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### Dispensing with Liberty: Conscientious Refusal and the "Morning-After Pill"

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## **Dispensing with Liberty: Conscientious Refusal and the “Morning-After Pill”**

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*Citing grounds of conscience, pharmacists are increasingly refusing to fill prescriptions for emergency contraception, or the “morning-after pill.” Whether correctly or not, these pharmacists believe that emergency contraception either constitutes the destruction of post-conception human life, or poses a significant risk of such destruction. We argue that the liberty of conscientious refusal grounds a strong moral claim, one that cannot be defeated solely by consideration of the interests of those seeking medication. We examine, and find lacking, five arguments for requiring pharmacists to fill prescriptions. However, we argue that in their professional context, pharmacists benefit from liberty restrictions on those seeking medication. What would otherwise amount to very strong claims can be defeated if they rest on some prior restriction of the liberty of others. We conclude that the issue of what policy should require pharmacists to do must be settled by way of a theory of second best. Asking “What is second best?” rather than “What is best?” offers a way to navigate the liberty restrictions that may be fixed obstacles to optimality.*

**Keywords:** *conscientious refusal, emergency contraception, liberty, moral equality, pharmacy*

### I. INTRODUCTION

Because emergency contraceptive treatment borders closely on very early abortion, a mini-storm is roiling pharmacological ethics. Although the “morning-after pill” is legally dispensable in all fifty states, some pharmacists

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have refused to make it available to clients, citing grounds of conscience (Cantor & Baum, 2004).<sup>1</sup> Whether correctly or not, they believe that it either constitutes the destruction of post-conception human life or poses a significant risk of such destruction.<sup>2</sup> Although it is likely that most of the pharmacists who have refused to fill prescriptions believe that abortion should not be available on demand, their conscientious refusal need not be predicated on any such general judgment. Rather, they claim a liberty for themselves not to be implicated in a practice they find personally objectionable. The upshot is that women who have had unprotected intercourse may find it difficult or impossible to secure contraceptive relief during the 72 hour window of opportunity for averting pregnancy.<sup>3</sup>

The interests of both conscientiously objecting pharmacists and women unwilling to become pregnant are morally weighty. They are also expressively weighty in the realm of electoral politics and so, unsurprisingly, legislation has been passed at the state level and proposed at the federal level on both sides of the conflict. The power of individual pharmacists to refuse to fill prescriptions is currently protected by state legislation in Mississippi, South Dakota, Georgia and Arkansas (State Policies In Brief, 2005); conversely, an emergency order issued by the Governor of Illinois in April 2005 requires pharmacists in that state to fill prescriptions for contraception “without delay” (Press Release: 2005, April 18).<sup>4</sup> On April 14, 2005 lawmakers in the United States Senate introduced the Access to Legal Pharmaceuticals Act (ALPhA), a bill that purports to protect both the right of individuals to access drugs prescribed to them by a physician and the right of pharmacists to object to certain prescriptions on moral grounds and, consequently, to refuse to fill and dispense prescribed drugs.

Many of the arguments invoked by the contending parties are recycled from the preceding three decades of the abortion wars. For this reason, they may seem stylized, tired. Barring a decisive conclusion to that conflict, this particular skirmish will also remain stalemated. Although the authors do not lack views concerning whether abortion ought to be available by right to women during various stages or circumstances of pregnancy, we bracket them here so as to address the specific issue of pharmacist refusal. Let  $P$  stand for the proposition “prescribing, dispensing, and ingesting emergency contraception are deeply wrong activities.” Irrespective of any determination of the truth/falsity of  $P$ , we ask whether a pharmacist who believes  $P$  is entitled to give effect to that belief by refusing to dispense. Second, we ask whether the law should protect such acts of conscientious refusal or instead restrict them.

