ The scope of refusal clauses varies by state, both in terms of what types of providers and which types of health services they cover.⁵⁴ Most refusal clauses apply only to abortion,⁵⁵ a reflection of the immediately post-*Roe*⁵⁶ period in which they were adopted.⁵⁷ Others apply only to abortion,

⁵³ See generally, Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MEDICINE 177 (1993).

⁵⁴ See generally, *Id.* at 189-90; Karissa Eide, Comment: *Can a Pharmacist Refuse to Fill Birth Control Prescriptions on Moral or Religious Grounds?*, 22 CAL. W. L. REV. 121, 126-44 (2005).

⁵⁵ States with refusal clauses that apply only to abortion or “termination of pregnancy”: ALASKA STAT. § 18.16.010(b) (2005) (abortion); ARIZ. REV. STAT. § 36-2151 (2006) (abortion); CAL. HEALTH & SAFETY CODE § 123420 (West 2006) (abortion); DEL. CODE ANN. tit. 24 § 1791(a) (2006) (pregnancy termination); HAW. REV. STAT. § 453-16(d) (2003) (abortion); IDAHO CODE ANN. 18-612 (2004) (abortion); IND. CODE § 16-34-1-5(2004) (abortion); IOWA CODE § 146.1 (2002) (abortion); KAN. STAT. ANN. § 65-443 (2006) (pregnancy termination); KY. REV. STAT. ANN. § 311.800(4) (LexisNexis 2004) (abortion); LA. REV. STAT. ANN. § 1299:31(A) (2004) (abortion); MICH. COMP. LAWS ANN. § 333.20181 (West 2004) (abortion); MINN. STAT. § 145.414(a) (2003) (abortion); MO. REV. STAT. § 197.032(1) (2004) (abortion); MONT. CODE ANN. § 50-20-111(2) (2004) (abortion); NEB. REV. STAT. § 28-337 (2003) (abortion); NEV. REV. STAT. § 632.475(1) (2004) (abortion); N.M. STAT. ANN. § 30-5-2 (West 2006) (pregnancy termination); N.Y. CIV. RIGHTS LAW § 79-i(1) (Consol. 2004) (abortion); N.C. GEN. STAT. § 14-45.1(e) (2004) (abortion); N.D. CENT. CODE § 23-16-14) (2003) (abortion); OHIO REV. CODE ANN. § 4731.91(D) (LexisNexis 2004) (abortion); OKLA. STAT. tit. 63, § 1-741(B) (2004) (abortion); 18 PA. CONS. STAT. § 3213(d) (2004) (abortion); S.C. CODE ANN. § 44-41-40 (2003) (abortion); UTAH CODE ANN. § 76-7-306(1) (2004) (abortion); VA. CODE ANN. § 18.2-75 (2004) (abortion).

Although Georgia has been cited as one jurisdiction that has extended its refusal clause to cover pharmacists refusing to dispense EC, see NAT’L CONFERENCE OF STATE LEGISLATURES, PHARMACIST CONSCIENCE CLAUSES: LAWS AND LEGISLATION (Aug. 2006), available at <http://www.ncsl.org/programs/health/ConscienceClauses.htm> (last visited Aug. 25, 2006) [hereinafter NCSL State Conscience Clause Survey], Georgia’s statute only applies to pharmacists who refuse to “fill a prescription for a drug which purpose is to terminate a pregnancy,” and states explicitly, “Nothing 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 and including any drug or device approved by the federal Food and Drug Administration for such purpose.” GA. CODE ANN. § 16-12-142(b) (West 2006). Because Plan B is classified by the FDA as a contraceptive and not an abortifacient, Harris, *supra* note 51, the refusal clauses of the foregoing 28 states do not extend to refusing pharmacists and cannot be used to shield such pharmacists from tort liability.

⁵⁶ *Roe v. Wade*, 410 U.S. 113 (1970).

⁵⁷ Wardle, *supra* note 53 at 180.

sterilization, artificial insemination or some combination thereof,⁵⁸ while ten states include under some circumstances contraception or family planning services within the scope of their refusal clauses,⁵⁹ and three more provide general rights of refusal for any procedure or service to which a health care provider has an ethical or moral objection.⁶⁰ These clauses usually specify what types of recrimination refusing health care providers are shielded from, typically prohibiting reprisals by employers or professional licensing boards or insulating refusing actors from criminal or civil liability. All told, 45 states have some form of refusal clause on the books,⁶¹ as has the federal government.⁶² In the 2006 legislative session, 21 states saw legislation

⁵⁸ MASS. GEN. LAWS ANN. ch. 112, § 12I (2006) (abortion and sterilization); R.I. GEN. LAWS § 23-17-11 (2005); WIS. STAT. § 253.09(1) (2005) (sterilization and “removing a human embryo or fetus”). MD. CODE ANN., HEALTH-GEN. § 20-214(a)(2)(ii) (West 2005) (artificial insemination, sterilization, and pregnancy termination).

⁵⁹ Ten states have refusal clauses that under some circumstances apply to contraceptives. *See* ARK. CODE ANN. § 20-16-304(4) and (5) (2006) (contraceptives) in addition to ARK. STAT. ANN. § 20-16-601(a) (2006) (abortion); COLO. REV. STAT. ANN. § 25-6-102(9) (2006) (contraceptives); FLA. STAT. ANN. § 381.0051(6) (2006) (contraceptives or family planning services); ME. REV. STAT. ANN. tit. 22 §1903(4) (2005) (family planning services) and ME. REV. STAT. ANN. tit. 22 § 1902(4) (defining “family planning services” to include contraception); N.J. STAT. ANN. § 30:11-9 (2006) (allowing hospitals to refuse to offer “sterilization of human beings, euthanasia, birth control or any similar practice contrary to the dogmatic or moral beliefs of any well established religious body or denomination”) and N.J. STAT. ANN. § 2A:65A-1 (2006) (abortion and sterilization); OR. REV. STAT. § 435.225 (2005) (allowing employees of state Department of Human Services to refuse to offer “family planning and birth control services”) and OR. REV. STAT. § 435.485(1) (2005) (“termination of pregnancy”); S.D. CODIFIED LAWS § 36-11-70 (2006) (pharmacist may refuse to dispense medication that would “destroy an unborn child”) and S.D. CODIFIED LAWS § 22-1-2(50A) (defining “unborn child” to mean “an individual organism of the species homo sapiens from fertilization until live birth.”); ; TENN. CODE ANN. § 68-34-104(5) (2006) (contraceptives); W. VA. CODE ANN. § 16-2B-4 (2006) (contraceptives); WYO. STAT. ANN. § 42-5-101(d) (2005) (“family planning and birth control services”).

