Tug of Rights: How Excessive Conscience Allowances to Physicians and Pharmacists Tug at a Woman’s Right to an Abortion.

Introduction

The decision to initiate or perpetuate pregnancy is, under U.S. jurisprudence, an almost private affair for a woman. Once the decision to terminate is made however, though that decision may be legally legitimate, and even “a right”, on the most practical level, the woman needs input from external sources to complete the deed. The traditional source of input is the physician, who, by virtue of his\(^1\) medical training is able to carry out the abortion procedure. In this scenario, since it takes two to tango, the physician “participates” in the abortion procedure by his rendering the medical service. In this dance, the relationship is one of physician and patient and the physician is acting out of the professional duty which he owes to his patient.

Developments in medical technologies have opened up a pathway for terminating (or debatably preventing) pregnancies via emergency contraception, which does not involve traditional physician input. If taken in a 72 hour window period after sexual intercourse, the chance of pregnancy is said to have been reduced by almost 80%\(^2\). Emergency conception being a medical drug and pharmacists being in the professional business of dispensing drugs, the issue has arisen whether in carrying out this “duty” of dispensing emergency contraception to a female customer the pharmacist is “participating” in the procurement of a possible abortion.

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\(^1\)Throughout this paper, members of the medical profession are referred to in the masculine for ease of reference.

Consideration of what constitutes “participation” aside, given the deep and probing moral questions that surround the effectuation of an abortion, the law has acknowledged and thereby respected the preference of many physicians or pharmacists not have to participate at all in such a procedure by providing a “way out” or exoneration from what would have otherwise been a duty in the form of a refusal clause, that is, a law which allows them to refuse to provide the medical service or render what would otherwise be their duty based on their religious or moral objection (also called a conscientious objection).

At the point where the “medical participant” responds to his conscience and plays his “get out of duty free” refusal clause “card”, an interesting interplay of rights and duties is apparent. Namely, the pregnant woman’s right to decide to abort, the physician’s duties as regard his female patient to provide medical services, the pharmacist’s duty to dispense medication legitimately requested, and the physician’s and pharmacist’s right to respond to the dictates of their conscience. The interplay results in a necessary intersection of the woman’s and physician’s or pharmacist’s rights with particular potential to compromise the woman’s right, since, once either of the latter two excessively exercises their “right” to act in accordance with the dictates of their conscience, the woman may be left unable to actually effect her choice to abort. I argue in this essay that the exercise of conscience is so personal and subjective that it is easy for an intensely principled and passionate person to go overboard and perceive an act to mean a loss of moral integrity when by reasonable or even religious standards it may not be so. This is especially so in the arena of abortion where opinions are strongly and passionately held.

Ideally, in the tug of war of rights and duties, the rope should be taut with the two entities on either side, that is, the woman and “medical participant” both having equal strength and able to hold their respective grounds within their sphere of rights. In other words, the woman should
be able to hold her own and never experience a compromise of her right to choose by the physician’s or pharmacist’s exercise of their right to object to participating in the termination of a pregnancy.

In this continually competing tug of rights the weaker side is in danger of falling (losing her right to choose), or worse, being pulled to the side of the stronger entity (forced to act according to the conscience of the physician or pharmacist). In this fierce battle, where the woman’s only weight is her constitutional right as granted in *Roe v. Wade*\(^3\) and eroded in *Planned Parenthood v Casey*\(^4\), and the medical participant’s side is largely unchecked and reinforced (and as will be shown below, the trend is movement towards increased reinforcement and removal of limits), the historically weaker and politically unconnected individual, the woman, is in danger of falling- losing her right to choose and, worse yet, being pulled to the other side- subject to the choice or conscience of the medical participant.

In this essay I consider the issues that arise out of this tug of rights and duties. In part one I consider the woman’s right choose to prevent or abort her pregnancy, I look at the legal development and justifications of such a right. In the same part, I consider the duties of the physician or pharmacist as they relate to the pregnant woman in her exercise of choice to abort or terminate her pregnancy. In part two, I consider the legal justifications and historical basis of the right of the members of the medical profession to conscientiously object to assisting with or participating in the act of termination of a pregnancy. I look at the relatively recent trend that has reinforced and broadened the scope of protection granted to conscientious objectors in the medical profession by looking closely at the Mississippi Health Care Rights of Conscience Act

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\(^3\) 410 U.S. 113 (1973)  
\(^4\) 505 U.S. 833 (1992)
(hereinafter called “The Mississippi Act”) as one of the clearest examples of this trend. In part three, I consider conscientious objection as a concept, its proper limits, and argue that these same limits must apply to the exercise of conscientious objection by a member of the medical profession. I demonstrate the potential for abuse of conscientious objection, if left purely to the dictates of the conscience-holder, to illustrate the need for external limits to be set within the very law that grants the right to conscientiously object. I scrutinize the Mississippi model to show its failure at setting necessary limits to the right to conscientiously object.

