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# Access to Prescription Drugs: A Normative Economic Approach to Pharmacist Conscience Clause Legislation

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# ACCESS TO PRESCRIPTION DRUGS: A NORMATIVE ECONOMIC APPROACH TO PHARMACIST CONSCIENCE CLAUSE LEGISLATION

*Joanna K. Sax*

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## ACCESS TO PRESCRIPTION DRUGS: A NORMATIVE ECONOMIC APPROACH TO PHARMACIST CONSCIENCE CLAUSE LEGISLATION

Joanna K. Sax\*

### I. INTRODUCTION

Imagine the year is 2050 and an older gentleman with Parkinson's disease hobbles up to the pharmacy counter to fill a prescription for a new drug that will help treat his ailment. The pharmacist refuses to fill the prescription because the drug was developed through the use of embryonic stem cell research. The pharmacist states that it violates his personal beliefs to fill prescriptions that are based on this immoral type of research. The next person in line attempts to fill a prescription for HIV medication. Again, the pharmacist refuses to fill the prescription because he thinks that the HIV positive person may have contracted the disease in a homosexual encounter and believes this type of behavior is immoral.<sup>1</sup> The next woman in line attempts to fill her prescription for birth control. The pharmacist refuses and states that he is personally opposed to contraception.<sup>2</sup> Indeed, the last of these scenarios repeatedly occurred in the 1990s and 2000s and it is only a matter of time before the first two scenarios come to fruition.<sup>3</sup> The failure to fill medical prescriptions may lead to serious medical harms.

The issue is whether it is optimal for society to support legislation that allows a pharmacist to escape liability for refusing to fill a valid prescription based on the pharmacist's personal beliefs, otherwise known as conscience clauses. Currently, at least five states have pharmacist conscience clause legislation and many more states are considering such legislation. This issue is particularly ripe as embryonic stem cell research progresses because this research is engulfed by many of the same controversies surrounding contraception. As stem cell research progresses, many hope it will lead to the discovery and development of new drugs for a variety

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1. Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW. ENG. J. MED. 2008, 2010 (2004) (discussing the potential for discrimination against persons with HIV).

2. Joan Bray, *Birth Control Is a Woman's Decision, Not Her Pharmacist's. Some Refuse To Honor Legal Prescriptions on Moral Grounds. We Must Remind Them That's Not Their Job.*, ST. LOUIS POST-DISPATCH, Apr. 21, 2005, at B7 (stating that "pharmacists in this country increasingly are refusing, based on personal moral objections, to fill women's lawful prescriptions for birth control").

3. See, e.g., *Noesen v. State of Wis. Dep't of Regulation & Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 385 (Wis. Ct. App. 2008).

of diseases. It is likely that pharmacists who object to filling prescriptions for contraception will also refuse to fill prescriptions for drugs developed through stem cell research. Legal scholarship in this area focuses on applying notions of fairness to support or oppose pharmacist conscience clause legislation; however, this fairness-based approach appears to be at an impasse. This Article proposes the application of welfare economics to analyze whether conscience clauses maximize social welfare.

Over the past several years, many states introduced legislation that protects a pharmacist's decision to refuse to fill a prescription.<sup>4</sup> Termed "conscience clauses," these pieces of legislation allow a pharmacist to refuse to fill a prescription because of moral or religious objections without fear of legal repercussions. In 2006, for example, twenty-one states considered legislation that permits pharmacists to refuse to fill prescriptions; some bills focus on contraception alone, while others are not specific to any one type of medication.<sup>5</sup> Arkansas, Mississippi, Georgia, Florida, and South Dakota have state laws that provide legal protection to pharmacists who refuse to fill prescriptions.<sup>6</sup> Alternatively, Illinois, Massachusetts, and North Carolina have duty-to-fill laws that do not afford legal protection to pharmacists that refuse to fill prescriptions due to personal beliefs.<sup>7</sup>

The current conscience clause legislation debate is largely focused on birth control.<sup>8</sup> Increasingly, however, other types of research are engulfed by the same moral and religious arguments as those used against the reproductive rights movement. Specifically, many similar arguments surround the therapeutic embryonic stem cell research debates.

In 2001, the federal government placed a practical ban on the federal funding of therapeutic stem cell research. In the ensuing years, numerous states passed legislation supporting stem cell research. In the spring of 2009, President Obama

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4. Marcia D. Greenberger & Rachael Vogelstein, *Pharmacist Refusals: A Threat to Women's Health*, 308 SCIENCE 1557, 1558 (2005) ("Since 1997, 28 states have introduced legislation that would permit pharmacists to refuse to dispense, and sometimes to refer or transfer, drugs on the basis of moral or religious grounds"). See also R. Alta Charo, *The Celestial Fire of Conscience—Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2471 (2005) (discussing the potential expansive application of medical conscience clause legislation, including therapy developed through stem cell research); NARAL PRO-CHOICE AMERICA, GUARANTEE WOMEN'S ACCESS TO PRESCRIPTIONS 1 (2009), available at <http://www.prochoiceamerica.org/assets/files/Birth-Control-Pharmacy-Access.pdf> (last visited Nov. 11, 2010) [hereinafter GUARANTEE WOMEN'S ACCESS TO PRESCRIPTIONS].

5. See GUARANTEE WOMEN'S ACCESS TO PRESCRIPTIONS, *supra* note 4, at 7. See also, Greenberger & Vogelstein, *supra* note 4, at 1558 ("Fifteen states have introduced such bills in the 2005 legislative session alone.").

6. NAT'L WOMEN'S LAW CTR., PHARMACY REFUSALS 101-3 (Apr. 2010), available at <http://www.nwlc.org/sites/default/files/pdfs/pharmacyrefusals101.410.pdf>; Cantor & Baum, *supra* note 1, at 2008 (stating that these states have explicit laws to legally protect the pharmacists to refuse who dispense contraception medication).

7. Charo, *supra* note 4, at 2472 fig.1 (illustrating the states' pharmacy policies).

8. See, e.g., Sarah Tomkowiak, Comment, *Reconciling Principles and Prescriptions: Do Pharmacist Refusal Clauses Strike the Appropriate Balance Between Pharmacists' and Patients' Rights?*, 2007 U. ILL. L. REV. 1329, 1329 (2007).

reversed the Bush Administration's practical ban on embryonic stem cell research.<sup>9</sup> In July 2009, the government released embryonic stem cell research guidelines.<sup>10</sup> Many hope that with the injection of federal money and support it is only a matter of time before beneficial medical procedures and medications develop through stem cell research.

Stem cell research raises numerous policy considerations that need to be analyzed as this research moves forward, such as compensation for donors and reproductive versus therapeutic stem cell research. This Article argues that, among the many policy avenues that need to be addressed regarding stem cell research, one important area is patient access to prescription drugs. State legislators are attempting to pass conscience clause legislation that is aimed at stem cell research. A state senator from Washington, for example, introduced a bill to expand a conscience clause to include treatments discovered through biomedical research.<sup>11</sup> Specifically, the introduced bill stated: "Biotechnology may create new objectionable medical options in the future."<sup>12</sup> The introduced bill provided: "Notwithstanding any other provision of law, no person may be required to pay for or otherwise provide, directly or indirectly, any biomedical treatment, service, procedure, pharmaceutical, or technology to which that person has a bona fide doctrinal religious objection."<sup>13</sup> Although this bill did not become law, it provides a glimpse of the potential expansive nature of pharmacist conscience clauses.<sup>14</sup>

The goals of this Article are two-fold: (1) to explain that pharmacist conscience clause legislation may be expanded to areas concerning controversial biomedical research; and (2) to demonstrate that welfare economics can be applied to analyze pharmacist conscience clause legislation. Regarding the first goal, the broad language of existing and proposed conscience clause legislation creates an umbrella that allows a pharmacist to escape liability for refusing to fill a prescription for almost any type of medication. With respect to the second goal, this Article applies welfare economics to demonstrate that pharmacist conscience clauses are a part of tort law and can be analyzed as such to determine whether social welfare is maximized.