⁶⁰ 745 ILL. COMP. STAT. 70/4 (2006) (providing, “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.”). However, a subsequently adopted emergency rule requires pharmacists to stock and dispense contraceptives—including EC—and, if temporarily out of stock, refer a client seeking the drug to another pharmacy. 68 ILL. ADMIN. CODE 1330.91(j). *See also* MISS. CODE ANN. § 41-41-225(5) (2006) and MISS. CODE ANN. § 41-107-3(b)); WASH. REV. CODE § 48.43.065(2)(a) (2006);

⁶¹ *See supra* notes 55, 58-60. Twenty-eight states have refusal clauses that apply only to abortion or “termination of pregnancy;” five apply only to some combination of abortion, sterilization, and artificial insemination; ten apply, at least under some circumstances, to contraception, and three provide broad, generally applicable rights of conscience for health care providers. The five states that do not have some form of refusal clause are Alabama, Connecticut, New Hampshire, Texas, and Vermont.

⁶² 42 U.S.C. § 300a-7(b)(1) (2004) (applying only to abortion and sterilization)

introduced that would create or expand existing refusal clauses, in some cases specifically including pharmacists' refusals of EC or traditional contraception in their protections.⁶³ Though none of these bills passed, this number constituted a marked increase from the 2005 legislative session, which saw such new or expanded refusal clauses introduced in only thirteen states.⁶⁴

Because refusal clauses differ so widely among states, they do not lend themselves to generalizations about their impact on pharmacists' potential tort liability for refusing to dispense EC. The applicability of any given refusal clause to the refusal-to-dispense-EC scenario will depend potentially on two factors: what types of refusals the clause protects, and whose refusals the clause protects.

Based on FDA's classification of Plan B as a contraceptive rather than an abortifacient,⁶⁵ the majority of existing refusal clauses, which apply only to refusals to perform or assist in abortions, do not affect pharmacists' duty to dispense EC. Refusal clauses including sterilization and artificial insemination are similarly inapplicable to the EC context. Omitting these jurisdictions from further analysis, only 13 states have enacted refusal clauses that could potentially apply to a pharmacist's refusal to dispense EC—ten that specifically protect refusals involving contraception or family planning, and three that broadly protect any health care provider's conscientious objection. However, one of these latter three jurisdictions, Illinois, has specifically limited the efficacy of its broad refusal clause with respect to EC and other forms of

⁶³ NCSL State Conscience Clause Survey, *supra* note 55.

⁶⁴ Id.

⁶⁵ Harris, *supra* note 51.

contraceptives, first by emergency rule adopted by Governor Rod Blagojevich,⁶⁶ and subsequently by administrative rule.⁶⁷

Turning to the remaining 12 refusal clauses, three more must be omitted from further analysis based on the type of actors they protect. New Jersey permits refusals to dispense contraception, but only extends that right of refusal to hospitals.⁶⁸ Because New Jersey's refusal clause encompasses only institutional entities rather than individual actors, it does not limit individual pharmacists' duty to dispense. Even hospital pharmacists are not covered by New Jersey's refusal clause so long as their employing hospital has chosen to stock EC. Oregon's refusal clause allows some individuals to refuse to dispense contraception, but limits its scope to employees of the Oregon Department of Human Services. Pharmacists not employed by that agency, including all pharmacists in private practice, therefore still have a duty to dispense EC.⁶⁹ Finally, West Virginia's refusal clause, which applies to all "family planning services," covers only "employee[s] of the State of West Virginia,"⁷⁰ and therefore does not allow any pharmacist working in private practice—at the corner pharmacy—to refuse to dispense.

Having identified and omitted from further analysis all existing refusal clauses irrelevant on their face to a pharmacist's duty to dispense EC, it appears that only nine states have adopted refusal clauses that protect both the actor and the act—both the pharmacist and the refusal to

⁶⁶ Press Release, Office of the Governor of Illinois, Gov. Blagojevich takes emergency action to protect women's access to contraceptives (Apr. 1, 2005), *available at* <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3805>, last visited Oct. 16, 2006.

⁶⁷ 68 ILL. ADMIN. CODE 1330.91(j).

⁶⁸ N.J. STAT. ANN. § 30:11-9(2006); see also N.J. STAT. ANN. § 2A:65A-1 (2006) (extending to only abortion and sterilization).

⁶⁹ OR. REV. STAT. § 435.225 (2005). Oregon, like New Jersey, also has a separate refusal clause specific to pregnancy termination. OR. REV. STAT. § 435.485(1) (2005).

⁷⁰ W. VA. CODE ANN. § 16-2B-4 (2006).

dispense EC: Arkansas,⁷¹ Colorado,⁷² Florida,⁷³ Maine,⁷⁴ Mississippi,⁷⁵ South Dakota,⁷⁶

⁷¹ (4) Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information; and

(5) No private institution or physician, nor any agent or employee of the institution or physician, nor any employee of a public institution acting under directions of a physician shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or physician shall be held liable for the refusal.

ARK. CODE ANN. § 20-16-394 (2006).

⁷² No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal.

COLO. REV. STAT. ANN. § 25-6-102(9) (2006).

⁷³ The provisions of this section shall not be interpreted so as to prevent a physician or other person from refusing to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons; and the physician or other person shall not be held liable for such refusal.

FLA. STAT. ANN. § 381.0051(6) (2006).

⁷⁴ No private institution or physician or no agent or employee of such institution or physician shall be prohibited from refusing to provide family planning services when such refusal is based upon religious or conscientious objection.

ME. REV. STAT. ANN. tit. 22 §1903(4) (2005). Maine defines “family planning services” to include contraceptives. ME. REV. STAT. ANN. tit. 22 § 1902(4).

⁷⁵ (5) A health care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience...

...

(7) A health care provider or institution that declines to comply with an individualized instruction of health care decision shall:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(b) Provide continuing care to the patient until a transfer can be effected; and

(c) Unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision

Tennessee,⁷⁷ Washington,⁷⁸ and Wyoming.⁷⁹ Each of these states either explicitly states that it includes pharmacists, uses general terms that are defined elsewhere to include pharmacists, or uses general terms that probably include pharmacists.⁸⁰ Similarly, each clause either explicitly encompasses refusals to dispense contraception, uses general terms that are defined elsewhere to

MISS. CODE ANN. § 41-41-225(5) and (7) (2006). “Health care provider” is a defined term including pharmacists. MISS. CODE ANN. § 41-107-3(b).

⁷⁶ No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to:

- (1) Cause an abortion; or
- (2) Destroy and unborn child as defined in subdivision 22-1-2(50A)...

No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against a pharmacist or the pharmacy of the pharmacist on the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist.

S.D. CODIFIED LAWS § 36-11-70 (2006). South Dakota elsewhere defines “unborn child” as “an individual organism of the species homo sapiens from fertilization until live birth.” S.D. CODIFIED LAWS § 22-1-2(50A).