We argue that the liberty of conscientious refusal grounds a very strong moral claim. With full acknowledgment of the gravity of women’s interests in not incurring an undesired pregnancy, that interest by itself does not suffice to defeat the pharmacist’s liberty right. We develop that argument in Section II where standard rationales for requiring pharmacists to fill all legal prescriptions

are examined and found lacking. We maintain in Section III that this does not, however, settle the policy issue. Within the prevailing legal context in which the profession is practiced, pharmacists are themselves beneficiaries of a liberty-restricting practice potentially burdensome on those who wish to secure emergency contraception. What would otherwise amount to very strong claims can be defeated if they rest on some prior restriction of the liberty of others. Importantly, that remains true even if the restriction is not wrongful. Overall justifiable policies may in crucial ways disadvantage parties who, therefore, are morally entitled to a form of compensation. Analogies to well-established economic theory are deployed to render this conclusion credible. Finally, Section IV sets out implications for policy.

## II. FIVE ARGUMENTS AGAINST A RIGHT OF CONSCIENTIOUS REFUSAL

Obligations to perform typically have to meet a higher burden of justification than do obligations to desist. That is because, all else equal, a requirement to perform *A* is more restrictive than a requirement to refrain from *A*. The latter leaves open all but one option from the set of available alternatives, while the former forecloses everything other than *A*. Nonetheless, only the most austere libertarianism maintains that the justificatory burden for performances is never met. Among generally acknowledged examples of justified compulsory performances are those that citizens tender one to another reciprocally and universally based on a principle of fairness (e.g., paying one's tax share), that are exacted from some but not all as the consequence of a fair lottery (e.g., mandatory jury duty), or, more controversially, required in response to an emergency (e.g., a draft in time of war). Exigent circumstances as such, however, do not support obligations of performance. The law rarely requires of individuals that they act as "Good Samaritans"<sup>5</sup> and generally distinguishes between inflictions of harm and failures to aid. If, then, pharmacists are to be denied a right of conscientious refusal, the case for compulsion must be compelling.

Standard objections to conscientious refusal conspicuously fail to meet that burden. The following examples are representative.

1. *Pharmacists acting in their professional capacity are not judges, legislators, or ethics review committee members. Their job is knowledgeably and effectively to fill prescriptions. Refusal to do so on non-medical grounds violates a standard of professional accountability.*<sup>6</sup>

Although the professional function of pharmacists is indeed to dispense to their clients, this does not entail an obligation to take on as clients all

comers. Just as physicians or lawyers or accountants enjoy a liberty to decline to transact with those who seek their services, so too do pharmacists. To be sure, because criteria of specialization and shortage of time rarely are factors for the practice of pharmacy, refusal to take on clients is less common here. However, other professionals also turn down potential clients with whom they feel uncomfortable working either for moral or other reasons. It is not inconsistent with professional practice to limit one's clientele. Indeed, just the reverse; one attribute of professionalism is an entitlement to employ one's own judgment concerning which associations to enter. There are exceptions to this principle (see the next rationale), but the essential point is that these are indeed exceptions.

2. *Although it is not incumbent on the population at large to render emergency assistance to those who will otherwise suffer significant harms, the same is not true for those possessing unique professional qualifications. So, for example, in case of medical emergency, physicians may be obliged to provide services.<sup>7</sup> By parity of reasoning, pharmacists may justifiably be held to a requirement of performance when prompt receipt of medication is essential.*

The key term here is "emergency." Unlike someone in cardiac arrest or lying by the side of the road with a spurting artery, effective contraceptive relief is not measured in minutes. Rather, women have up to 72 hours after unprotected intercourse to secure medicine to block pregnancy. In all except isolated rural locations, there are multiple alternative providers of pharmacy services. Just so long as other sources are willing to step in, the case falls under the category of convenience rather than emergency. Moreover, whether averting an unwanted pregnancy can ever count as an emergency is precisely the crux of the parties' dispute.<sup>8</sup> The pharmacist who insists on a right of conscientious refusal maintains that it is the nascent human life that is in dire jeopardy, not the prospective mother. Of course she will demur from this judgment, but it is a stretch to say that this case is as clear-cut as the heart attack/accident victim ones. That the law should decisively take the side of one party is under-supported by the analogy. Note also that failure to receive emergency contraceptive services does not amount to infliction of mandatory motherhood; conception may not have occurred and, whatever the wishes of the pharmacist, subsequent abortion is available if pregnancy does in fact eventuate.