A legal framework is needed to ensure that patients receive their medications. Applying principles from welfare economics may allow states to acknowledge that conscience clauses are akin to a no-liability regime, and this may not be in the best interest of its citizens. As a precursor, conscience clause legislation has no bearing on the pharmacist's professional role in patient safety. By applying welfare economics, courts or policymakers may determine that pharmacists should be held to the duty of care as established by the state courts or state licensing boards and

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9. Exec. Order No. 13505, 74 Fed. Reg. 10,667 (Mar. 9, 2009) [hereinafter Exec. Order No. 13505].

10. Raynard S. Kington, Acting Director, Nat'l Inst. of Health, NATIONAL INSTITUTES OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH, <http://stemcells.nih.gov/policy/2009guidelines.htm> (last visited Nov. 11, 2010) [hereinafter NAT'L INST. OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH].

11. S.B. 5879, 58th Leg., Reg. Sess. (Wash. 2003) (unenacted).

12. *Id.* § 1.

13. *Id.* § 2(1).

14. In addition, this bill did not receive a hearing. Washington Votes, 2003 Senate Bill 5879, <http://www.washingtonvotes.org/2003-SB-5879#aBillComments> (last visited Nov. 11, 2010).

potentially subject to liability for a refusal to fill a valid and safe prescription. If, however, the states continue to pass conscience clause legislation, then the federal government may decide to legislate or regulate a policy to protect patients' access to prescription drugs.

Part II of this Article explains the role of pharmacists as the gatekeeper for drugs.<sup>15</sup> Pharmacists receive specialized education designed to understand drug pathways, interactions, side effects, and other important characteristics in order to ensure a patient receives an appropriate drug that will not interact adversely with other medications. Pharmacists hold the responsibility to communicate with a prescribing physician if they identify adverse drug interactions or to clarify other issues surrounding prescriptions.<sup>16</sup> During the past ten years, this country witnessed an expansion of the pharmacist's role in dispensing prescription drugs, in large part due to refusals through conscience clause legislation.

In Part III, this Article describes conscience clause legislation designed to protect pharmacists who refuse to dispense prescriptions. These conscience clauses spurred a huge debate over the interaction of a pharmacist with a patient in the medical literature, legal scholarship, and popular press, and this Article will present the myriad of arguments on all sides.<sup>17</sup> The current legal debate in this area applies principles of fairness to argue for or against conscience clause legislation. In Part V, however, this Article argues that an economic approach—as opposed to fairness arguments—should be utilized to determine whether pharmacist conscience clauses maximize social welfare.

Part IV considers whether the momentum of the state initiatives to allow pharmacists to refuse to dispense birth control could potentially be expanded to drugs discovered by controversial biomedical research. Already, for example, some Catholic hospitals do not provide emergency contraception to rape victims for religious reasons.<sup>18</sup> Furthermore, watchdog groups communicate to pharmacists promoting the use of conscience clauses.<sup>19</sup> Because many of the arguments used to support anti-contraception positions are also applied against embryonic stem cell research, it is reasonable to believe that groups that advocate

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15. William L. Allen & David B. Brushwood, *Pharmaceutically Assisted Death and the Pharmacist's Right of Conscience*, 5 OHIO N.U. J. PHARMACY & L. 1, 2-5 (1996) (describing the role of pharmacists).

16. See, e.g., *id.* at 4-5; Sarah J. Vokes, Comment, *Just Fill the Prescription: Why Illinois' Emergency Rule Appropriately Resolves the Tension Between Religion and Contraception in the Pharmacy Context*, 24 LAW & INEQ. 399, 406-07 (2006).

17. See, e.g., Cantor & Baum, *supra* note 1, at 2009-10 (stating the arguments against a pharmacist's right to object); 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, 78 (2002-03) (suggesting measures should exist to protect "pharmacists from having to act contrary to their basic moral convictions"); Katie Fairbank, *Waging a Moral Battle From Behind the Counter—Pharmacists' Refusal to Fill Contraception Prescriptions Prompts the Question: Whose Choice is it to Make?*, DALL. MORNING NEWS, Apr. 24, 2005, at 1A (quoting a Planned Parenthood Employee as saying "I can almost guarantee you those same pharmacies wouldn't have an objection to Viagra").

18. Deborah Weiss, *Emergency Contraception—History and Access*, at 4, [http://www.plannedparenthood.org/files/PPFA/EC\\_060309.pdf](http://www.plannedparenthood.org/files/PPFA/EC_060309.pdf) (last visited Nov. 11, 2010) (describing the study of rape victims' access to emergency contraception in emergency rooms).

19. See, e.g., Pharmacists for Life International, <http://www.pfli.org/> (last visited Nov. 11, 2010).

for pharmacists to refuse to fill prescriptions for birth control will communicate information to pharmacists concerning drugs developed through stem cell research. This Article describes how some of the conscience clause laws are so broadly worded that they could potentially be applied to other controversial areas, in particular, medications discovered through stem cell research.<sup>20</sup>

Part V of this Article provides that the application of principles from welfare economics may demonstrate that the protection from liability for pharmacists who refuse to fill a prescription due to the pharmacist's personal or religious beliefs fails to maximize social welfare. The application of welfare economics in this Article is a markedly different approach compared to the fairness arguments discussed in legal scholarship, medical literature, and the popular press. In general, each state's common law or state licensing provisions will set the professional standard of care for pharmacists. Conscience clauses, however, statutorily protect pharmacists from liability when refusing to fill a prescription. This Article suggests that pharmacist conscience clauses mimic a no-liability regime under tort law, which may fail to maximize social welfare. Should the states continue to ignore the impact of pharmacist conscience clauses, federal oversight through legislative and regulatory measures may be enacted to ensure patients receive prescription drugs. Duty-to-fill legislation, for example, introduced in the Senate<sup>21</sup> and the House of Representatives,<sup>22</sup> is one proposed alternative that requires pharmacies to fill prescriptions. This Article proposes amendments to strengthen the proposed duty-to-fill legislation.

As we move forward into areas of controversial biomedical research, such as stem cell research, broadly worded conscience clauses can be applied to an increasing number of drugs. Understanding the position of opponents to stem cell research in relation to the conscience clause landscape provides an opportunity to analyze and progressively address issues related to patients' access to prescription drugs.

## II. THE PHARMACIST'S ROLE AS A GATEKEEPER

The Food and Drug Administration (FDA) classifies drugs as safe and effective for use by one of two main mechanisms. Drugs can be purchased as "over the counter" (OTC) meaning that the drug's benefits outweigh the risks, potential for abuse is low, labels provide adequate information, and a person can self-medicate.<sup>23</sup> The FDA classifies a second group of drugs as "prescription only" if they believe the drug could be misused under the self-medication regime

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20. Cf. Angela K. Brown, *Lawsuit Protection Helps South Dakota Druggists Bring Beliefs to Work*, CHI. TRIB., May 14, 1998, at C2 ("They've been chipping away at Roe vs. Wade for years," said Thelma Underberg, South Dakota Director of the National Abortion Reproductive Rights Action League. "They're starting with what they can control.").

21. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005).

22. Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005).

23. U.S. Dep't of Health & Human Servs., U.S. FDA, Regulation of Nonprescription Products, <http://www.fda.gov/AboutFDA/CentersOffices/cder/ucm093452.htm> (last updated Oct. 19, 2010).

described for OTC drugs.<sup>24</sup> To receive the second class of drugs, a physician writes a prescription for a particular drug that must be submitted to a licensed pharmacist for dispensing. In addition, pharmacists have a heightened responsibility when dispensing controlled substances, such as narcotics, because of the highly addictive nature of the drugs and the potential for abuse.

A pharmacist is a medical professional.<sup>25</sup> A pharmacist plays a role as gatekeeper to ensure prescriptions are written according to proper procedures and to dispense drugs with accuracy.<sup>26</sup> First, a pharmacist can only fill a prescription written by a physician with the authority to prescribe that particular type of medication. For example, if a patient changes doctors, a pharmacist is no longer obligated to fill prescriptions for a person once the doctor-patient relationship has ceased.<sup>27</sup> Second, pharmacists review prescriptions for safety concerns such as adverse drug interactions, allergies, and incorrect drug for the disease.<sup>28</sup> Pharmacists consult with the patients about doses and side effects.<sup>29</sup> If problems are detected, the pharmacist intervenes by contacting the prescribing physician. The pharmacist is part of the chain of patient care.

The pharmacist gatekeeper functions relate to the medical needs of patients and it does not include an exception for moral, religious, or ethical objections to certain types of medications. Without the protection of a conscience clause, a pharmacist may be held liable for failing to dispense valid and safe prescriptions due to personal beliefs.<sup>30</sup> Indeed, as described in more detail below, some state's conscience clause laws specifically provide protection for pharmacists refusing to fill prescriptions for contraception and assisted suicide. Other states have broader conscience clauses that are not limited to specific classes of drugs. In response to states with conscience clauses, other states, such as New Jersey, enacted legislation that places the responsibility on the pharmacy to fill safe and valid prescriptions.<sup>31</sup>

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24. Ctr. for Drug Evaluation and Research, INFORMATION ABOUT THE PRODUCTS WE REGULATE, <http://www.fda.gov/cder/drug/default.htm#Prescription%20Drug%20Information> (last updated Sept. 27, 2005).

25. See, e.g., *Professional*, WIKIPEDIA, <http://en.wikipedia.org/wiki/Professional> (last visited Nov. 11, 2010); Merriam-Webster's dictionary defines professional as:

A high standard of professional ethics, behavior and work activities while carrying out one's profession (as an employee, self-employed person, career, enterprise, business, company, or partnership/associate/colleague, etc.). The professional owes a higher duty to a client, often a privilege of confidentiality, as well as a duty not to abandon the client just because he or she may not be able to pay or remunerate the professional. Often the professional is required to put the interest of the client ahead of his own interests.

MERRIAM-WEBSTER, <http://merriam-webster.com/dictionary/professional>.

26. See Vokes, *supra* note 16, at 406-07 (describing role of pharmacists); See also Claire A. Smearman, *Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 ARIZ. L. REV. 469, 512-13 (2006).

27. Allen & Brushwood, *supra* note 15, at 3.

28. Henri R. Manasse Jr., *Conscientious Objection and the Pharmacist*, 308 SCIENCE 1558, 1559 (2005) ("Pharmacists also perform critical quality checks to detect and prevent harmful drug interactions, adverse reactions, and mistakes.").

29. Allen & Brushwood, *supra* note 15, at 4-5 (describing the role of pharmacists under the Pharmaceutical Access and Prudent Purchasing Act of 1990).

30. See *Noesen*, 751 N.W.2d at 393-94. See also Smearman, *supra* note 26, at 512-13 (describing that state regulations enumerate the circumstances when a pharmacist should refuse to dispense a drug).

31. N.J. STAT. ANN. § 45:14-67.1(a) (West 2007). The statute provides in relevant part:



The upshot is that traditionally a pharmacist is supposed to fill all valid and safe prescriptions for FDA approved drugs; however, the recent surge of state conscience clauses is changing the ability of a patient to receive their prescription drugs.

### III. CONSCIENCE CLAUSE LEGISLATION AND THE ATTENDANT ARGUMENTS

Following *Roe v. Wade*, the federal government and forty-six states enacted conscience clauses to protect medical professionals who do not want to perform procedures that are against their personal beliefs, most notably abortions.<sup>32</sup> Recently, multiple states enacted similar measures for pharmacists who may not want to dispense medication that is against their beliefs.<sup>33</sup> At least five states have pharmacist conscience clause legislation<sup>34</sup> and these conscience clauses can be divided into two groups. The first group includes pharmacist conscience clauses that specifically enumerate the types of drugs that a pharmacist may refuse to fill.<sup>35</sup> The second group contains broadly worded conscience clause legislation that protects a pharmacist who refuses to dispense any drug that is against their personal beliefs.<sup>36</sup>

Diverse opinions in the religious, legal, and medical communities argue along a continuum about these statutes. Proponents of conscience clauses argue that these statutes are a welcome effort to allow pharmacists to exercise their personal beliefs. At the other end, opponents argue these clauses are a major threat to the doctor-patient relationship and women's rights. Those in the middle see the conscience clauses as a balancing act where the pharmacist may exercise personal beliefs so long as another method, such as referral, is available to the patient. These arguments look at notions of fairness regarding the pharmacists and patients. In Part V, however, this Article argues that the application of welfare economics—

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A pharmacy practice site has a duty to properly fill lawful prescriptions for prescription drugs or devices that it carries for customers, without undue delay, despite any conflicts of employees to filling a prescription and dispensing a particular prescription drug or device due to sincerely held moral, philosophical or religious beliefs.

32. 42 U.S.C. § 300a-7 (1973) [hereinafter Church Amendment]; Holly Teliska, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 233-34 (describing the history of refusal clauses); Smearman, *supra* note 26, at 476 (2006) (“In 1973, the same year *Roe v. Wade* was decided, Congress enacted the first federal refusal statute, known as the Church Amendment”); Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 144-47 (2003) (describing the background of the Church Amendment). See generally, Bryan A. Dykes, *Notes: Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers*, 36 GA. L. REV. 565, 569-85 (2002) (describing in detail numerous state conscience clauses for medical providers).

33. Greenberger & Vogelstein, *supra* note 4; Charo, *supra* note 4; GUARANTEE WOMEN'S ACCESS TO PRESCRIPTIONS, *supra* note 4.

34. ARK. CODE ANN. §§ 20-1-304, 20-1-304(4) (West 2010); FLA. STAT. ANN. § 381.0051(6) (West 2001); S.D. CODIFIED LAWS § 36-11-70 (2010); GA. COMP. R. & REGS. 480-5-.03(n) (2001); The Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. § 41-107-1 (West, 2010).