Part One

The woman’s right to abort

In 1965, the Supreme Court in its landmark decision *Roe v. Wade*, continuing the privacy tradition, established in former cases that recognized the “right of the individual, married or single, [to use medical contraception and] be free from governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child,” found that a woman has a constitutional right to determine whether or not she wishes to terminate her pregnancy before fetal viability. The Court declared unconstitutional the Texas criminal abortion laws (and other like state laws) that made it a crime for a doctor to perform an abortion except for the purpose of saving the life of the mother. In finding also that the woman’s constitutional privacy right may be limited only by a compelling state interest in the health of the mother and

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6 410 U.S. 113 (1973)
7 *Id.*, at 453
8 Founded either as a “liberty” protected against state interference by the substantive component of the Due Process Clause of the Fourteenth Amendment, or the Ninth Amendment reservation of rights to people: *Id.*, at 153
the potential life in her uterus, the court used a trimester framework to organize how the privacy right is balanced against the compelling state interests.9

In the later case of Planned Parenthood of Southeastern Pennsylvania v. Casey10 the Supreme Court maintained the central holding in Roe v. Wade, upholding a woman’s decision to have an abortion before fetal viability because it represents a “choice central to personal dignity and autonomy”, that falls within the “right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life”,11 but rejected the incremental compelling interest approach of the Roe v. Wade Court and found instead that the State has a legitimate interest in the woman’s health and the potential life at the outset of the pregnancy which requires that the woman’s right be protected from state intervention only to the extent that the right is unduly burdened.

Applying this somewhat eroded standard of constitutional protection to the woman’s privacy right, the Court approved the 1989 amendments to the Pennsylvania Abortion Statute which imposed an informed consent requirement, a 24-hour waiting period after certain information relating to the abortion is provided and before the procedure is performed, a parental consent provision and a reporting and recording requirement on the basis that these State requirements did not impose an undue burden on the woman’s right of reproductive autonomy before fetal viability.

How the physician is involved in the right to abort

9 Accordingly, (1) at the stage prior to approximately the end of the first trimester the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician, (2) at the stage subsequent to approximately the end of the first trimester, the state in promoting its compelling interest in the health of the mother may regulate the abortion procedures in ways reasonably related to maternal health and (3) at the stage subsequent to viability, the state in promoting its compelling interest in the potentiality of human life may regulate or proscribe abortion subject to the preservation of the life or health of the mother: Id., at 164-165
10 505 U.S. 833 (1992)
11 Id., at 852
One thing that was made patently clear by both *Wade* and *Casey* was the indispensability of physician participation in abortion. On the most basic level, physician participation is necessary because the woman cannot carry out the procedure on her own. But these cases take it even further. In *Roe v. Wade*, the Supreme Court seemed to place the point of participation beyond mere medical involvement (with the physical procedure) and towards the point of actually facilitating the decision. In the part of his decision where the woman’s right to choose is stated most forcefully\(^{12}\), Justice Blackmun justified the fundamental nature of woman’s right to choose to terminate her pregnancy or not by illustrating a number of medical and social factors that could arise that affect her personhood and future\(^ {13}\). After listing these factors, he states that the woman and her responsible physician should consider them in consultation. Further, in the trimester chronology, at the earliest stage of the pregnancy, where the woman’s right to choose to terminate or not is at its pinnacle, he frames the abortion decision and its effectuation as one to be left “to the medical judgment of the pregnant woman’s attending physician”\(^ {14}\).

In *Casey*, the Court acknowledged the role of the doctor in providing informed consent, but was careful to describe the doctor-patient relationship, when giving informed consent as “derivative of the woman’s position” and “not underlying or overriding her more general right to (1) make family decisions and (2) physical autonomy. So we see in these seminal cases the role of the physician as firstly, a *facilitator* to enabling a woman’s autonomous choice about whether or not she wishes to have an abortion and secondly, as the expert who can carry out the medical procedure.