3. *Emergency contraceptive relief is not abortion* (Glaiser, 1997).<sup>9</sup>

In *Roe v. Wade* the Supreme Court refused to take a position on the vexed question of when human life begins. We follow that precedent. Prompt treatment after intercourse with oral medication will interrupt the progression

to full-fledged pregnancy. It is clear that early interruption is not abortion, less clear that late interruption is not (see note 2). This too is a question concerning which reasonable individuals may differ. Someone who is uneasy about crossing the line between morally permissible and morally dubious actions is usually to be praised rather than blamed for displaying risk-aversion. Of course it might be questioned whether the possible destruction of a zygote rises to the level of moral seriousness, let alone significant wrongness, but this is a question that pharmacists and others are entitled to answer in a manner opposed by those who seek emergency contraception—if indeed it is contraception. Besides, in a liberal pluralist society, even eccentric moral stances are afforded considerable protection, not least when they have a religious foundation. Paired beliefs that abortion is morally impermissible and that emergency contraception risks transgression are not so out of bounds as to be overridden by compulsion.

4. *Refusal to provide contraceptive relief is tantamount to the infliction of harm.*<sup>10</sup>

A woman who enters a pharmacy with a legitimate prescription only to be turned away is, minimally, disappointed in her expectations of securing desired relief. She is inconvenienced in pursuing her ends and may experience discomfort at being branded a moral transgressor, this at a time when she is especially vulnerable. Moreover, that vulnerability can be transformed, by refusal, into an unwanted pregnancy. But granting all that, these considerations nonetheless fall short of demonstrating the occurrence of an actionable harm. By refusing to enter into a transaction that the other party desires, one thereby *fails to provide a benefit* but not to *inflict a liability*. If that were not so, then anyone who turns down an offer from a prospective buyer, seller, employer, or suitor is guilty of inflicting a harm on the disappointed party. This would be to expand the notion of harm beyond usability. To be refused a transactional opportunity is to be denied a chance to better one's position from the status quo ante; it is not to be forced below that level. When overtures are refused, one is left in essentially the same position as if the prospective transactor were absent or otherwise unavailable for cooperative endeavors. Some philosophers have argued that failure to render aid is morally on all fours with the infliction of harm (Rachels, 1975). This is a conclusion especially congenial to utilitarianism. However, such a stance runs counter to common morality. That is not to declare it refuted, but it does suggest that it is a shaky basis for a legal mandate.

It might be objected that harm is not occasioned by the simple refusal to transact but by the attitude thereby expressed. It is one thing to decline to do business with someone, quite another to classify her intended action as reprehensible. The judgment implied by rejecting the prescription, continues the objector, amounts to humiliation, and it is within the purview of

social policy to shield individuals, especially those whose circumstances render them particularly vulnerable, from the infliction of distress. Laws prohibiting hate speech or racial discrimination have that purpose; a requirement to fill all legitimate prescriptions would operate similarly.

That, though, is to push the semantic envelope of “harm” a step too far. In a pluralistic society it is common for individuals to differ in their judgments of moral acceptability. If declining to embrace the values of another constituted harm, then all of us would be harming countless others all the time. The feasibility of individuals acting to further their own disparate conceptions of the good presupposes a generalized entitlement not to be involuntarily implicated in the projects and pursuits of others. No one is entitled to the approval of one’s chosen mode of life, let alone assistance, only to noninterference. No doubt there are ways in which declining to fill a prescription would amount to infliction of harm—browbeating, ordering the sinner out of one’s establishment—but simple refusal is not among them.