35. ARK. CODE ANN. §§ 20-1-304, 20-1-304(4) (West 2010); FLA. STAT. ANN. § 381.0051(6) (West 2001); S.D. CODIFIED LAWS § 36-11-70 (2010)

36. GA. COMP. R. & REGS. 480-5-.03(n) (2001); The Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. § 41-107-1 (West, 2010).

and not fairness positions alone—is the preferable method to analyze whether pharmacist conscience clauses maximize social welfare.

#### A. State Conscience Clause Legislation for Pharmacists

Proponents of conscience clauses view this legislation as a way to protect a pharmacist who faces a moral dilemma when dispensing a drug that may be against their personal beliefs.<sup>37</sup> Often centered on the birth control and abortion debates, supporters argue that pharmacists who are against drugs that fall within the family of offensive reproductive services should not be required to dispense them.<sup>38</sup> Indeed, they believe that even the passive distribution of birth control pills or emergency contraception (EC) is an integral part of the decision not to have a child.<sup>39</sup> In the legal scholarship, some argue that the Free Exercise Clause may lend support for the protection of pharmacists via conscience clauses.<sup>40</sup> In addition, proponents of conscience clauses posit that protections under Title VII—which prohibits discrimination against employees on the basis of religion—may not afford enough protection to pharmacists; therefore, conscience clauses are needed to protect the pharmacist’s religious position.<sup>41</sup> In sum, the legal scholarship and other commentators in support of conscience clause legislation argue that it is fair to allow a pharmacist to refuse to fill a prescription that is against the pharmacist’s personal beliefs.

##### 1. Group 1: Pharmacist Conscience Clauses

Arkansas, Florida, and South Dakota are in the first group of states with pharmacist conscience clause legislation. In these states, a pharmacist is protected from facing liability for refusing to dispense enumerated classes of drugs.

Shortly after the Supreme Court’s decision in *Roe v. Wade*, Arkansas enacted a conscience clause that allows pharmacists to refuse to fill a prescription for contraceptives.<sup>42</sup> Specifically, the Arkansas law provides: “Nothing in this subchapter shall prohibit a physician, pharmacists, or any other authorized

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37. Herbe, *supra* note 17, at 78 (suggesting measures should exist to protect “pharmacists from having to act contrary to their basic moral convictions”); *see generally* Courtney Miller, Note, *Reflections on Protecting Conscience for Health Care Providers: A Call for More Inclusive Statutory Protection in Light of Constitutional Considerations*, 15 S. CAL. REV. L. & SOC. JUST. 327, 342-62 (2006) (proponent of expansive conscience clause legislation).

38. Miller, *supra* note 37, at 351 (“These individuals have a *moral allergy* to something in the workplace similar to a physical allergy that others might have to a certain substance in the workplace.”) (emphasis added).

39. Cantor & Baum, *supra* note 1, at 2009 (“Although some observers argue that active participation in an abortion is distinct from passively dispensing emergency contraception, others believe that making such a distinction between active and passive participation is meaningless, because both forms link the provider to the final outcome in the chain of causation.”).

40. 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, 789-91 (2007) (raising underlying issues as to why pharmacists may want the protection afforded under conscience clause legislation).

41. *Id.* at 791-95 (discussing arguments related to protection under Title VII); *see also* Miller, *supra* note 37, at 335 (noting that “Title VII does not constitute a very solid line of defense”).

42. ARK. CODE ANN. § 20-16-304 (West 2010).

paramedical personnel from refusing to furnish any contraceptive procedures, supplies or information.”<sup>43</sup> Although limited to contraceptives, this statute does not provide any patient safeguard, such as referral or transfer to another provider.

In 2003, Florida enacted a statute that applies to pharmacists. Florida’s statute governing family planning provides:

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 physicians *or other person* shall not be held liable for such refusal.<sup>44</sup>

Florida’s statute is limited to birth control; however, it does not require a referral to another provider.

South Dakota enacted a pharmacist conscience clause that protects pharmacists when refusing to dispense medication for services including abortion, assisted suicide, euthanasia, or mercy killing.<sup>45</sup> While the South Dakota law is specific in the types of medications covered under the statute, other states have enacted more encompassing laws.

In sum, in this grouping of conscience clauses, pharmacists are protected if they refuse to fill prescriptions for certain types of drugs, mostly birth control. These conscience clauses are narrower than the second group of conscience clauses.

## 2. Group 2: Pharmacist Conscience Clauses

Georgia and Mississippi are in the second group of states with pharmacist conscience clauses. In these states, the language of the legislation is broadly worded and a pharmacist can avoid liability for refusing to fill a prescription for *any* medication.

In 2001, Georgia enacted a broad regulation allowing pharmacists to refuse to fill a prescription for any medication based on “professional judgment or ethical or moral beliefs.”<sup>46</sup> Georgia’s regulation is broad in two respects. First, the regulation can be applied to any drug.<sup>47</sup> That is, nothing in the regulation limits a pharmacist from refusing to fill a prescription for drugs developed through controversial biomedical research, such as drugs developed through stem cell research. Second, Georgia’s regulation does not provide the patient with any protection, such as a referral or transfer provision.<sup>48</sup>

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43. *Id.* § 20-16-304(4).

44. FLA. STAT. ANN. § 381.0051(6) (West 2001) (emphasis added).

45. S.D. CODIFIED LAWS § 36-11-70 (2010); Angela K. Brown, *Lawsuit Protection Helps South Dakota Druggists Bring Beliefs to Work*, CHI. TRIB., May 14, 1998, at C2 (stating the South Dakota bill passed the house 57-10 and the senate 30-3. This article discusses that the debates about the bill were more emotional than logical).

46. GA. COMP. R. & REGS. R. 480-5-.03(n) (2001).

47. *Id.*; see generally NAT’L WOMEN’S LAW CENTER, PHARMACY REFUSALS: STATE LAWS, REGULATIONS, AND POLICIES, <http://www.nwlc.org/resource/pharmacy-refusals-state-laws-regulations-and-policies> (last visited Dec. 15, 2010) [hereinafter PHARMACY REFUSALS: STATE LAWS, REGULATIONS, AND POLICIES].

48. GA. COMP. R. & REGS. R. 480-5-.03(n); see also PHARMACY REFUSALS: STATE LAWS, REGULATIONS, AND POLICIES, *supra* note 47.

In 2004, the Mississippi Health Care Rights of Conscience Act was signed into law.<sup>49</sup> This Act protects pharmacists who refuse to participate in any health-related service that is against their personal beliefs.<sup>50</sup> In addition, the Mississippi Act does not require referral to another provider.

In contrast to the Group 1 legislation, which is limited in scope, the broad coverage of the Mississippi Act and Georgia's regulation could potentially be interpreted to cover any area of health care.<sup>51</sup> That is, it is possible that a pharmacist could refuse to dispense a variety of medications as well as refuse to refer a patient elsewhere. As the therapeutic stem cell research debate is engulfed by many of the same arguments seen in the reproductive rights struggle,<sup>52</sup> it is possible that patients will be refused access to drugs that are developed through stem cell research if states continue to pass wide-reaching Group 2 Pharmacist Conscience Clause-type legislation.