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\(^{12}\) 410 U.S. at 153

\(^{13}\) The purely medical factors that the court listed were (i) specific and direct physical harm to the mother and (ii) that mental and physical health of the mother that can be taxed by child care. But the court also listed social factors like (i) that maternal or additional offspring may force upon the woman a distressful life and future (ii) the distress associated with an unwanted child, (iv) the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it and (v) the continuing stigma of unwed motherhood. *Id.*

\(^{14}\) *Id.*, at 164
These two cases provide a framework for discussing the duty which a physician owes a pregnant woman. In the U.S., access to health care (in this case reproductive services) is not a “right”. Absent a consensual relationship there is no legal duty on a physician to render treatment, however, assuming that a physician-patient relationship exists, absent a refusal clause, a physician cannot refuse to treat and provide information to his pregnant female patient who may want to pursue an abortion without exposure of liability for negligence, medical malpractice, breach of contract or breach of fiduciary duty.

**How pharmacists are involved in the issue of abortion- Emergency Contraception (The Morning after Pill)**

The physician that performs the abortion has a clear physical, participatory role in the procedure. Scientific breakthrough that has resulted in the invention and ease of accessibility of emergency contraception (commonly known as the morning after pill) has raised an issue on the extent to which it can now be said that pharmacists can be participants in the abortion act.

In 2006 the FDA approved non-prescription access to the morning after pill making it available over the counter for persons over 18. Therefore, persons under 18 must provide a prescription and persons over 18 must prove their age before they can obtain the drug. The effect

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15 For example, the Supreme Court has held that public hospitals are not required to perform abortions, nor are governmental health insurance programs obligated to cover abortions: *Poelker v. Doe*, 432 U.S. 519 (1977); *Harris v. Mc Rae*, 448 U.S. 297 (1980); *Webster v. Reprod. Health Services*, 492 U.S. 490 (1989)

16 And certain statutory requirements, in particular, the Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C.A. § 1395dd, which requires hospitals that participate in the Medicare program to screen and stabilize persons who enter their emergency department in the case of an emergency, and federal laws which prohibit discrimination based on race, religion, age, gender or disability

17 See Restatement (Second) of Torts §314 (1965); *Childers v. Frye*, 201 N.C. 42, 158 S.E. 744 (1931)

18 FDA OK’s non-prescription “morning-after” pill, msnbc, Thursday, August 24, 2006

http://www.msnbc.msn.com/id/14497678/
is that both categories of persons must have a face-to-face encounter with a pharmacist before the pharmacist can (or will) dispense the medication\(^\text{19}\).

The morning after pill contains higher doses of the active ingredients used in birth control pills. The common birth control pill is comprised of a combination of hormones that work in four possible ways: (1) suppressing ovulation; (2) inhibiting fertilization; (3) reducing the possibility of fertilization and (4) inhibiting implantation\(^\text{20}\). The mystery of the common birth control pill is that no one can tell which of the four ways actually work to inhibit a pregnancy in a given menstrual cycle\(^\text{21}\). The morning after pill, though more potent than common birth control, works just like the ordinary birth control pill with the same uncertainty of the mechanism of action\(^\text{22}\). That is, it is unclear whether it acts to inhibit the fertilization of the female egg with sperm or prevent the implantation of the fertilized egg.

Though it has not been proven with absolute certainty, the best scientific evidence to date is that the morning after pill does not work if the fertilized egg is already implanted\(^\text{23}\). This is relevant when considering the question – When does life begin? If one believes that pregnancy starts from when the egg is fertilized, then the morning after pill can potentially be an abortifacient. But, if one instead believes that pregnancy starts only after the fertilized egg has

\[^{19}\text{BARRY R. FURROW, THOMAS L, GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST, ROBERT L. SCHWARTZ, HEALTH LAW, CASES, MATERIALS AND PROBLEMS, 6TH ED., at 1206 (2008)}\]
\[^{21}\text{Pruthi, supra note 1}\]
\[^{22}\text{Id.}\]
been implanted (which is the standard medical definition), then the morning after pill can never induce abortion and at most, only prevents the initiation of a pregnancy.

Many pharmacists agree with the official position of the Roman Catholic Church which is that life begins at conception, that is, at the moment of fertilization and sincerely believe that in dispensing the morning after pill they are participating in or enabling an abortion. When compared to the magnitude of physician involvement in the abortion decision making process and procedure, some may validly feel that a pharmacist’s argument that by merely dispensing a questionable “abortifacient” (pursuant to a request that is legitimated by age or a prescription) they are “participating” in abortion is attenuated and even ludicrous. However, in true “free market place of ideas” style the pharmacist’s moral and ethical objection to dispensing the morning after pill have been acknowledged and respected in U.S. jurisprudence and by various medical associations.