5. *Declining to fill medically and legally legitimate prescriptions shows disrespect toward women. Because women become pregnant and men do not, refusing them service is impermissibly sexist.*<sup>11</sup>

It is true that burdens of unwanted pregnancy fall disproportionately, if not exclusively, on women, and it is a biological datum that only women can preclude or interrupt pregnancy by ingesting a pill. In that sense, then, women are the primary object of conscientious refusal. But differential impact by itself does not constitute impermissible sexism. Laws against rape also have a disproportionate impact on one sex, but that hardly constitutes an argument against their legitimacy. The intent of conscientious refusal is not disrespect to the woman who is turned down but concern, whether well-aimed or not, for nascent human life. It can be presumed that if it were the woman’s partner who had brought in the prescription instead, he would have been refused for similar reasons. This is not to deny that there exist misogynistic pharmacists, but those who engage in conscientious refusal are not to be summarily enrolled in that unsavory class.

### III. RESTRICTIONS AND COUNTER-RESTRICTIONS

A case is not established by showing that a handful of objections to it are ill-founded. Enumeration, however, can be indicative. There is a pattern to the arguments sketched out above. They are, in the main, predicated on the existence of some disadvantage or other that accrues to women whose prescriptions are not filled. They would be better off if the pharmacist had cooperated with their requests. However, the advantage of one party does not typically provide a satisfactory rationale for compelling compliance by a

dissenting other. That is not a conclusion restricted to the narrow realm of pharmacological ethics but rather one that obtains generally in a liberal order. When individuals confront one another as moral equals, they are not (barring exceptional circumstances) obliged to render more than simple noninterference with the projects of others.

The crux of our argument is that *in the case under examination, moral equality does not obtain*. That is because the pharmacist is in a privileged position vis-à-vis potential clients. For a wide range of drugs, only physicians are legally entitled to prescribe, and only pharmacists to dispense. An individual who wishes to secure one of these is limited in her choices to those designated channels of supply. Her freedom to cooperate with willing others is thereby limited. This may, on balance, not amount to a disadvantage, because offsetting the liberty restriction is protection from unqualified practitioners and one's own uninformed or impulsive predilections. That is to say, in an all-things-considered accounting, the liberty deficit may be outweighed by benefits of paternalism. Nonetheless, qua limitation of choice, restrictive prescription policies do place burdens on those desirous of securing medications.

Clearer still, restrictions serve the interests of pharmacists insofar as they are shielded from competition by those outside the guild. Restrictive licensing boosts their income, because they are not in jeopardy of being undercut by alternative providers who lack the relevant credentials. They enjoy greater employment security because the supply of new pharmacists is constrained by narrowness of the educational pipeline. More speculatively, such regulation confers prestige on those who are confirmed as possessing professional standing. For all these reasons, the regulatory regime that restricts the liberty of their clients serves the interests of pharmacists. That is not, of course, to say that the benefits of the latter are unwarranted. Perhaps they are, perhaps they are not; this is not the occasion to take up that issue. Rather, the salient point is that pharmacist and prospective client do not stand to each other as any two random agents endeavoring to secure their various ends as they make their way through the world. With regard specifically to the liberty to transact in the distribution/procurement of regulated drugs, they do not stand as moral equals. The institutional structure within which pharmacy is practiced has advantaged one party, and that advantage is secured to some extent at the expense of the other. It cannot, therefore, be presumed that the general principle of rejecting coerced cooperation with other persons' endeavors continues to hold.

Specifically, we claim that some limitation of pharmacists' right to choose their clients is justifiable compensation to that clientele for having their own domain of choice limited. Lest we be misunderstood, we note this is not to be understood as compensation extracted from a wrongdoer's ill-gotten gains so as to render the victim whole. It is not, after all, pharmacists who have brought about the legal restrictions on trade in drugs; that is a

determination produced via the ordinary workings of democratic governance.<sup>12</sup> Rather, the compensation is internal to the policy so as to render its distribution of burdens and benefits more acceptable.