⁷⁷ No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal.

TENN. CODE ANN. § 68-34-104(5) (2006).

⁷⁸ No individual health care provider... may be required by law or contract in any circumstances to participate in the provision of... a specific service if they object to so [sic] for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

WASH. REV. CODE § 48.43.065(2)(a) (2006).

⁷⁹ Any person may refuse to accept the duty of offering family planning and birth control services to the extent the duty is contrary to his personal or religious beliefs. The refusal shall not be grounds for:

- (i) Any disciplinary action;
- (ii) Dismissal;
- (iii) Any departmental transfer;
- (iv) Any other discrimination in employment;
- (v) Suspension from employment; or
- (vi) Any loss in pay or other benefits.

WYO. STAT. ANN. § 42-5-101(d) (2005).

⁸⁰ Although one commentator has concluded that statutes extending rights of refusal to “private institutions” or to agents or employees of such institutions probably do not extend rights of refusal to pharmacists, *see* Eide, *supra* note 54, it is likely that any privately owned pharmacy would in fact qualify as a private institution, and any pharmacist employed by such a pharmacy would thereby be protected by the statute.

encompass refusals to dispense contraception, or broadly allows actors to refuse to participate in any practice or process to which they morally or ethically object.

1. *Failure To Explicitly Preclude Civil Liability*

Refusal clauses typically contain provisions specifically enumerating the types of reprisals against which the clause insulates refusing actors.⁸¹ Although a number of these refusal clauses do not specifically insulate refusing actors from civil liability,⁸² it is unlikely a court would impose liability on a refusing pharmacist solely on the basis of such a statutory omission. At least where liability would be imposed on negligence grounds, the existence of a refusal clause covering pharmacists who refuse to dispense EC appears effectively to limit the pharmacist's duty of care with respect to that act. If a refusal to dispense, or a refusal to refer,⁸³ does not violate the pharmacist's duty of care, it cannot provide the basis for negligence liability, regardless of whether or not the operative refusal clause states specifically that the pharmacist will not be held liable for a refusal to dispense or refer. However, to the extent that a pharmacist refuses to return a minor's valid EC prescription or deliberately insults or humiliates a woman seeking EC, even the broadest refusal clauses may not protect the pharmacist from charges of theft or from claims of trespass to chattels or infliction of emotional distress. Though any such claim would necessitate a highly fact-specific inquiry, the pharmacist's actions underlying any such claim probably exceed the scope of the actions protected by the operative refusal clause.

2. *Duty to Refer*

⁸¹ See, e.g., ARK. CODE ANN. § 20-16-394 (2006) ("No such institution shall be held liable for the refusal." *Id.*); S.D. CODIFIED LAWS, § 36-11-70 (2006) ("No such refusal... may be the basis for any claim for damages against a pharmacist or the pharmacy of the pharmacist or the basis of any disciplinary, recriminatory, or discriminatory action against the pharmacist." *Id.*).

⁸² See, e.g., WASH. REV. CODE § 48.43.065(2)(a) (2006) (providing protection from employment or professional discrimination stemming from refusal); WYO. STAT. ANN. § 42-5-101(d) (2005) (same).

⁸³ See discussion in text *infra*, Section I.B.2

Commentators who have argued that pharmacists do not have a duty to dispense EC have admitted that refusing pharmacists probably do have a duty to refer and duly transfer clients elsewhere.⁸⁴ In fact, this is not universally true: five states' refusal clauses appear to give pharmacists a right to refuse to participate even in referring a client to a dispensing pharmacist. Arkansas, Colorado, and Tennessee each have a refusal clause that provides a right of refusal with respect to the provision of "contraceptive procedures, supplies, *and information*."⁸⁵ Florida similarly states that no covered actor shall be prevented from "refusing to furnish any contraceptive or family planning service, supplies, or information" if that refusal is made for medical or religious reasons.⁸⁶ These states' refusal clauses, by including a largely unqualified right of refusal with respect to contraceptive information—as distinct from contraceptive services or supplies—arguably provide covered individuals with a right to refuse even to tell clients where they might attempt to obtain such supplies. Washington's refusal clause is also sufficiently broad that it may allow covered individuals to refuse to refer: it states that health care providers cannot be required "to participate in the provision of... a specific service if they object for reason of conscience or religion."⁸⁷ Refusing pharmacists have argued that they should not be required to refer clients elsewhere because making a referral still constitutes participation in the provision of drugs to which they object.⁸⁸ Because the act of making a referral requires a

⁸⁴ Herb, *supra* note 21 at 90; Rambaud, *supra* note 21 at 221; Cantor & Baum, *supra* note 18 at 2011.

⁸⁵ ARK. CODE ANN. § 20-16-349(4), (5) (2006); COLO. REV. STAT. ANN. § 25-6-102(9) (2006); TENN. CODE ANN. § 68-34-105(5) (2006) (emphasis added).

⁸⁶ FLA. STAT. ANN. § 381.0051(6) (2006).

⁸⁷ WASH. REV. CODE § 48.43.065(2)(a) (2006).

⁸⁸ *See, e.g.*, Stein, *supra* note 9.

pharmacist to participate, albeit indirectly, in a client’s attempt to obtain EC, Washington courts may interpret the state’s refusal clause to allow pharmacists to refuse to refer clients.

On the other hand, Maine, South Dakota, and Wyoming, which provide rights of refusal for “providing family planning services,”⁸⁹ “dispens[ing of] medication,”⁹⁰ and “offering family planning and birth control services,”⁹¹ respectively, each have refusal clauses too narrow to encompass refusals to refer. Further, Mississippi’s refusal clause explicitly affirms that a refusing pharmacist must provide continuing care to the client and, unless the client refuses further assistance, must “immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution” who will dispense the medication the client seeks.⁹² In these four states, then, a refusing pharmacist must nonetheless assist the client to obtain EC through alternative channels. In these jurisdictions, a failure, much less a refusal, to refer breaches the pharmacists’ duty of care, notwithstanding the refusal clauses that protect the pharmacist from having to dispense.

In no state does the refusal clause permit the refusing pharmacist to refuse to return the client’s prescription or to harass or insult the client.

C. Refusal To Dispense As Civil Disobedience: The Impact on Tort Liability

In light of this general duty to dispense, what should be made of pharmacist refusals? It is true that some pharmacists have stated publicly they believe they are within their rights in

⁸⁹ ME. REV. STAT. ANN. tit. 22 § 1903(4) (2005).

⁹⁰ S.D. CODIFIED LAWS § 36-11-70 (2006).

⁹¹ WYO. STAT. ANN. § 42-5-101(d) (2005).