24 Noted by the Court in *Karlin v. Foust*, 975 F. Supp. 1177, 1228 (W.D. Wis. 1997), aff’d in part, rev’d in part, 188 F. 3d 446 (7th Cir. 1999)
26 Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 Fla St. U. L. Rev. 779, at 806 (2007) (makes potent arguments why pharmacists cannot be said to hold the same role as physicians on the issue of dispensing medication that may have the effect of terminating a pregnancy, namely (1) though pharmacists, like physicians are licensed individuals that owe a duty to their patients, their primary responsibility lies in their professional judgment to ensure that the prescription presented by the patient is properly filled and the medication order is not unlawful, erroneous, unauthorized or unsafe, (2) they do not examine or diagnose the patient or discuss the indications for medication with the patient, (3) in most states, they do not, unlike the physician have a duty to warn the patient of a medication’s side effects and (4) they generally lack the information necessary to assess the reasons why a drug has been prescribed to a patient, e.g. many women take contraceptives for medical conditions unrelated to the prevention of pregnancy).
27 *Menges v. Blagojevich* 451 F. Supp. 2d 992 (2006), *Vandersand v. Wal-Mart Stores Inc* 525 F.Supp. 2d 1052 (2007) (Both cases dealt with an Illinois State promulgation which required pharmacists to dispense emergency contraception despite their moral take on the matter. Both cases held that the pharmacists stated a claim that the state regulation violated Title VII duty that an employer accommodate an employee’s religious belief and that the pharmacist employees were within the scope of protection of the Illinois Right of Conscience Act which allowed a medical professional to refuse to render a scope of services which they believed was religiously or morally wrong)
28 E.g. the American Pharmacists’ Association (APhA) (finding pharmacists should not have to engage in activity to which they object) See British Medical Journal (BMI), *American Medical Association fights pharmacists who won’t dispense contraceptives*, July 2, 2005, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC558568/
Part Two

Conscientious objection

The right to conscientiously object in a health related context is intimately connected to duty. The “right” as it operates, is an exoneration granted to physician or pharmacists, on their assertion of religious or moral grounds, from exercising what would otherwise be their duty. The basis of such a protection has been acknowledged in normative terms as a moral right intrinsic to the basic well-being of humans, which mandates that they be allowed to act in accordance with their conscience, “inner voice” or conviction of what is right or wrong or otherwise suffer the unbearable results of guilt, remorse and shame.

The right of the individual to act according to their conscience is also founded on human rights law and is inserted in leading international human rights covenants. Therefore, for example, the Universal Declaration of Human Rights 1948, Article 18(1) provides that “Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to manifest his religion or belief in teaching, practice, worship and observance.” International conventions however, also limits rights in so far as necessary to “protect public safety, order, health or moral, or the fundamental rights and freedoms of others.” Though ratified by the U.S., these conventions are not yet legally binding because they have never been

(quoting the APhA), American College of Clinical Pharmacy (though it recognizes the right of the pharmacist to decline on moral grounds to provide medications for services such as abortion or contraception, they also recognize the ethical responsibility on the pharmacist to refer patients to another pharmacist so that patients can have access to medications in an “effective, professional, timely, confidential and nonjudgmental manner”: See Harrington supra note 25, at 807


30 Pellegrino, supra note 28, at 226-227

31 The UN International Covenant on Civil and Political Rights, Article 18(3)
actually adopted into U.S. domestic law\textsuperscript{32}. However, they are useful precedents in showing the appropriateness of limiting a right of conscience to protect the freedoms of others.

The Intimate Link between Conscientious Objection To Abortion and Religion

In the early years after \textit{Roe v. Wade} and the ensuing abortion debate, many advocates of conscientious objection argued that such a right was protected as a fundamental right against discrimination by the State under the First Amendment which protects the free exercise of religion\textsuperscript{33}. Though conscientious objections to abortion that are based on purely moral as opposed to specifically religious beliefs are equally protected by state legislation\textsuperscript{34}, the fact that early advocates for same hinged its legal justification on the Free Exercise Clause, which is viewed as protecting beliefs “only rooted in religion”\textsuperscript{35} and not a “purely rational, philosophical ethical system regardless of how moral or central to a person’s life”\textsuperscript{36}, illustrates a truth that in protecting the right to object to participation in abortion, what was originally recognized as deserving protection was the right to act according to the urgings of an external Supreme Being. That is, religion, in its most potent and original sense.