An analogy might make this clearer. Businesses are generally at liberty to price their wares as they see fit. Purchasers enjoy a concomitant liberty either to accept the price or take their custom elsewhere. Suppose, however, that there is no elsewhere to take the custom because the vendor is the sole purveyor: e.g., a public utility. Possession of monopoly status may not reflect any antecedent wrongdoing, but it does create a situation in which buyers and seller do not confront each other as economic equals. Therefore, it is customary to “level the playing field” via public regulation of the prices that the company is permitted to charge for its goods. Note that such regulation is common not only for concerns that enjoy a monopoly status in virtue of being the sole licensee allowed to engage in that business but also for natural monopolies. Even more salient for purposes of this essay, these companies are not at liberty to pick and choose with whom they will do business. Possessing the status of common carrier, they are obliged to render their services impartially to all potential customers within the geographical area over which the monopoly holds sway. The CEO of the power company who on moral grounds strongly opposes abortion may not give effect to that stance by withholding electricity from the Planned Parenthood clinic. The owner of a local plumbing supply company labors under no such constraint with regard to whom he chooses to sell his faucets.<sup>13</sup>

Pharmacy is not a monopoly; it is more the nature of a cartel or guild. Drug dispensers do compete with each other on price, service, and amenities. They are, however, shielded from competition by non-pharmacists. This suggests that the degree of restriction imposed on monopolies would be excessive if applied to a professional guild, but complete absence of restriction might err in the opposite direction. For example, that will be the case if pharmacies cozily conspire within the guild to set prices. Here, familiar anti-trust interventions would be appropriate. But regulation is also indicated if pharmacists’ withholding of services will impose significant hardships on people who have nowhere else to turn.

Suppose for the sake of argument that the moral optimum is an order in which all parties enjoy full liberty subject only to the requirement of non-interference with the similar liberty of others.<sup>14</sup> Suppose further that this optimum is disturbed by the intrusion of one liberty restriction. It does not follow that a second liberty restriction necessarily takes us yet further from the optimum. It may instead partially repair that breach. Punishing a wrong by inflicting on the wrongdoer a harm that would otherwise be impermissible is a familiar instance of this principle. Within philosophy, this is a one-off example, but there exists in economics a highly developed literature on what is called the *Theory of Second Best*.<sup>15</sup> Put crudely, that theory takes

upon itself investigation of the conditions under which distortions from optimality are best countered by removing one of the distortions, leaving things as they are, or supplementing them with a countervailing distortion. Trade, let us say, is most efficient when unencumbered by tariffs. Suppose that one product carries a tariff and, for whatever reason, removal is not feasible. It may be the case that one approaches rather than recedes further from the efficiency frontier by imposing further tariffs. It would be overkill to attempt here to sketch out the conditions under which that will be so. (Roughly, it will be when the initial burden is "balanced out" by others.) The point is that assessment of policies in isolation is misleading when there exist externalities such that costs and benefits are not additive.

"Two wrongs do not make a right" is Mother's dictum, and far be it from us to question her wisdom. Two wrongs, though, may amount to less total badness than one wrong.<sup>16</sup> For some reason, philosophers tend to be uninterested in exploring the ramifications of that proposition. Rather, they are prone to restrict themselves to what Rawls calls "strict compliance theory" (Rawls, 1971, p. 8). From Plato's *Republic* to the present, they prefer to ask "What is best?" rather than "What is marginally less defective than other feasible alternatives?" Utopia is a perpetual lure; construing ethics as the realm of developing and displaying virtue rather than moderation of vices is all but ubiquitous.<sup>17</sup> One cost of this tendency can be to render practical philosophy impractical. The world's imperfections are recalcitrant. They can be massaged via well-considered policy but not removed in one fell swoop. Thus the pursuit of strict compliance theory may have few implications concerning the application of philosophical theory to things as they are. Conversely, a philosophical theory of the morally second best will have wide scope when obstacles to optimality are fixed points around which we are obliged to navigate as best we can.