### B. Duty-to-Fill—Opposition to Pharmacist Conscience Clauses

Opponents to conscience clause statutes argue that pharmacists have a professional duty of care and their refusal to dispense prescriptions violates this duty and adversely affects patients.<sup>53</sup> Others feel that these statutes are a covert operation by anti-choice groups in an attempt to find yet another way to interfere with a woman's reproductive rights.<sup>54</sup> Women's rights groups argue that a pharmacist's refusal to fill a birth control prescription can have devastating effects on women who want to prevent unintended pregnancies and wish to time and space their pregnancies.<sup>55</sup> In addition, others argue that the pharmacist, acting as a third-party, has no right to override a physician's decision to prescribe a drug to a patient.<sup>56</sup>

Legal scholarship in this area analyzes the application of a myriad of arguments related to conscience clauses. Some argue that pharmacists would fail to establish that a common law duty-to-fill all prescriptions would violate the Free Exercise Clause.<sup>57</sup> Other scholars debate whether conscience clauses violate the

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49. The Mississippi Health Care Rights of Conscience Act, MISS. CODE ANN. § 41-107-1 (West 2010).

50. Teliska, *supra* note 32, at 243-44 (describing the Mississippi Act).

51. See Georgia Chudoba, Comment, *Conscience in America: The Slippery Slope of Mixing Morality with Medicine*, 36 SW. U. L. REV. 85, 99 (2007) (generally observing that the broad Mississippi conscience clause could apply to treatments developed through stem cell research).

52. Deborah Barfield, *Abortion, Suicide Issues Thrust Pharmacists Into Moral Debate*, BUFF. NEWS, May 19, 1998, at A3 (stating that the South Dakota conscience clause bill was pushed by the South Dakota Right to Life group).

53. Cantor & Baum, *supra* note 1, at 2009-10 (stating the arguments against a pharmacist's right to object).

54. J.W. Griffiths, Jr. Editorial letters: *Pharmacists Can Refuse to be Part of an Abortion*, ST. PETERSBURG TIMES, June 2, 1997 at 9A.

55. Greenberger & Vogelstein, *supra* note 4, at 1557 (explaining how pharmacist refusals can have "devastating consequences" for women's health).

56. Bray, *supra* note 2 ("When a woman and her doctor decide that a prescription for contraception is in the woman's best interest, a third party has no right to override that decision.").

57. Lora Cicconi, Comment, *Pharmacist Refusals and Third-Party Interests: A Proposed Judicial Approach to Pharmacist Conscience Clauses*, 54 UCLA L. REV. 709, 728-34 (2007) (concluding that "[i]n sum, though federal and state religious freedom clauses prohibit the state from infringing upon the

Establishment Clause.<sup>58</sup> Further, it appears undisputed in the literature that a pharmacist could not sustain a Title VII claim against an employer that would not agree to accommodate an objecting pharmacist.<sup>59</sup> The American Bar Association (ABA) weighed in against conscience clauses. The ABA drafted a report condemning conscience clause regulations that interfere with any patient's ability to receive information from his or her health care providers in order to make informed decisions.<sup>60</sup> In sum, the debate in the legal scholarship, medical literature, and other groups present fairness arguments—it is not fair to the patients for the pharmacist to refuse to fill the prescription.

In opposition to the pharmacist conscience clause legislation described above, several states passed or considered legislation that requires pharmacies or pharmacists to fill all valid prescriptions.<sup>61</sup> Collectively referred to as “duty-to-fill” legislation, they require the pharmacist to fill all prescriptions, absent a medical reason not to fill the prescription. For example, in response to a highly publicized refusal by a pharmacist in Chicago to dispense emergency contraception (EC), Illinois enacted an emergency rule ordering pharmacists to fill “morning-after pill” prescriptions.<sup>62</sup> Some states such as New York, Massachusetts, and Colorado have enacted or are considering bills that specifically address EC by requiring hospitals to provide it to rape victims or to allow certain pharmacists to sell EC without a prescription.<sup>63</sup> These laws, however, only address EC and not the myriad of other drugs that could be covered under expansive conscience clauses.

At the state level, certain states enacted legislation requiring pharmacies to ensure that pharmacists fill legal prescriptions.<sup>64</sup> The New Jersey statute, for

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religious exercise of its citizens, they may not exempt pharmacists from their general duty to serve patients”).

58. Smearman, *supra* note 26 at 530-34 (“[T]he Establishment Clause would not prohibit such a religious accommodation, provided that the refusal clause did not impose significant burdens on the rights of others.”).

59. Cicconi, *supra* note 57, at 725-28 (discussing how Title VII would not protect a pharmacist who refuses to fill a prescription). See also Harrington, *supra* note 40, at 791-96 (discussing the interaction of conscience clauses with Title VII).

60. Tresa Baldas, *Fighting Refusal to Treat: ‘Conscience’ Clauses Hit the Courts*, THE NAT’L L. J., Feb. 7, 2005, at 1. Baldas noted:

According to [Robyn Shapiro, who sits on the ABA’s section of Individual Rights and Responsibilities], the recent legislation, known as ‘refusal’ and ‘conscience’ clauses, stirred some interest in the ABA, which formed a panel to investigate the proposed bills. As a member of that team, she helped draft a report that condemned the proposed statutes and will be presented to the ABA’s House of Delegates at its upcoming ABA Mid-Year Meeting . . . .

*Id.*

61. See GUARANTEE WOMEN’S ACCESS TO PRESCRIPTIONS, *supra* note 4.

62. Abdon M. Pallasch, *Sell Contraceptives, Gov Orders Druggists; Rule Follows Refusal by Pharmacist to Dispense Morning-After Pills Here*, CHI. SUN-TIMES, Apr. 2, 2005, at 5.

63. Manasse Jr., *supra* note 29, at 1559.

64. Monica Davey & Pam Belluck, *Pharmacies Balk on After-Sex Pill and Widen Fight*, N.Y. TIMES, Apr. 19, 2005 at A16 (stating that California and West Virginia have both duty-to-fill bills and conscience clause bills pending in the state legislature); Tomkowiak, *supra* note 8, at 1353 (stating California, Illinois, Nevada, Maine, and New York have duty-to-fill laws); AM. PHARMACISTS ASS’N, ISSUE BRIEF ON CONSCIENCE CLAUSES (2009); Cicconi, *supra* note 57, at 710, noting:

On September 29, 2005, California Governor Arnold Schwarzenegger signed Senate Bill 644 into law, which allows a pharmacist to refuse to dispense medications on ethical, religious, or moral grounds, but

example, provides:

A pharmacy practice site has a duty to properly fill lawful prescriptions for prescription drugs or devices that it carries for customers, without undue delay, despite any conflicts of employees to filling a prescription and dispensing a particular prescription drug or device due to sincerely held moral, philosophical or religious beliefs.<sup>65</sup>

While New Jersey's statute places the onus on the pharmacy to ensure that valid prescriptions are filled, this legislation does not require the pharmacy to carry all medications—that is, the pharmacy could choose not to stock contraceptives or drugs developed through controversial biomedical research. Although New Jersey's statute provides safeguards so that a patient will be referred to a pharmacy that is reasonably accessible to the patient and transfers the prescription, the pharmacy itself is not obligated to carry any particular prescription drug or device.<sup>66</sup>

At the federal level, Senators Barbara Boxer and Frank R. Lautenberg introduced a bill, the Pharmacy Consumer Protection Act of 2005, which requires all legal prescriptions are filled.<sup>67</sup> This bill provides: “The pharmacy ensures that each valid prescription is filled without unnecessary delay or other interference, consistent with the normal timeframe for filling prescriptions.”<sup>68</sup> A similar bill, entitled the “Access to Legal Pharmaceuticals Act,” was proposed in the House as well.<sup>69</sup> The House bill ensures that pharmacies fill prescriptions regardless of the personal beliefs of a single pharmacist.<sup>70</sup> Further, it contains a private cause of action.<sup>71</sup> The findings to the House bill, however, appear to relate only to the struggle between a pharmacist's religious beliefs and the individual's right to legal contraception.<sup>72</sup> Arguably, the House bill is limited because it does not state findings beyond contraception, thus potentially limiting its application to contraception alone. Neither of these federal bills is enacted.