The Constitutional Landscape of Protection of Conscientious Objection


\textsuperscript{34} See page 14 below

\textsuperscript{35} Thomas \textit{v. Review Bd. Of Ind. Employment Sec. Div} 450 U.S. 707, 713 (1981) ; \textit{Stanley Ingber, Religion or Ideology: A Needed Clarification of the Religion Clauses}, 41 Stan L. Rev. 233, 277 (1989) (noting that the framers of the Constitution recognized the difference between religion and conscience and chose not to include a right of conscience in the First Amendment)

The issue of whether what is protected at its foundation is a religious or moral belief aside for a moment, it is useful to consider, in discussing the legitimacy of conscientious objection, the protection, if any, that the Constitution affords to same. A review of Supreme Court interpretation of the level of protection afforded to the exercise of religion has considerably lessened, if not annihilated the arguments of early conscientious objection advocates that the right is protected under the Free Exercise Clause. The watershed case of Employment Div. Dept. of Human Resources of Ore v. Smith\(^\text{37}\) overturned previous approaches of the Supreme Court that vigorously protected religious practices by subjecting any state imposition upon such practice to strict scrutiny.\(^\text{38}\) In so overturning, the Court in Smith substantially curtailed the use of the First Amendment as a protection of religious practice or exercise of conscience.

*Smith* involved an action by members of the Native American Church who ingested peyote for purposes related to their religion and were as a result denied unemployment benefits on the grounds that an Oregon Statute made use of the drug criminal. Despite the legitimate religious purpose connected to the use, the Court held that the denial of benefits did not violate the Free Exercise Clause. Instead of applying the traditional compelling interest test of strict judicial scrutiny, the Court proposed a new, lower standard of protection for freedom of religion. Justice Scalia’s opinion for the Court reasoned that so long as government regulations or statutes are “laws of general applicability” which do not discriminate against any specific religion or

\(^{37}\) 494 U.S. 872 (1990)

\(^{38}\) E.g. in earlier jurisprudence like *Sherbert v. Verner* 374 U.S. 398 (1963) any prohibition that substantially burdened a religious practice, whether facially neutral or not was only justified if the state action was in furtherance of a compelling state interest
against religions generally, the laws will be sustained if rationally related to legitimate governmental interests, despite any incidental burden they may have on religious freedom.\textsuperscript{39}

The Supreme Court’s choice in \textit{Smith} to interpret the Free Exercise Clause in a manner that constricts the level of protection afforded to religion is a movement in stark departure from its previous position in affording religious belief and exercise the highest protective shield available under the Constitution. This choice is representative of the gradual shift in U.S. society from a notion of viewing religious values and insights as directed by an external “Supreme Being” as central and pivotal to law and culture, towards a view that traditional religion is no more important and deserving of protection than internally derived notions of conscience that are secular and absent any consideration of the requirements of a Supreme God\textsuperscript{40}. Therefore the notion of religious dominance being afforded special protection has been rejected and the thing protected by the Free Exercise Clause is more and more being understood as a “religiously neutral, autonomy-driven understanding of conscience”\textsuperscript{41}. This shift is apparent in Supreme Court jurisprudence on the Establishment Clause, which, though described as “confused” and “murky”\textsuperscript{42} draws out the basic principle that government is prevented from favoring one religion over another or “privileging religion over non-religion”\textsuperscript{43}.

This is important because it demonstrates that under current jurisprudence and cultural norms, the zone of conscience and belief that is internally driven and informs a woman’s decision to have an abortion should be afforded the same level of protection, deference and

\textsuperscript{39} \textit{Smith}, 494 U.S. at 888  
\textsuperscript{40} Further discussion and historical legal authorities are considered in Daniel O. Conkle, \textit{The Path of American Religious Liberty: From the Original Theology to Formal Neutrality and an Uncertain Future}, 75, Ind. L.J. 1 (2000)  
\textsuperscript{41} Conkle  \textit{supra} note 35, at 84-85  
\textsuperscript{43} Weiss, Borgmann, Kenny, Sternberg and Crosby, \textit{Religious Refusals and Reproductive Rights}, ACLU Reproductive Freedom Project, available at \texttt{http://www.aclu.org/FilesPDFs/ACF911.pdf}
respect as the zone of conscience that is (historically) externally driven and informs a physician’s objection to providing or performing abortion services. This acknowledgement brings perspective in visualizing the tug of war of rights. It reinforces the woman’s right to choose as a choice not at all morally inferior to an anti-abortion stance and shows the undesirability of the woman being “converted” from her position.