Consider the following possible world: unlike in ours, filling prescriptions is not restricted to pharmacists. Rather there also exists a profession of *pill-pushing*. Pill-pushers are not trained in pharmacological science. Rather, they operate algorithmically. When presented with a prescription, they match its words with those on the labels of jars in their dispensary. They then count out the requisite number of pills, look up the total cost, and complete the transaction. Pill-pushers could all be human beings, but there is no reason why they could not be medium-intelligent vending machines.<sup>18</sup> Consumers who value expertise and information will tend to patronize pharmacists; those who are more confident in their own judgments will more often shop from pill-pushers. In this world, the case for requiring pharmacists—or, for that matter, pill-pushers—to fill all legitimate prescriptions is weak. Buyers and sellers enjoy equal full liberty, and so there is no basis for compensating one intrusion on liberty with an opposed restriction. But that is not our world. Rather, we operate within the realm of second best in which liberty is permissibly restricted for the sake of liberty.

Let us attempt to avert a possible confusion by repeating a caution we have offered previously. The critic might claim that we have not demonstrated that limiting fulfillment of prescriptions to licensed pharmacists is defective social policy. The critic is correct. Cartelization may indeed be the recommended policy to protect individuals from harmful dosing. In claiming that it calls for redress under principles of second best, we are not making an all-things-considered assessment of wrongness but rather focusing specifically on the liberty imbalance consequent on restriction. Returning to the economic analogy, a tariff on widgets may represent the best tax for funding public expenditures yet nonetheless create distortions that call for remedy. Similarly, limiting prescription fulfillment to pharmacists may on balance best serve clients' welfare interests yet engender vulnerabilities with regard to people's capacity to secure valued medications. It is only along this dimension of transactional liberty that we are claiming divergence from optimality. That, however, is enough to establish a justificatory foundation for countervailing restriction on the transactional liberty of pharmacists.

#### IV. POLICY CONCLUSIONS

So should pharmacists be required by law to fill all legitimate prescriptions? In a word, no. Although it has been shown that the general presumption against compelling specific performance in the service of some other person's ends does not obtain when there exists a prior liberty imbalance between the parties, it does not follow that every liberty restriction begets a counter-restriction. Not all encroachments tend to correct prior distortions; sometimes they further exacerbate the situation. Specifically, no compensating restriction is called for if the initial constraint imposes no significant burden on the affected party. That will be the case if the restriction is trivial in itself or if it is adequately coped with via low-cost behavioral adjustments. Nor are cures acceptable if they are worse than the disease.

Averting an unwanted pregnancy constitutes a significant welfare interest. Being relieved of the possibility of encountering someone who finds one's decision morally flawed is a benefit, but one of comparatively slight status. While the former is sufficiently weighty to establish a presumptive case for compelling pharmacists' performance, the latter does not. The significant question, then, is whether conscientious refusal seriously impairs women's opportunities to avoid pregnancy. The indicated answer is: it depends. Pharmacists' liberty interest in not being compelled to cooperate, even if only tangentially, with undertakings that they find morally distasteful should not be overridden if potential clients can easily avail themselves of other means for advancing their ends. So, in an urban environment in which drugstores abound and, importantly, in which diversity of moral viewpoints among pharmacists also abounds, it is no great hardship to be

rejected by one pharmacist. Other outlets are eager for one's business, so ordinary economic incentives support voluntary transaction for mutual benefit. But what holds true for Chicago may not obtain in rural areas downstate. There, pharmacies may be few on the ground, and moral viewpoints may be more homogeneous. In such circumstances, being turned away does indeed pose a significant hardship.