⁹² MISS. CODE ANN. § 41-41-225(7) (2006).

refusing to dispense drugs to which they morally object.⁹³ “Pro-life” interest groups have certainly tried to foster this view,⁹⁴ and policy statements from national pharmacy associations have also furthered this understanding,⁹⁵ albeit less stridently. However, the pharmacy community is well aware that the legality of such refusals are, at best, in dispute,⁹⁶ and individual pharmacists have been subject to licensure or workplace sanctions and employment terminations stemming from their refusals.⁹⁷ Pharmacists are therefore on notice that by refusing to dispense drugs such as EC on nonmedical grounds, they may be acting in violation of the law.

Refusals to dispense EC may be best understood as acts of civil disobedience: an intentional violation of a legal duty, which violation is undertaken to protest a law or requirement the protester believes to be immoral.⁹⁸ Courts generally do not recognize civil disobedience as a defense to criminal or civil liability. On the contrary, “it is commonly concluded that the exercise of a moral judgment based upon individual standards does not carry with it legal justification or immunity from punishment for a breach of the law.”⁹⁹ The moral and ethical

⁹³ See e.g., Frankel, *supra* note 8.

⁹⁴ See Stein, *supra* note 9; Jim Suhr, *Pharmacists won't give in on pills: Suspended for not dispensing emergency contraceptives*, CHICAGO SUN TIMES, Dec. 25, 2005, at A11.

⁹⁵ APhA Refusal Statement, *supra* note 40 and ASHSP Refusal Statement, *supra* note 40.

⁹⁶ Jesse C. Vivian, *Intervention of Unwanted Intrusion?*, 8 U.S. PHARM. 90 (2006).

⁹⁷ *In re Noesen*, *supra* note 12 (professional sanction); Suhr, *supra* note 94 (employment termination); Associated Press, *Protest follows denial of morning-after pill*, Feb. 24, 2004 (available at www.cnn.com/2004/US/Southwest/02/03/pharmacy.protest.ap/index.html (last visited Aug. 24, 2006) (unspecified disciplinary action).

⁹⁸ See generally Kevin H. Smith, *Therapeutic Civil Disobedience: A Preliminary Exploration*, 31 U. MEM. L. REV. 99, 115-27, and especially 115-21 (setting forth the attributes of civil disobedience).

⁹⁹ *U.S. v. Moylan*, 417 F.2d 1002, 108 (4th Cir. 1969). See also ABE FORTAS, CONCERNING DISSENT AND CIVIL DEMOCRACY (1968); *Hamm v. City of Rock Hill*, 379 U.S. 306, 328 (1964) (J. White, dissenting); *Forman v. City of Montgomery*, 245 F.Supp. 17, 24-25 (M.D. Ala. 1965).

convictions of refusing pharmacists, though no doubt sincere, therefore do not provide them special protection from an otherwise-applicable duty to dispense.

II. Example Of Pharmacist Tort Liability: Wrongful Conception

A. Elements, Generally

Wrongful conception, sometimes called “wrongful pregnancy,” is one of the so-called “birth torts.”¹⁰⁰ Courts generally treat wrongful conception as a medical malpractice action brought under a theory of negligence¹⁰¹ and have assessed damages in accordance with traditional tort liability theory.¹⁰² Wrongful conception claims have arisen most frequently in the context of a failed sterilization procedure, whether a vasectomy or tubal ligation or cauterization, when the patient who believed himself or herself to be sterile subsequently conceives. In such surgical sterilization cases, the traditional elements of negligence are straightforward: the doctor breaches the duty of care owed to his or her patient by improperly performing a surgical sterilization; this breach is the proximate cause of an unplanned pregnancy; and the unplanned pregnancy results in damages to the patient.¹⁰³ This action is widely recognized—32 of the 33 jurisdictions to consider the question have treated wrongful conception as a cognizable tort.¹⁰⁴

¹⁰⁰ Courts have not adopted standardized terms when referring to the birth torts, sometimes appearing to use the terms “wrongful birth,” “wrongful life,” “wrongful conception,” and “wrongful pregnancy” interchangeably to refer to the cause of action in which an act or omission by a medical professional with respect to temporary or permanent contraceptive methods proximately causes an unplanned pregnancy. To avoid confusion, this article uses the term “wrongful conception” to refer to all such causes of action, regardless of what term any given court might have used.

¹⁰¹ See e.g. Boone v. Mullendore, 416 So. 2d 718, 720 (Ala. 1982); Jackson v. Bumgardner, 347 S.E.2d 743, 747 (N.C. 1986); Jones v. Malinowski, 473 A.2d 429, 432 (Md. 1984); Custodio v. Bauer, 59 Cal. Rptr. 463, 467 (Ca. 1967).

¹⁰² Jurisdictions have reached differing conclusions on the question of precisely which damages are recoverable, see Section II.B.3., *infra*, but these differing results are always couched in terms of traditional tort theory.

¹⁰³ See e.g. James G. v. Caserta, 332 S.E. 2d 872, 876 (W. Va. 1985).

¹⁰⁴ Nevada has held that wrongful conception is not actionable in that state because “the birth of a normal, healthy child is not ‘legally compensable damages in tort;’” however, the court allowed recovery for the medical,

Although wrongful conception claims have most frequently involved surgical sterilization procedures, two jurisdictions have recognized the tort in the context of more temporary forms of birth control. In Jackson v. Bumgartner, the North Carolina Supreme Court imposed liability on a doctor who negligently failed to reinsert a woman’s intrauterine device (“IUD”) after performing emergency uterine surgeries.¹⁰⁵ Finding no basis for distinguishing between permanent and temporary contraceptive methods for the purpose of assessing liability, the Jackson court held that “[t]here appears to be no compelling reason to limit a patient’s right to non-negligent health care to permanent sterilization as opposed to the insertion of an IUD.”¹⁰⁶

Even more directly applicable to the EC context, a Michigan court found a pharmacist liable when he negligently dispensed tranquilizers instead of the birth control pills his client had been prescribed.¹⁰⁷ The plaintiff, erroneously believing that she was taking birth control pills, became pregnant, and she subsequently sued her pharmacist for wrongful conception. The Tropi court, noting that pharmacists are “held to a very high standard of care in filling prescriptions,” held that “the possibility that [Mrs. Troppi] might become pregnant was certainly a foreseeable consequence of the defendant’s failure to fill a prescription for birth control pills; we therefore could not say that it was not a proximate cause of the birth of the child.”¹⁰⁸ The Tropi court construed those facts as a clear-cut case of tort liability: “We have here a negligent,

surgical, and hospital expenses associated with an improper surgical sterilization under contract theory. Szekeres v. Robinson, 715 P.2d 1076 (Nev. 1986). This distinction between contract and tort may preclude recovery in Nevada for wrongful conception in the context of a pharmacist who denies a client EC because there arguably exists no contract between client and pharmacist prior to the pharmacist’s dispensing of the drugs.