Given the Supreme Court’s retreat from protecting religion under the constitution, States may decline to recognize religious exemptions from generally applicable and neutral laws that further the public good. Therefore, in several cases subsequent to Smith, the Supreme Court refused to declare unconstitutional a number of governmental health policies that burden religious beliefs. Further in Smith itself the Supreme Court was clear to say that a refusal clause is “permitted” or “even desirable”, “just not constitutionally required”, rather it is a right to be given negative protection and the contours of its accommodation is to be determined by the political process.

Refusal Clauses

Congress has taken on the baton handed to it by the Supreme Court in Smith and in 1973, shortly after the decision in Roe v. Wade, in a move to protect doctors who did not wish to perform abortions, passed the “Church Amendment”, a refusal clause named after its sponsor Senator Frank Church, which protects individuals and entities receiving federal funds from being forced to provide or perform abortion services if the provision or performance of such a procedure would be contrary to their “religious beliefs or moral convictions”. The law also

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44 E.g. Catholic Charities of Sacramento Inc. v. Superior Catholic Charities Inc. v Superior Court, 85 P.3d 67, 84-89 (Cal. 2004)( where the court held that a law requiring Catholic Charities Court to include coverage for contraceptives did not violate the First Amendment)
45 Smith, 494 U.S. at 890
46 Pub. L. No. 93-45, §401 (a)-(c) (codified as amended at 42 U.S.C. §300a-7(b) (2000)).
forbids entities receiving federal funds from discriminating against health care employees based on their religious or moral convictions regarding these procedures.

States have forcefully followed Congress’ lead. By 1978 more than forty states enacted such refusal clauses and to-date forty-six states allow health care providers to refuse to provide abortion services on the basis of conscientious objection\textsuperscript{47}. For a couple of decades after the initial spate of legislation the issue of conscientious objection in an abortion context remained relatively dormant\textsuperscript{48}. A proliferation of developments in health in the U.S.\textsuperscript{49} which started in the mid-1990’s however, has brought new players and powers into the reproductive health care game and has heightened the tensions in the debate as advocates of refusal clauses have been able to throw their political weight to encourage the promulgation of state laws that reinforce and broaden the reach and scope of the right to conscientiously object.

An explicit example of this trend is The Mississippi Act which permits virtually every worker in the health care field (explicitly including pharmacists)\textsuperscript{50} to object to participating in any service even remotely connected to abortion including patient referral or counseling or advice\textsuperscript{51}. Participate is defined broadly as to “counsel, advise, provide, perform, assist in, refer

\textsuperscript{47} All of these 49 states permit individual health care providers to refuse to provide abortion services. 43 states allow health care institutions to refuse to provide abortion services, 14 limit the exemption to private health care institutions and 1 state allows only religious health care entities to refuse to provide such care: Guttmacher Institute, State Policies in Brief. Refusing to Provide Health Services as (March 1, 2010) http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf
\textsuperscript{48} Weiss et al., supra note 42
\textsuperscript{49} Id., (describing the various factors leading to a burst of activity in refusal clauses, including the Clinton movement for universal health care, the rise in mergers of religiously-affiliated and secular hospitals, the managed care revolution and the introduction of emergency contraception and the abortion pill RU-486)
\textsuperscript{50} Miss. Code Ann. §41-107-3(b) (defining health care provider as any individual who may be asked to participate in any way in a health care service including but not limited to the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions)
\textsuperscript{51} Miss. Code Ann§41-107-3(a) (which defines health care services that health care workers can object to providing very broadly, as including, but not limited to: a physician, physician’s assistant, nurse, nurses’ aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher,
for, admit for the purposes of providing, or participate in providing, any health care service or any form of such service”52. Further, there is no exception for emergency situations and no requirement that the public is notified that a health care provider would likely object to providing services related to the termination of pregnancy.

**Part Three**

**The Proper Limits of Conscientious Objection**

As demonstrated above, the right to conscientiously object to participating in abortion is a personal exoneration from duty. Though morally wrong to the sincere objector, within the limits set by the Supreme Court, the law recognizes abortion as a legitimate option which may be exercised by an autonomous woman. The limit of conscientious objection is therefore clear. It is not an invitation for physicians or pharmacists to become uninvited proselytes, imposing an anti-abortion belief on the women who may rely on their expertise. Rather, it is only a narrow space for these health care professionals to avoid partaking in an act that is morally repulsive to them. They must be careful however not to stop the act by imposing their belief on the woman.