Social policy deals in generalities, not fine-tuning responsive to each individual case. So there are limits to the discriminations that can be written into law. Still, to mandate for all pharmacists that they fulfill all legitimate prescriptions brought to them or to provide to all pharmacists a blanket dispensation to engage in conscientious refusal is to paint with too broad a brush. Calls for either sort of legislation reflect prior ideological commitment rather than a sincere attempt to afford a nuanced response to moral disagreement. In many circumstances the interests of both parties are well-served by an economic order of voluntary transaction, but occasionally they are not. When competitive incentives flag, compulsion may be called for. That, though, should not be the only or first alternative considered, because there may be ways to protect interests by widening the field of potential transactors. For example, without going so far as to legitimize the counter-profession of pill-pushing, emergency contraceptive medications could be licensed for over-the-counter sales. Or, if this is deemed to carry too many risks, physicians could be allowed to write and then fill their own prescriptions.<sup>19</sup> That may raise apprehensions about possible conflicts of interest or threaten to obscure the generally useful line between the conjoined but distinct practices of medicine and pharmacy. However, in the world of second best, ideal answers are rarely forthcoming.

Still, we are inclined to believe that a geographically restricted policy of requiring prescription fulfillment may be as good as any way to respond to all the interests at stake. Women will then usually find it relatively easy to acquire desired medication, and only a fraction of pharmacists will be subjected to compulsion. It might be asked: what about the rights of that fraction? Are they to be disregarded because they are few in number and, besides, swimming against the currents of the *Zeitgeist*? Without denying that some pharmacists will be confronted by an unwelcome quandary, we reject the charge that this is to override either their substantial interests or their basic rights. Someone who sets up shop in an area governed by mandatory prescription fulfillment will know in advance that this is a condition of doing business. Those who find that condition unduly onerous will do well to look for work nearer to Manhattan, New York than Manhattan, Kansas. This is far less burdensome than being faced with a dilemma of forfeiting either one's profession or one's conscience. Nor does compulsion impinge on a liberty right because, as has been argued, it is permissible to restrict the choices of someone who stands in a position of moral superiority toward others whose own liberties have been circumscribed.

We conclude with a narrower and a wider moral. The narrow one is that both extreme positions concerning conscientious refusal to fulfill prescriptions for emergency contraception are unsustainable. The wide moral commences from a recognition that professional practice, especially in and around medicine, is rife with restrictions on the liberty of one or several parties. We should, therefore, expect many of the conundrums encountered therein to be situated firmly in the world of second best.

## V. ACKNOWLEDGMENTS

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## NOTES

1. See also Stein (2005) and Jones (2004).

2. The FDA and NIH define pregnancy as the implantation of a fertilized egg (embryo) in the wall of the uterus (endometrium) (45CFR 46.202). One drug that can be taken as an emergency contraceptive, RU486 or mifepristone, operates by blocking the hormone progesterone. Since progesterone is required for a pregnancy to continue, mifepristone can be prescribed to end an early pregnancy, that is, as an abortifacient (Center for Drug Evaluation and Research, U.S. Food and Drug Administration, at [www.fda.gov](http://www.fda.gov)). Mifepristone is effective after implantation of the embryo in the endometrium in 80 percent of women, and any drug acting after implantation "is conventionally regarded as an abortifacient rather than a contraceptive" (Glasier, 1997). However, mifepristone also inhibits ovulation and implantation, and can therefore act as a contraceptive rather than as an abortifacient, and this use of mifepristone as a contraceptive has, according to one author, compounded the confusion that because emergency contraception is taken after rather than before intercourse, it is therefore a form of abortion (Glasier, 1997). Other forms of emergency contraception work only by interrupting processes prior to implantation. These pills either inhibit or disrupt ovulation, interfere with fertilization or with the transport of the embryo to the uterus, or inhibit the implantation of the embryo in the endometrium (Glasier, 1997; National Women's Health Information Center). Since implantation occurs approximately seven days after ovulation, emergency contraception taken within five days following intercourse is not considered to interrupt pregnancy, according to the above definition (Glasier, 1997). However, controversy over when human life begins is also controversy about how to define "pregnancy." Because, for example, the National Right to Life organization regards fertilization as the beginning of life, they will consider prevention of the implantation of embryos to constitute abortion. If, however, an emergency contraceptive pill prevents either ovulation or fertilization, then under no construal is it an abortifacient. When we speak in what follows of "emergency contraception," we do not mean to beg any crucial question having to do with the moral status of the procedure. Readers who find that terminology objectionable are free to read it as "so-called contraception."