¹⁰⁵ Jackson v. Bumgardner, 347 S.E.2d 743 (N.C. 1986).

¹⁰⁶ Id. at 749.

¹⁰⁷ Tropi v. Scarf, 187 N.W.2d 511 (Mich. Ct. App. 1971).

¹⁰⁸ Id. at 513.

wrongful act by the defendant, which act directly and proximately caused injury to the plaintiffs.”¹⁰⁹

B. Wrongful Conception Flowing from Refusal to Dispense EC

Although case law indicates courts’ willingness to apply the elements of wrongful conception broadly, having already extended liability to temporary birth control and to pharmacist-provided care, no case has yet been brought seeking to impose wrongful conception liability on a pharmacist who has refused to dispense EC or prescription contraceptives. With the FDA’s August 2006 approval of limited over-the-counter access to EC,¹¹⁰ and EC’s increasingly high profile due to increased media coverage and public education work efforts, it seems likely that both the demand for EC and the frequency of refusals by pharmacists to dispense the drug will continue to rise. Because the effectiveness of EC is so highly time-sensitive, each refusal to dispense causes a delay that decreases the drug’s effectiveness and makes pregnancy more likely. It may therefore be useful to sketch out how the elements of a wrongful conception claim might apply to a pharmacist’s breach of a legal duty to dispense EC.

1. Breach and Causation—The Goldilocks Approach to Balancing Title VII and Tort Liability

It is perhaps a truism that when a woman has been denied access to an effective form of post-coital contraceptives that she has every right to obtain and use, that denial of access has “caused” any resulting pregnancy. It is even more obvious that where there is no breach—no refusal, in this case—the causation element of a negligence claim cannot be satisfied. And yet these two obvious statements notwithstanding, simply requiring all pharmacists to fill every

¹⁰⁹ *Id.* at 514.

¹¹⁰ U.S. Food and Drug Administration, FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older, Prescription Remains Required for Those 17 and Under, Aug. 24, 2006, at <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html> (last accessed Aug. 29, 2006).

request for EC they encounter may not be legally viable under Title VII, which requires employers, where possible, to reasonably accommodate their employees' sincerely held religious beliefs. How can pharmacies walk this tightrope between pharmacists' Title VII claims and women's wrongful conception claims? Quite simply, they can do so by accommodating employees' religious beliefs where they can, but never at the expense of clients' timely, on-site access to EC. This approach satisfies employers' Title VII responsibility while ensuring that the pharmacy never breaches its duty to dispense the drug.

Title VII prohibits discrimination, including religious discrimination, in the workplace.¹¹¹ This prohibition on religious discrimination does not require employers to recognize a total right of refusal for pharmacists;¹¹² it requires merely that employers provide "reasonable accommodations"¹¹³ for pharmacists who harbor religious objections to filling contraceptive prescriptions.¹¹⁴ Such reasonable accommodations might include "asking another pharmacist to fill the prescription; assigning the pharmacist to work only on shifts or in stores where another non-objecting pharmacist is on duty; or assigning the pharmacist to a line or place of work not involving the dispensation of prescription contraceptives."¹¹⁵ No absolute right of refusal is recognized by Title VII, however. If an employer cannot make any of these accommodations without incurring "undue hardship,"¹¹⁶—for example, in a small pharmacy where staffing the pharmacy at all times with a second, EC-dispensing pharmacist would require additional staff

¹¹¹ 42 U.S.C. § 2000e-2000e-1 (2000).

¹¹² See Chanrasekhar, *supra* note 18, at 170-72.

¹¹³ See Ansonia Bd. of Educ. v. Philbrook, 479 U.S. 60, 68 and 70 (1986).

¹¹⁴ Id.

¹¹⁵ Id. at 171.

¹¹⁶ Id. at 68-69; Trans World Airlines, Inc. v. Hardison, 432 U.S. 63, 84-85 (1977).

hires—Title VII does not require employers to accommodate refusing pharmacists at all costs.¹¹⁷ Any accommodation that would impose more than a *de minimis* cost on an employer constitutes an undue hardship and is not required by Title VII.¹¹⁸ Under this *de minimis* rule, any accommodation that cannot ensure timely, on-site access to EC is likely not required by Title VII, as it would alienate clients and cause the pharmacy to lose business.¹¹⁹ Where allowing a pharmacist to refuse to dispense would mean client access could not be ensured, employers may, without running afoul of Title VII, require their pharmacists to dispense EC.

Failure to make available reasonable accommodations violates Title VII where such accommodations are feasible; but where they are not, failure to require pharmacists to dispense EC subjects both employer and employee to liability. Between these poles of under-protection and over-protection¹²⁰ lies a solution that is just right. A pharmacy policy that is precisely co-extensive with the requirements of Title VII—providing pharmacists no more and no less protection than they are allowed under that law—will protect collaterally against tort liability by ensuring, by whatever mechanism, that women are able to access EC where and when they need it. Where access is ensured, there is no breach, and therefore no causation.

2. *Proximate Causation and Harm*

As the wrongful conception cases, and Troppi in particular, recognize, pregnancy is a foreseeable result of a medical professional's failure to provide competent contraceptive care to a

¹¹⁷ See generally Amy Bergquist, Note, *Dispensing (With) Religious Accommodation Under Title VII*, 90 MINN. L. REV. 1073 (2006).

¹¹⁸ See Trans World Airlines, 432 U.S. at 84-85.

¹¹⁹ See Bergquist, *supra* note 117, at 1093-99.

¹²⁰ Allowing pharmacists to refuse to dispense overprotects the rights of pharmacists at the expense of their female clients; requiring them to dispense even where reasonable accommodations exist overprotects women at the expense of pharmacists' Title VII rights.

patient.¹²¹ At least where the client has diligently attempted and failed to secure such care elsewhere, the pharmacist's failure to provide competent care is the proximate cause of any resulting pregnancy.¹²² As the New Hampshire Supreme Court observed when it recognized the actionability of wrongful conception claims, "Non-recognition of any cause of action for wrongful conception leaves a void in the area of recovery for medical malpractice and dilutes the standard of professional conduct and expertise in the area of family planning, which has been clothed with constitutional protection."¹²³

In those jurisdictions where a pharmacist may refuse to dispense but has a duty to refer, a refusal to refer may constitute the proximate cause of a subsequent pregnancy. It is well documented that a delay in beginning the course of EC dramatically decreases the effectiveness of the treatment. A refusal to refer exacerbates this urgency, particularly where the pharmacist knows with reasonable certainty where a client might obtain EC but instead puts the client in a position where she must spend hours or even days searching for an alternative source. Even if the client is able to obtain EC at a much later time, the pharmacist's refusal to refer may be said to have "caused" the pregnancy in that it forced the woman seeking treatment to delay her treatment until a later time, perhaps a much later time, when the effectiveness of EC would have been substantially lower.