The law has recognized this limit of conscientious objection by disallowing health care institutions from imposing their beliefs on others. An excellent example of this is the case of *Catholic Charities of Sacramento Inc. v. Superior Court*53. There the Supreme Court of California affirmed the validity of the California state law, the Women’s Contraception Equity Act (WCEA) which required employers, except for a narrow exception of religious employers, to include contraceptive coverage in their health plans for employees. The appellant, Catholic

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52 Miss. Code Ann.§41-107-3(f)
53 85 P.3d 67 (Cal. 2004)
Charities, though not meeting the stringent definition of “religious employers”, believed that prescription contraceptives are sinful and argued that they should be allowed, pursuant to its sincerely and deeply held religious belief to not “facilitate financially the sin of contraception by employees who use the prescription drug benefit to obtain contraception”. The court refused to provide the exemption on grounds including that it would have meant imposing the employers’ religious beliefs on employees who did not share those beliefs.\(^{54}\)

The Court in *St Agnes Hospital of the City of Baltimore Inc. v Riddick*\(^{55}\) shows a similar approach by the District Court of Maryland. The plaintiff Catholic Hospital brought a claim that the denial of accreditation by the state accreditation board on the basis of its refusal to provide to allow its medical residents to obtain clinical training in contraception, sterilization or abortion procedures amounted to religious discrimination. In denying the claim, the Court declared a compelling state interest in ensuring that physicians receive comprehensive medical training and stressed the importance of the hospital not being allowed to “impose its Catholic philosophy on its residents, many of whom are not Catholic”.\(^{56}\)

Abortion is a topic that triggers passionate emotion and where there is passion there is danger of excesses. The case *Wilson v U.S. West Communications*\(^{57}\) demonstrates this. There, a tenacious and slightly fanatical Roman Catholic woman made a religious vow that she would wear an anti-abortion button\(^{58}\) until there was an end to abortion or until she could no longer fight the fight. She insisted on wearing the button continually, even though many of her co-employees were very offended and disturbed by it, because she believed that if she took off the

\(^{54}\) *Id.*, at 542
\(^{55}\) 748 F. Supp. 319 (1990)
\(^{56}\) *Id.*, at 330
\(^{57}\) 58 F. 3d 1337 (8th Cir. 1995)
\(^{58}\) The button was two inches in diameter and showed a color photograph of an eighteen to twenty-week old fetus. *Id.*, at 1339
button she would compromise her vow to be a living witness. It was found on cross-examination and scrutiny of the evidence that her religious beliefs and vow did not in fact require her to be a living witness\textsuperscript{59}. She added this requirement to justify her position before the employer when she was asked to cover the offensive pin. She used religion as a tool to justify what was really fanatical and excessive behavior.

Given the subjective and personal nature of conscientious objection, it is conceivable that a physician or pharmacist could become fanatical in their exercise of conscience. Further, there exists the possibility that health care workers may not know their own belief system well enough to recognize where compromise is possible without loss of moral integrity and where it is not\textsuperscript{60}.

The seclusion of the interaction within which a medical professional exercises an act of conscientious objection generally allows his decisions to go unchecked and un-monitored. This largely unrestrained freedom, coupled with the likelihood of excess, mandates at the very least that States should, in drafting refusal clauses, be careful not to facilitate an overly passionate objector, by expressly allowing acts that go beyond the narrow bounds of objection. Without clear boundaries, an overly zealous physician or pharmacist would be allowed to impose their anti-beliefs on a woman seeking an abortion or dispensation of emergency contraception. It is highly arguable that The Mississippi Act does just this in allowing health care workers to refuse to counsel, advise or refer a woman who relies on them for their services relating to abortion/terminating/preventing her pregnancy and not mandating notice requirements.

\textsuperscript{59} Id., at 1341
\textsuperscript{60} Pellegrino \textit{supra} note 28, at 243(cites this possibility and urges Catholic physicians to know the content of their own faith so that they don’t impose hardship on the patient where alternative routes are morally permissible)
Errors of the Mississippi Act- Allowing unrestrained refusals to counsel advise or refer; No notice requirements

As regards a physician, the most obvious way that he could impose his belief on the woman is in consultation. Endowed with medical knowledge and unaffected by the emotions or consequences related to being in a pregnant state, the physician, in this private, unrecorded session, stands in a position of considerable power over the pregnant woman who may be overwhelmed, conflicted and confused about which step she wishes to take. As shown above, the physician may be involved in the decision to abort, but his involvement should be limited to facilitating the woman’s decision. One important way of doing this is providing his patient with all information necessary to enable her to make an autonomous decision. Any omission of information which he thinks may encourage an abortion or of options available to the woman other than going through with the pregnancy could be a subtle persuasion to pursue the course of action that suits the physician’s conscience. By allowing physicians to refuse to counsel or advise patients on abortion, The Mississippi Act reinforces physician power to impose his belief on a woman and goes beyond the proper limits of what a refusal clause should allow, since, merely providing information does not correlate with participation in the “act” of abortion. This part of The Mississippi Act is both unnecessary and dangerous; Unnecessary because it furthers no right of conscience and dangerous because it potentially overrides the woman’s morally equal and valid claim to self-determination.