Some opponents to pharmacist conscience clauses are concerned about both hypocrisy and expansion. Some argue that it is hypocritical for pharmacists to fill prescriptions for Viagra while not dispensing birth control.<sup>73</sup> Others suggest that the conscience clauses could be expanded to other controversial areas including

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only in cases where the pharmacist has notified his employer in advance of the drugs to which he objects, and only if the employer can reasonably accommodate the objection without undue hardship.

65. N.J. STAT. ANN. § 45:14-67.1(a) (West 2007). *See also* AM. PHARMACISTS ASS'N, ISSUE BRIEF ON CONSCIENCE CLAUSES (2008).

66. *Id.* § 45:14-67.1(c).

67. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005). *See also* Davey & Belluck, *supra* note 64, at A1 (discussing the federal actions).

68. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. § 2(a) (2005).

69. Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005).

70. *Id.* § 3(a).

71. *Id.*

72. *Id.* § 2.

73. Sheila Swenholt, *Reader Response, Pharmacist's Refusal Raises Questions*, THE DALLAS MORNING NEWS, Apr. 2, 2004, at 10B (“What about Viagra?”); Fairbank, *supra* note 17, at 1A (quoting Planned Parenthood Employee Tony Thorton: “I can guarantee you those same pharmacies wouldn't have an objection to Viagra”).

mental health,<sup>74</sup> HIV,<sup>75</sup> antibiotics for sexually transmitted diseases,<sup>76</sup> and drugs discovered through stem cell research.<sup>77</sup> Some analogize the discretion as to whether to fill a prescription to the days of segregation. A letter to the editor in the Washington Post stated: “This reminds me of the days of desegregation, when some restaurants[?] owners argued that they would not serve blacks because it was contrary to their beliefs. The country decided that they were wrong.”<sup>78</sup>

### C. A Middle Ground Proposal

In this debate, some groups propose a compromise that edits the current pharmacist conscience clause legislation to allow pharmacists to refuse to fill prescriptions due to personal beliefs, while requiring that an alternative method for the patient to receive the prescription be made available.

While not legally enforceable, the American Pharmacists Association (APhA) sets ethical guidelines that many states refer to when crafting and adopting their state laws regulating pharmacists.<sup>79</sup> The APhA has taken what it considers to be a middle ground and provided that a pharmacist should not be required to dispense a medication that is against his or her personal beliefs; however, an alternative system should be in place to allow the patient to fill the prescription.<sup>80</sup> Examples of alternative systems could be another pharmacist on duty at the same time that can fill the prescription or a referral to another pharmacist that will either be working a different shift at that pharmacy or is employed by a different pharmacy. Opponents to the APhA’s position cite guidelines in the Code of Ethics that conflict with the referral policy.<sup>81</sup> The Code articulates that pharmacists place “concern for the well-being of the patient at the center of professional practice” and that the pharmacist must “respect personal and cultural differences.”<sup>82</sup>

Another middle ground approach is offered by Julie Cantor and Ken Baum.

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74. Carolyn G. Maurer, *Reader Response: Pharmacist’s Refusal Raises Questions*, THE DALLAS MORNING STAR, Apr. 2, 2004, at 10B (fearing the refusal to fill prescriptions for mental health drugs).

75. Cantor & Baum, *supra* note 1, at 2010 (discussing potential discrimination against persons with HIV).

76. Bray, *supra* note 2, at B7 (arguing that pharmacists may deny antibiotics for sexually transmitted diseases based on perceived immorality).

77. Charo, *supra* note 4, at 2471 (discussing therapies developed through stem cell research).

78. Joe Lieberman, Letter to the Editor, *Just What the Doctor Ordered*, WASH. POST, Apr. 3, 2005, at B6.

79. Teliska, *supra* note 32, at 235-36 (describing the APhA’s role with respect to pharmacists and the position it takes on refusal clauses).

80. 2010 HOUSE OF DELEGATES, REPORT OF THE POLICY REVIEW COMMITTEE, AMERICAN PHARMACISTS ASSOCIATION 2 (2010), available at [http://www.pharmacist.com/AM/Template.cfm?Section=House\\_of\\_Delegates&Template=/CM/ContentDisplay.cfm&ContentID=22384](http://www.pharmacist.com/AM/Template.cfm?Section=House_of_Delegates&Template=/CM/ContentDisplay.cfm&ContentID=22384) (last visited Nov. 11, 2010). See also Rob Stein, *Pharmacists’ Rights at Front of New Debate: Because of Beliefs, Some Refuse to Fill Birth Control Prescriptions*, WASH. POST, Mar. 28, 2005, at A10 (“The American Pharmacists Association recently reaffirmed its policy that pharmacists can refuse to fill prescriptions as long as they make sure customers can get their medications some other way”); Editorial, *Business, Morality and Privacy*, S. FLA. SUN SENTINEL (Fort Lauderdale), Apr. 3, 2005, at 5H (stating the APhA position).

81. Greenberger & Vogelstein, *supra* note 4, at 1558 (discussing the APhA’s potentially conflicting policies).

82. *Id.* (internal quotation and citations omitted).

They propose a balancing approach similar to the APhA's approach with respect to EC.<sup>83</sup> In their proposal, all pharmacies should stock EC and have at least one pharmacist on duty at all times willing to dispense the prescription.<sup>84</sup> In the alternative, if the pharmacy adopts a policy not to stock EC, then a notice should be clearly displayed that they do not sell EC and provides information as to where one could fill the prescription.<sup>85</sup> In addition, objecting pharmacists would be required to provide referrals within a reasonable distance to the pharmacy.<sup>86</sup> Opponents to this plan argue that EC is a time sensitive drug and that having to travel to other pharmacies may place a heavy burden on a woman, particularly on women living in rural communities.<sup>87</sup>

Legal scholarship, medical literature, advocacy groups, and the popular press debate the pharmacist conscience clause landscape. The positions described above focus on notions of fairness—either what is fair to the pharmacist, or the patient, or a middle ground that is somewhat fair to both sides. These groups battle using fairness-based arguments and the debate is unsatisfactory because each side appears vested in value-based assessments. The current state of the debate appears to be at an impasse. This Article proposes that pharmacist conscience clauses have the potential to expand in an era of controversial biomedical research and that welfare economics—and not fairness arguments alone—provides the appropriate analysis for conscience clause legislation.