3. *Damages*

Although most jurisdictions recognize the tort of wrongful conception, three competing methods have emerged for assessing compensatory damages flowing from such claims. It is not disputed that the costs associated with pregnancy and birth are compensable in a wrongful

¹²¹ See Troppi, 187 N.W.2d at 514.

¹²² Troppi, 187 N.W.2d at 514.

¹²³ Kingsbury v. Smith, 442 A.2d 1003, 1005-06 (N.H. 1982).

conception action. These damages include prenatal care, childbirth, prenatal and postnatal care, physical and mental pain suffered by the woman as a result of the pregnancy and birth, lost wages due to prenatal care and postnatal recovery, and loss of consortium during pregnancy and immediately thereafter.¹²⁴ In the case of negligently performed sterilization procedures, compensatory damages may also include the cost of the initial, unsuccessful surgery and a second operation, if obtained.¹²⁵

More controversial is the question of whether costs of childrearing through the age of majority are recoverable in a wrongful conception action. California, recognizing that childrearing is a costly endeavor that can have a real and negative financial effect on a family who had not anticipated and had in fact sought to avoid that cost, has implied that childrearing costs are wholly recoverable because such recovery will “replenish the family exchequer so that the new arrival will not deprive other members of the family of what was planned as their just share of the family income.”¹²⁶ Although lower California courts have followed a different theory of recovery in practice,¹²⁷ Custodio is frequently cited in favor of the “full recovery” rule.¹²⁸ The majority of states have taken the opposite view, holding that childrearing costs are,

¹²⁴ See e.g. James G. v. Caserta and Jennifer S. v. Kirdnual (consolidated), 332 S.E.2d 872, 877 (W. Va. 1985); Johnston v. Elkins, 736 P.2d 935, 940 (Kan.1987); P. v. Portadin, 432 A.2d 556, 559-60 (N.J. Superior Ct. 1981); Mason v. Western Pennsylvania Hospital, 453 A.2d 974, 975 (Pa. 1982). Among this list of compensable damages, Georgia (alone?) has specifically rejected those damages for a woman’s pain and suffering stemming from the unplanned pregnancy and birth, finding it a “backdoor approach” to recovering childrearing costs, which Georgia otherwise disallows. Wasdin v. Mager, 619 S.E.2d 384, 888 (Georgia 2005).

¹²⁵ Wasdin v. Mager, 619 S.E.2d 384, 888 (Georgia 2005).

¹²⁶ Custodio v. Bauer, 59 Cal. Rptr. 463, 477 (1967). Finding the factual record insufficient to review any question of proper damages, the Custodio Court held only that “if successful on the issue of liability, [plaintiffs] have established a right to more than nominal damages.” Id. at 477.

¹²⁷ Stills v. Gratton, 127 Cal. Rptr. 652, 658-59 (Cal. App. 1976) (departing from the full compensation approach alluded to in Custodio in favor of the more moderate benefit rule, discussed below at page 36).

¹²⁸ See, e.g., Univ. Arizona Health Sciences Center v. Superior Court, 667 P.2d 1294,

as a matter of law, not recoverable in wrongful conception actions.¹²⁹ Courts have advanced four rationales for denying such recovery. First, courts have held that the speculative nature of such costs bars their recovery.¹³⁰ Second, the cost of childrearing is out of proportion to the defendant's negligence.¹³¹ Third, courts have expressed concern that assessing the cost of childrearing as a damages element "could have a significant impact on the stability of the family unit and the subject child" or is otherwise contrary to public policy.¹³² Fourth, some courts have made a policy choice that as a matter of law, "the benefits of the birth of a healthy, normal child outweigh the expense of rearing a child" and the existence of the child cannot constitute an element of damage.¹³³ Finally, a small minority of six states has attempted to split the difference

¹²⁹ Boone v. Mullendore, 416 So. 2d 718 (Ala. 1982); Wilbur v. Kerr, 628 S.W.2d 568 (Ark. 1982); Coleman v. Garrison, 327 A.2d 757 (Del. 1974); Flowers v. District of Columbia, 478 A.2d 1073, 1076 (D.C. 1984); Wasdin v. Mager, 619 S.E.2d 384, 386 (Georgia 2005); Cockrum v. Baumgartner, 447 N.E.2d 385, 388 (Ill. 1983); Garrison v. Foy, 486 N.E.2d 5, 8-9 (Ind. 1985); Nanke v. Napier, 346 N.W.2d 520, 522-23 (Iowa 1984); Byrd v. Wesley Medical Center, 699 P.2d 459, 468 (Kan. 1985); Schork v. Huber, 648 S.W.2d 861, 862 (Ky. 1983); Macomber v. Dillman, 505 A.2d 810, 813 (Maine 1985); Kingsbury v. Smith, 442 A.2d 1003, 1006 (N.H. 1982); P. v. Portadin, 431 A.2d 556, 559 (N.J. Sup. Ct. 1981); Weintraub v. Brown, 98 A.D.2d 339, 349 (NY Sup Ct. App. Div. 1983); Jackson v. Bumgardner, 172 S.E.2d 743 (N.C. 1986); Morris v. Sanchez, 746 P.2d 184, 188 (Okla. 1987); Miller v. Johnson, 343 S.E.2d 301, 307 (Va. 1986); McKernan v. Aasheim, 687 P.2d 850, 855 (Wash. 1984); James G. v. Caserta and Jennifer S. v. Kirdnual (consolidated), 332 S.E.2d 872, 877 (W. Va. 1985); Beardsley v. Wierdsma, 650 P.2d 288; 292 (Wyo. 1980).

¹³⁰ Although the cost of raising a child could be determined with reasonable specificity, the amount by which the court would need to offset those costs to account for the joys and benefits of parenting is a fundamentally noneconomic calculation, and is therefore necessarily speculative. See Jackson v. Bumgardner, 172 S.E.2d 743 (N.C. 1986) ("Who, indeed, can strike a pecuniary balance between the triumphs, the failures, the ambitions, the disappointments, the joys, the sorrows, the pride, the shame, the redeeming hope that the child may bring to those who love him?" *Id.* at 750); Boone v. Mullendore, 416 So. 2d 718, 721 (Ala. 1982); Coleman v. Garrison, 327 A.2d 757 (Del. 1974); Cockrum v. Baumgartner, 447 N.E.2d 385, 388 (Ill. 1983); Schork v. Huber, 648 S.W.2d 861, 862 (Ky. 1983); Kingsbury v. Smith, 442 A.2d 1003, 1006 (N.H. 1982); McKernan v. Aasheim, 687 P.2d 850, 855 (Wash. 1984); James G. v. Caserta, 332 S.E.2d 872, 878 (W. Va. 1985); Beardsley v. Wierdsma, 650 P.2d 288; 292 (Wyo. 1980).