Similarly, an imposition of beliefs could occur in the pharmacist-customer relationship if the pharmacist, in addition to refusing to dispense requested emergency contraception, also

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61 This is the basis of informed consent: that is, a legal and ethical duty on a physician to disclose the risks and benefits of treatment and alternatives to treatment: *Canterbury v. Spence*, 464 F. 2d 772, 782 (D.C. Cir. 1972)
62 E.g. information on the likelihood of a future child being born with a birth defect or other anomaly which may be disclosed in prenatal tests: See Harrington *supra* note 25, at 813-814
refuses to refer or transfer the customer to another pharmacist or pharmacy which has no moral objection to serving her\textsuperscript{63} based on the rationale that the act of referral “makes him morally complicit in association with an evil”\textsuperscript{64}. Especially in light of the brief window period within which emergency contraception could work, it is not impossible to conceive that refusal to refer may in some cases deny a woman the option of using the medication, thus imposing the pharmacist’s belief on the woman. Surely to refer a woman to another pharmacist that has no conflict in dispensing the pill, in the case of what may well be an emergency is not a morally impermissible compromise to the most vociferous of conscientious objectors.

Further, there may be situations of extreme emergency where even transfer of care would deprive a woman of the chance to take emergency contraception within the window period. This is especially the case in a rural state with high levels of poverty like Mississippi\textsuperscript{65}, since women without the financial means may not have the option of travelling the inevitable long distances to see another pharmacist. In such a case, the woman’s condition may not permit transfer and referral to another pharmacist could well be tantamount to denying the service. It behooves the pharmacist to ensure that methods are put into place to guarantee that feasible alternatives are available to the woman in the event that such circumstances arise. The Mississippi Act does not even contemplate this state of affairs and simply grants a broad right to refuse referrals. It is clear 

\textsuperscript{63} An extreme example of such behavior by a pharmacist can be seen in the widely publicized Noesen Case. Cited at Harrington \emph{supra} note 25, at fn 182 (In re Noeson, No. LS0310091PHM (State of Wis. Pharmacy Examining Bd. Apr, 13, 2005) where Noeson refused to refill Amanda Renz’s prescription for an oral contraceptive because of his religious objection, refused to tell her where else she could get her prescription filled because he did not want to help her obtain contraceptives and refused to provide information necessary to transfer the prescription to another pharmacist who was willing to dispense the drug

\textsuperscript{64} Harrington \emph{supra} note 25, at 822

\textsuperscript{65} Holly Teliska, \textit{Obstacles To Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women}, Berkley J. of Gender L. & Just. 229, at 244 (2005) (pointing out the high level of poverty in Mississippi- 21 percent of women aged 15-44 have incomes under the federal poverty level. Further, Mississippi is a very rural state with 60.6 persons per square mile as compared with the U.S. average of 79.6 persons per square mile)
that such a position unnecessarily reinforces a right to object and oversteps the proper limits of what a refusal clause should allow.

Another way that The Mississippi Act fails to properly limit the right of refusal is by not requiring health care providers to make their positions publicly known so that women can know in advance what sort of reception they would receive from certain persons and plan accordingly. The Mississippi Act should place more regard on the woman’s right by at least requiring individual physicians to prepare publicly available leaflets outlining the services that they can and cannot do, and pharmacies to post public notice that a particular pharmacist does not fill specific prescriptions along with his working schedule.

**Conclusion**

Players in the health field should play fairly. The strengths on opposite sides of the tug of war of rights as it relates to abortion should be equally distributed between the woman and the medical profession. If anything, since the members of the medical profession must couple their right with duties and the woman has only her rights to concern her, if any side should be strengthened, it’s the woman’s. Despite possible discontentment with the present state of the law with respect to abortion, it is what it is and, for that reason, should be respected. Members of the medical profession and influential anti-abortionists should not abuse one right to erode another.

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66 Pellegrino *supra* note 28, at 242-243
67 Teliska *supra* note 65, at 247