#### IV. APPLICATION OF CONSCIENCE CLAUSES TO DISCOVERIES BASED ON STEM CELL RESEARCH

To date, the majority of pharmacists' personal objections to the requirement to dispense all medications are scooped up by the abortion debates. Indeed, it was the "abortion wars" that started the conscience clause movement.<sup>88</sup> Pharmacists with anti-choice beliefs argue they should not be required to fill prescriptions for birth control or EC. Nuanced within this position is the issue that some pharmacists will fill prescriptions for birth control, but not EC because they mistakenly believe EC causes an abortion. Medical research, however, shows that EC is contraception and has no effect on established pregnancies.<sup>89</sup> Furthermore, some pharmacists do not accept the medical definition of pregnancy as beginning with implantation in the uterus, believing instead that life begins at fertilization.<sup>90</sup> Pharmacists for Life International, an Ohio-based group, argue that pharmacists should not have to fill

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83. Cantor & Baum, *supra* note 1, at 2011.

84. *Id.*

85. *Id.*

86. *Id.*

87. Teliska, *supra* note 32, at 243-48 (discussing the impact on low-income and rural women).

88. Charo, *supra* note 4, at 2471.

89. Cantor & Baum, *supra* note 1, at 2009.

90. Deanna Martin, *Rx Abortion Bill Stalls in Senate*, J. GAZETTE (Fort Wayne, Ind.), Jan. 25, 2008, at 5C ("[S]ome may believe that life begins at fertilization—not at the medical definition of implantation in the uterus—and could therefore think some contraceptives cause an abortion.").



prescriptions that prevent pregnancy.<sup>91</sup> The abortion issue continues to be a divisive topic in political campaigns, judicial appointments, press reports, and numerous other areas of daily life.<sup>92</sup> Opponents to abortion support their beliefs by attacking on multiple fronts,<sup>93</sup> including biomedical research such as stem cell research.<sup>94</sup>

Many arguments against stem cell research grow out of the abortion debates. What follows is an explanation of stem cell research and the surrounding debate. Similar to the misperceptions surrounding EC, many of the ethical and value-based objections to embryonic stem cell research are based on misinformation and fall away with a clear understanding of the science involved. Those who oppose contraception on religious grounds will most likely oppose embryonic stem cell research because the starting material for some stem cell research is embryos discarded from fertility clinics. The Catholic Church, for example, explicitly and openly opposes embryonic stem cell research.<sup>95</sup>

In 2001, the Bush Administration placed a practical ban on the use of federal funds to support stem cell research, which was recently revoked by the Obama Administration.<sup>96</sup> While this ban was in effect, states and private entities pushed forward with stem cell research with the expectation that continued research can provide insights into new treatments and drugs. If stem cell research is successful, patients could face obstacles when attempting to fill prescriptions for drugs developed through this research. For pharmacists who are protected by broad conscience clauses, it would only be a small step to expand their objections to therapies based on stem cell research. Furthering this stance by pharmacists, groups that promote the use of conscience clauses may then disseminate information to pharmacists so that the pharmacists are aware of which drugs are developed through stem cell research.<sup>97</sup>

#### A. A Description of Stem Cell Research

An understanding of stem cell research is critical to any scientific, legal or ethical discussion. Researchers became interested in embryonic stem cells because stem cells have properties that make them good candidates to treat multiple diseases. Stem cells can be maintained in an undifferentiated state and then

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91. Karen L. Brauer, *Pharmacists Put Patients' Interest First*, ATLANTA J.-CONST., Oct. 14, 2004, at A19 (describing Pharmacists for Life International). Of note, Karen Brauer is President of Pharmacists for Life International.

92. See, e.g., Rob Stein, *Health Workers' 'Conscience' Rule Set to Be Voided*, WASH. POST, Feb. 28, 2009, at A1 (describing the issue of abortion as "one of the most divisive political issues").

93. Brown, *supra* note 20.

94. See generally, Connie Bruck, *Hollywood Science*, THE NEW YORKER Oct. 18, 2004, at 62, 62-82.

95. See, e.g., THE VATICAN, REGARDING THE INSTRUCTION *DIGNITAS PERSONAE* 8, [http://www.usccb.org/comm/Dignitaspersonae/Dignitatis\\_Vatican\\_Summary.pdf](http://www.usccb.org/comm/Dignitaspersonae/Dignitatis_Vatican_Summary.pdf) (last visited Nov. 11, 2010) [hereinafter THE VATICAN].

96. Exec. Order No. 13505, *supra* note 9 ("The Presidential statement of August 9, 2001, limiting Federal funding for research involving human embryonic stem cells, shall have no further effect as a statement of governmental policy.").

97. See, e.g., Pharmacists for Life International, *supra* note 19.

induced to form a specific cell lineage.<sup>98</sup> Scientists hypothesize that this characteristic will allow them to turn stem cells into various tissues in order to replace diseased neurons, muscles or organs in a sick person. Illnesses that could be benefited by this type of treatment include Parkinson's Disease, heart disease, diabetes, Alzheimer's Disease, and others.<sup>99</sup> Other promising areas of research that could be expanded with embryonic stem cell research include understanding various genetic diseases and generating diseased cells for drug screening.<sup>100</sup>

Scientists work with two different types of human stem cells, either adult or embryonic. Adult stem cells may not be ideal starting materials because they have limitations which may prohibit the ability to induce them to form the wide variety of cell types that embryonic stem cells can. Most of the controversy surrounding stem cell research concerns the process of obtaining embryonic stem cells.

Embryonic stem cell lines are usually obtained through an *in vitro*, i.e. test tube, fertilization procedure.<sup>101</sup> The egg is fertilized *in vitro* and it is allowed to grow in a Petri dish for approximately three-to-four days to form a blastocyst that contains three concentric circles of cells.<sup>102</sup> Stem cells are isolated from the innermost circle and then grown in a tissue culture on a plastic dish coated with feeder cells that provide a sticky surface, nutrients, and growth factors.<sup>103</sup> Once the stem cells are established, they can be grown and used in experiments or frozen and sent to other laboratories for experiments.<sup>104</sup>

Another way to create stem cells is to use a technique called somatic cell nuclear transfer (SCNT).<sup>105</sup> This technique allows a scientist to create a diseased stem cell line by transferring the nucleus of a patient's cell into an enucleated egg.<sup>106</sup> The egg is then stimulated to divide *in vitro* and form a blastocyst.<sup>107</sup> As described above, cells from the inner cell mass are extracted after a few days growth and then induced to form the diseased tissue. This technique is far from being perfected and controversy surrounded a South Korean scientist who falsified data in an article in the journal *Science* stating that his lab could create diseased cells using SCNT.<sup>108</sup> While the promise of studying diseased tissues through stem

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98. *Stem Cell Information*, NAT'L INSTS. OF HEALTH, STEM CELL INFORMATION, <http://stemcells.nih.gov/staticresources/info/basics/StemCellBasics.pdf> (last visited Nov. 11, 2010) [hereinafter NIH STEM CELL INFORMATION]. See generally Joanna K. Sax, *The States "Race" with the Federal Government for Stem-Cell Research*, 15 ANNALS. HEALTH L. 1, 5-13 (2006) (describing stem cell research and see references therein).

99. NIH STEM CELL INFORMATION, *supra* note 98; Allen M. Spiegel and Gerald D. Fischbach, *NIH Statement Before Senate Appropriations Subcommittee* (April 26, 2000), <http://stemcells.nih.gov/policy/statements/State.asp> (last visited Nov. 11, 2010).

100. Editorial, *Disease Insights from Stem Cells*, 422 NATURE 787, 787 (2003).

101. *Id.*

102. NIH STEM CELL INFORMATION, *supra* note 98.

103. *Id.*

104. *Id.*; see also NAT'L INST. OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH, *supra* note 10 (federal funding is only available for embryonic stem cells "derived from embryos created using in vitro fertilization (IVF) for reproductive purposes and no longer needed for these purposes").