¹³¹ Flowers v. District of Columbia, 478 A.2d 1073, 1077 (D.C. 1984); P. v. Portadin, 431 A.2d 556, 559 (N.J. Sup. Ct. 1981); Beardsley v. Wierdsma, 650 P.2d 288; 292 (Wyo. 1980);

¹³² Boone v. Mullendore, 416 So. 2d 818, 721 (Ala. 1982). Accord Wilbur v. Kerr, 628 S.W.2d 568 (Ark. 1982); Flowers v. District of Columbia, 478 A.2d 1073, 1076 (D.C. 1984); Cockrum v. Baumgartner, 447 N.E.2d 385, 390 (Ill. 1983); Garrison v. Foy, 486 N.E.2d 5, 8-9 (Ind. 1985); Weintraub v. Brown, 98 A.D.2d 339, 349 (NY Sup Ct. App. Div. 1983); McKernan v. Aasheim, 687 P.2d 850, 855 (Wash. 1984);

¹³³ Beardsley v. Wierdsma, 650 P.2d 288, 293 (Wyo. 1982). Accord Weintraub v. Brown, 98 A.D.2d 339, 348-49 (N.Y. App. Div. 1983) (allowing recovery for childrearing costs "would be incompatible with contemporary

between these two poles of full recovery and total denial of recovery for childrearing costs; this third way is known as the “benefit rule.”¹³⁴ The benefit rule requires the negligent defendant to compensate the plaintiff-parents in a wrongful conception claim for all childrearing costs until the child reaches the age of majority, but offsets the plaintiff-parents’ recovery with the benefits the parents derive from their relationship with their child.¹³⁵ So while women pursuing claims for wrongful conception may generally expect, if successful, to recover for damages flowing from prenatal, delivery, and postnatal care, as well as any lost wages or loss of consortium claims that might be relevant, their ability to recover childrearing costs will depend on the jurisdiction in which they bring their claim.

In addition to the compensatory damages stemming from a negligence claim, women who have been refused EC and who subsequently conceive or suffer some other injury as a result may be able to recover punitive damages from the denying pharmacist. In many jurisdictions, punitive damages are available where the defendant has acted with “reckless indifference to the

views concerning one of life’s most precious gifts—the birth of a normal and healthy child.” *Id.* at 349); Coleman v. Garrison, 327 A.2d 757 (Del. 1974) (in choosing to raise the child, its parents indicate that “the benefits, at least in their particular case, outweigh any hardship or expense incident to the raising of the child.” *Id.* at 761); Wasdin v. Mager, 619 S.E.2d 384, 386 (Georgia 2005); Cockrum v. Baumgartner, 447 N.E.2d 385, 388 (Ill. 1983); Byrd v. Wesley Medical Center, 699 P.2d 459, 468 (Kan. 1985); Schork v. Huber, 648 S.W.2d 861, 862 (Ky. 1983); Macomber v. Dillman, 505 A.2d 810, 813 (Maine 1985); Jackson v. Bumgardner, 347 S.E.2d 743, 749 (N.C. 1986); Morris v. Sanchez, 746 P.2d 184, 188 (Okla. 1987); Beardsley v. Wierdsma, 650 P.2d 288; 293 (Wyo. 1980). *See also* Miller v. Johnson, 343 S.E.2d 301, 307 (Va. 1986) and Nanke v. Napier, 346 N.W.2d 520, 522-23 (Iowa 1984) for two cases involving actions by women who underwent negligently performed, unsuccessful abortions, and which were analyzed under the same rubric as wrongful conception that stems from negligently performed surgical sterilization).

¹³⁴ Univ. Arizona Health Sciences Center v. Superior Court, 667 P.2d 1294, 1300 (Ariz. 1983); Stills v. Gratton, 127 Cal. Rptr. 652, 658-59 (1976); Ochs v. Borrelli, 445 A.2d 883, 885 (Conn. 1982); Jones v. Malinowski, 473 A.2d 429, 435 (Md. Ct. App. 1984); Troppi v. Scarf, 187 N.W.2d 511, 518-19 (Mich. Ct. App. 1971); Sherlock v. Stillwater Clinic, 260 N.W.2d 169, 176 (Minn.1977).

¹³⁵ *See, e.g.,* Univ. Arizona Health Sciences Center v. Superior Court, 667 P.2d 1294, 1299 (“In our view, the preferable rule is that followed by the courts which, although permitting the trier of fact to consider both pecuniary and nonpecuniary elements of damage which pertain to the rearing and education of the child, also require it to consider the question of offsetting the pecuniary and nonpecuniary benefits which the parents will receive from the parental relationship with the child.” *Id.*).

rights of others.”¹³⁶ Recklessness may be assessed by either an objective or a subjective standard. A finding of recklessness requires that the actor “realizes or, from facts which he knows, should realize that there is a strong probability that harm may result, even though he hopes or even expects that his conduct will prove harmless.”¹³⁷ Because reckless indifference “is almost never admitted, and can be proved only by the conduct and the circumstances,” recklessness is generally assessed by an objective measure.¹³⁸ But even by a more stringent, subjective, measure pharmacists’ refusals to dispense EC are reckless. Refusing pharmacists object to medical technologies that could impede the creation or development of a zygote,¹³⁹ and by their refusals seek to preserve the existence or formation of a zygote. Their refusals acknowledge that denying women access to EC creates a substantial probability that a woman will become—or, as they would put it—“remain” pregnant. This awareness of the risks associated with refusing to dispense EC satisfies the recklessness standard required to justify an award of punitive damages.

A further argument could be made in favor of punitive damages based on the public role of the pharmacy profession and consequent deterrent effect of imposing punitive damages on the pharmacist. At least one court has held that “[p]unitive damages are especially

¹³⁶ RESTATEMENT (SECOND) OF TORTS § 909(2) and § 908 cmt. b (1979). *See also e.g., Owens-Illinois, Inc. v. Zenobia*, 601 A.2d 633, 652 (Md. 1992); *see also Goo v. Cont’l Cas. Co.*, 473 P.2d 563, 566 (Haw. 1970) (punitive damages available “willful, malicious, wanton or aggravated wrongs where a defendant has acted with a reckless indifference to the rights of another”); *Smith v. Jones*, 169 N.W.2d 308, 319 (Mich. 1969) (punitive damages may be awarded where a negligent act is “so great as to indicate a reckless disregard of the rights or safety of others”). *See e.g., IOWA CODE ANN.* § 668A.1(1)(b) (the defendant’s conduct must constitute “willful and wanton disregard for the rights or safety of another;”); *MINN. STAT. ANN.* § 549.20(1)(1)(b) (West 2000 and Supp. 2002) (defendant’s disregard for the rights or safety of others may justify punitive damages where he or she deliberately acts “in conscious or intentional disregard of” or “with indifference to the high degree of probability of injury to the rights or safety of others”).