3. Although the window in which to take the first pill in a regimen of emergency contraception is 72 hours, it is most effective when taken between 12 and 24 hours following intercourse (Cantor and Baum, 2004).

4. The Governor later filed a permanent rule to protect this emergency action (Press Release, 2005, April 18).

5. Arguments have been made for the existence of a "moral minimum" of samaritanship for all moral agents, and something above the minimum for those, such as physicians, who are specially qualified to respond in critical situations (Clark, 2005, p.79). However, this is a moral, rather than a legal duty. Since there is no common law obligation for physicians to provide emergency treatment when there is no pre-existing duty (it is not required as a condition of employment, for example), there will not be

legal consequences of opting out of providing care, though "the same behavior might establish grounds for professional discipline as a breach of ethical standards" (American Medical Association). Also according to the AMA the "no duty to rescue" doctrine applies "even when the potential 'rescuer' had the ability, equipment, and expertise to render effective medical assistance."

6. The notion of a standard of professional accountability is encoded in the American Pharmacists Association Code of Ethics, for example: "Pharmacists are health professionals who assist individuals in making the best use of medications," "A pharmacist places concern for the well-being of the patient at the center of professional practice," "A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health" (American Pharmacists Association). For an example of this argument see also Cantor and Baum (2004, p. 2009).

7. An argument in favor of the duty of physicians to treat patients in an emergency such as an epidemic or a bioterrorist attack is given by Clark (2005).

8. This suggests that the term *emergency* contraception is misleading, since the 72 hour window in which women can effectively take the required drugs makes the situation *urgent* rather than an emergency. See Cantor and Baum (2005).

9. See also Pentel, et al. (2004), according to which there is a consensus among the World Health Organization, the U.S. Food and Drug Administration, the American College of Obstetricians and Gynecologists, the Association of Reproductive Health Physicians, the American Public Health Association, and the American Medical Association, that emergency contraception is not abortion (Manasse, 2005). Cf. endnote 2 above for a discussion of the difference between contraceptives and abortifacients.

10. Chalmers Clark argues that a failure on the part of a professional to meet certain social expectations may be "tantamount to violations of commission," or, as an author he cites claims, "a sin of omission becomes a sin of commission" (Clark, 2005, p.80). However, since these sins are tied to emergency situations, whether one accepts that a pharmacist's failure to dispense contraception is a sin of commission will depend on whether one accepts that the need for contraception is in fact an emergency.

11. An example of this argument is provided by Representative Debbie Wasserman-Schultz (D- FL), who, in a statement on the introduction of the Access to Legal Pharmaceuticals Act, made the following comment: "Make no mistake about this, the refusal to fill birth control prescriptions targets women and their choice of contraception, not men's . . . I have no doubt that if pharmacists were refusing to sell men condoms that this issue would have already been addressed legislatively." (Press Release, 2005, April 14).

12. It can, though, be argued that by embracing and defending their guild status pharmacists have incurred greater responsibility than that possessed by the representative citizen for the consequences of restrictive policy.

13. That is not because electricity is vital in a way that sink fixtures are not. The cable television monopoly may not pick and choose its customers either.

14. Or, to avoid what appears to be a controversial claim, call this the *libertarian moral optimum*. As will become apparent, nothing hangs on this.

15. The classic text is Lipsey and Lancaster (1956).

16. Following Mother's estimable precedent, we are using "wrong" loosely. In this context it means something more like "*prima facie* wrong" than "all-things-considered wrong."

17. An exception is Lomasky (1999).

18. Online so-called pharmacies may in fact be operating essentially as pill-pushers. Because of time-sensitivity, pushing emergency contraception presents a less promising business model than pushing Viagra or Xanax.

19. This raises concerns about conscientious refusal by physicians. Although we believe that the considerations adduced in this essay apply with equal cogency to that case, working out that conclusion is a project for another day.

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