¹³⁷ RESTATEMENT (SECOND) OF TORTS § 909(2) and § 908 cmt. b (1979).

¹³⁸ W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 34, at 213 (5th ed. 1984).

¹³⁹ A zygote is the single-celled result of fertilization that will develop into an embryo.

appropriate if the wrongdoer occupies a position of trust with members of the general public as well as with the victim.”¹⁴⁰ Pharmacists are among the most public of public health officials, dispensing all prescription drugs and some nonprescription drugs, frequently working in a capacity where they interact directly with and provide advice to the public.

Finally, the very nature of the relationship between the refusing pharmacist and the EC-seeking client may support an award of punitive damages. Previous cases have recognized malpractice claims for emotional distress where the medical services, such as those relating to birth or death, “carry with them deeply emotional responses in the event of breach.”¹⁴¹ In such cases, a breach of duty “will necessarily or reasonably result in mental anguish or suffering”¹⁴² and punitive damages may be supported. Deliberately causing a woman to become pregnant against her will by refusing to provide her with post-coital contraceptives to which she is legally entitled might reasonably, if not necessarily, result in mental anguish to the woman, and might therefore support an award of punitive damages on these grounds.

The question of whether punitive damages are permissible is highly fact specific, but in light of the pharmacists’ role as a trusted figure in public health and the denying pharmacist’s subjective recklessness, plaintiffs injured by a pharmacist’ refusal to dispense EC may be able to recover punitive damages.

C. Vicarious Employer Liability

Several large pharmacy chains have adopted corporate policies that permit pharmacists to refuse to dispense EC. When pharmacists at Target and Walgreens, for example, refuse to

¹⁴⁰ Bell v. Clark, 653 N.E.2d 483 (Ind. Ct. App. 1995).

¹⁴¹ See Oswald v. LeGrand, 453 N.W.2d 634, 639 (Iowa 1990).

¹⁴² Oswald, 453 N.W.2d at 639 (citing Taylor v. Baptist Medical Center, 400 S.2d 369, 374 (Ala. 1981)).

dispense EC, they do it with the approval of their employers,¹⁴³ even if their actions are not supported by law. These employers may be held liable in tort for the actions of the refusing pharmacists they employ under the theory of vicarious liability. An employer may be held liable for the torts of an employee where the employee's tortious activity was within the scope of his or her employment.¹⁴⁴ An employee's action may be said to be within the scope of employment where "the employee has the employer's authority to perform the action."¹⁴⁵ In addition to their exposure to assessments of compensatory damages, employers who authorize their pharmacist employees to refuse to dispense EC may be exposing themselves to awards of punitive damages. Even under the relatively restrictive scheme proposed by the Restatement (Second) of Torts, an assessment of punitive damages may be appropriate against an employer or other principal where the principal authorized, ratified, or approved of the agent's actions.¹⁴⁶ These conditions are satisfied where an employer has explicitly granted permission to pharmacist employees to refuse to dispense EC. Alternatively, an employer may be able to avoid vicarious liability, both for compensatory and punitive damages, where a refusal to dispense is *outside* the scope of a pharmacist's employment¹⁴⁷—for example, where the employer has instructed its pharmacist employees to fill all safe, valid prescriptions even where the pharmacist has personal, nonmedical objections to doing so, or by allowing pharmacists to refuse to dispense only where another pharmacist on duty can fill the prescription with no interruption in client service.

¹⁴³ E-mail from Jennifer Hansen, Target, to the author, (Oct. 2005) (on file with author); Vivian, *supra* note 96 (describing Walgreen's "Referral Pharmacist Policy," which applies nationwide with the exception of Illinois, where it conflicts with 68 ILL. ADMIN. CODE 1330.91(j)).

¹⁴⁴ *See generally* Am. Jur. 2d § 378.

¹⁴⁵ Am. Jur. 2d § 380.

¹⁴⁶ RESTATEMENT (SECOND) OF TORTS § 909 (1979).

¹⁴⁷ Id.

III. Conclusion

Individuals are confronted every day with ethical choices, from how they make their money to how they spend their time to the countless other decisions that fill the spaces in between work and leisure. Workplaces are hardly immune from ethical pressures. Few would dispute that to a pharmacist who genuinely believes EC may act as a form of abortion, and for whom abortion is something approaching murder, the issue of how to handle requests for EC must have very high stakes, and may be a very difficult decision. But the pharmacist does not act in a vacuum; his or her personal beliefs are not the only relevant question. By the nature of their profession, pharmacists have a unique role in the delivery of health care. They have a monopoly on the distribution of prescription drugs and even control access to some nonprescription drugs, including EC. Without the assent of a pharmacist, a client may be unable to access safe medical treatments, even where a doctor with direct knowledge of the patient's condition and medical history has determined what course of treatment is most advisable. Case law strongly supports the existence of the pharmacist's legal duty to dispense all safe, validly prescribed or legally available drugs requested by a pharmacy client. Though this duty may be limited in some states by refusal clauses, the refusal clauses enacted by most states do not protect a pharmacist's refusal to dispense EC. In most states, therefore, a refusal to dispense EC exposes both the refusing pharmacist and the employing pharmacy to tort liability.

Some pharmacists will no doubt continue refusing to dispense EC in spite of the illegality of their actions. Others will lobby their state governments to pass more expansive refusal clauses that would clearly protect pharmacists' ethically or morally motivated refusals. Still others may rethink their decision to refuse to dispense EC altogether in light of the legal risks that such a refusal entails. Any of these outcomes is preferable to the status quo, in which pharmacists are

being misled by their professional organizations and by lobbyists who intimate or openly counsel that a pharmacist's right to refuse is undisputed. This inaccurate counsel may be leading pharmacists to engage in what amounts to civil disobedience without an awareness of the legal risk to which they are exposing themselves and their employers.

It is the nature of any duty analysis to focus on the potentially liable actor. But at the risk of sounding circular, I end this article the way it began: by redirecting our focus on the women who step up to the pharmacy window, sliding their prescriptions across the counter or staring down a hostile employee on the other side as they say, "I'm here for Plan B." Medicine, after all, is a patient-centered profession, and pharmacists are medical professionals. For a woman who is refused access to EC even though she has every right to that drug, that statement probably seems like an empty platitude. Pharmacist refusals are conclusive, disempowering; there may be no effective, immediate recourse. They moot a woman's legally undisputed right of access to this effective, safe drug. Though the option of after-the-fact tort litigation may be small comfort indeed to a woman who was refused EC, it is one step toward correcting the current balance of power in which the personal beliefs of the pharmacist can always outweigh those of the pharmacist's client.