105. *Disease Insights from Stem Cells*, *supra* note 100.

106. *Id.*

107. *Id.*

108. Associated Press, *Faked Research on Stem Cells is Confirmed by Korean Panel*, N.Y. TIMES, Dec. 23, 2005, at A6 (describing confirmation of the fabrication of stem cell lines); Michael Specter,

cells created by SCNT is exciting, it appears that the scientific community will be confronted by many obstacles in mastering this technology.<sup>109</sup> The SCNT technique, in particular, can be used for drug screening.

A national debate, focused on whether life begins in a Petri dish, surrounds the stem cell research debate. Proponents of stem cell research argue that life does not begin in a Petri dish. Moreover, they argue, most of the starting material comes from fertilized eggs destined to be discarded at fertility clinics.<sup>110</sup> Proponents believe that it is more useful to use the discarded eggs for research than to throw them in the garbage. Opponents argue that it is morally and ethically wrong to create a “life” with the purpose of destroying it by isolating the inner cell mass.<sup>111</sup> The arguments about when life begins echo the abortion debates and it is reasonable to believe that opponents to stem cell research would employ conscience clauses and refuse to fill prescriptions for drugs developed through stem cell research.<sup>112</sup>

### *B. Federal and State Policy Governing Stem Cell Research*

In 2001, President Bush declared by executive order that the federal government would not fund stem cell research for any new embryonic stem cell lines.<sup>113</sup> Following the President’s announcement, the National Institutes of Health (NIH) announced that they would not fund research for embryonic stem cell lines created after 9:00 EDT August 9, 2001.<sup>114</sup> This created a practical ban for federal funds on embryonic stem cell research because only a limited number of stem cell lines had been created prior to August 9, 2001, and these cells lines had not yet been characterized, making it unclear whether they could be used in any

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*Political Science: The Bush Administration’s War on the Laboratory*, THE NEW YORKER, Mar. 13, 2006, at 58, 67 (asserting that Hwang Woo Suk’s fabricated data hurts the publicity for stem cell research).

109. The 2009 Federal Guidelines for stem cell research do not allow federal funding for SCNT. NAT’L INST. OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH, *supra* note 10.

110. *Disease Insights from Stem Cells*, *supra* note 100 (describing that the cell lines are generated from no longer wanted fertilized eggs at fertility clinics); William Safire, *Reagan’s Next Victory*, N.Y. TIMES, June 7, 2004, at A27 (“[P]roponents say these are left over from in vitro banks and already destined for destruction, donated by people to whom ‘pro life’ also means saving the lives of suffering patients.”).

111. Safire, *supra* note 110 (“Opponents say the harvesting of these cells destroys potential human life”). See also John M. Broder & Andrew Pollack, *Californians to Vote on Spending \$3 Billion on Stem Cell Research*, N.Y. TIMES, Sept. 20, 2004, at A1 (opponents to stem cell research argue that “researchers must destroy human embryos, an act that is abhorrent to some religious conservatives and opponents of abortion”).

112. As noted above, some groups promote the use of conscience clauses and may communicate with pharmacists regarding drugs developed through stem cell research. See, e.g., Pharmacists for Life International, *supra* note 19.

113. President George W. Bush, President Discusses Stem Cell Research, THE WHITE HOUSE (Aug. 9, 2001, 8:01 PM CDT), <http://georgewbush-whitehouse.archives.gov/news/releases/2001/08/20010809-2.html> (last visited Nov. 11, 2010) [hereinafter Discussion of President Bush].

114. The Nat’l Inst. Of Health, *NIH’s Role in Federal Policy: Stem Cell Research*, <http://stemcells.nih.gov/policy/NIHFedPolicy.asp> (last visited Nov. 11, 2010).

research.<sup>115</sup>

Congress considered stem cell legislation. The House passed a bill that prohibits both therapeutic and reproductive cloning and includes a criminal penalty.<sup>116</sup> Senators, on the other hand, introduced a bill that would allow therapeutic cloning, but ban reproductive cloning.<sup>117</sup> In 2007, the Stem Cell Research Enhancement Act of 2007 was passed in both the House and the Senate—President Bush, however, vetoed the legislation.<sup>118</sup> Recently in 2009, the Stem Cell Research Enhancement Act of 2009 was introduced in both the House and the Senate.<sup>119</sup> These bills are in committee at the time of this writing.<sup>120</sup> To date, Congress does not have a federal policy in effect.

In response to the practical ban on stem cell research at the federal level, several states passed initiatives allowing stem cell research, although many of these initiatives were under-funded.<sup>121</sup> In 2004, however, Californians passed a \$3 billion referendum creating a hospitable home for stem cell researchers.<sup>122</sup> Much of the controversy surrounding California's initiative centered on the ethical debates described above.<sup>123</sup> Interestingly, however, the California referendum faced opposition within the scientific community because some believe that state-by-state funding is not an adequate substitute for federal policies and funding.<sup>124</sup> Thus, some hoped the federal government would change its policy.<sup>125</sup> Since California passed its stem cell research initiative, other states, such as New Jersey and Massachusetts, proposed investing millions of dollars in their states' stem cell research.<sup>126</sup>

Both individual states and private institutions fund and conduct stem cell research. For example, Harvard University opened the Harvard Stem Cell Institute, where they conduct research that is partially funded by the Howard Hughes

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115. *Federal Funding for Stem Cell Research: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 20-21 (2003) (statement of Dr. Ronald McKay, Senior Investigator, Nat'l Inst. of Neurological Disorders and Stroke); see also Sax, *supra* note 98, at 15-19 (see references therein to the scientific debate regarding the stem cell policy).

116. Human Cloning Prohibition Act of 2003, H.R. 534, 108th Cong. (2003).

117. Human Cloning Ban and Stem Cell Research Protection Act of 2003, S. 303, 108th Cong. (2003).

118. Stem Cell Research Enactment Act of 2007, S. 5, 110th Cong. (2007), available at <http://www.govtrack.us/congress/bill.xpd?bill=s110-5> (last visited Nov. 11, 2010).

119. Stem Cell Research Enhancement Act of 2009, H.R. 873, 111th Cong. (2009), available at <http://www.govtrack.us/congress/bill.xpd?bill=h111-873> (last visited Nov. 11, 2010); Stem Cell Research Enhancement Act of 2009, S. 487, 111th Cong. (2009), available at <http://www.govtrack.us/congress/bill.xpd?bill=s111-487> (last visited Nov. 11, 2010).

120. H.R. 873, § 487.

121. See, e.g., N.J. REV. STAT. § 26:27 (2004).

122. CAL. HEALTH & SAFETY CODE § 125300 (West 2004). See also Ceci Connolly, *Calif. Stem Cell Initiative Could Backfire Nationally*, WASH. POST, Nov. 14, 2004, at A15.

123. Connolly, *supra* note 122, at A15.

124. Bruck, *supra* note 94, at 64-70.

125. *Id.*

126. Jonathan Finer, *Mass. Senate Passes Stem Cell Bill That May Face Governor's Veto*, WASH. POST, Mar. 31, 2005, at A2; Laura Mansnerus, *New Jersey Forges Ahead on Stem Cells*, N.Y. TIMES, Feb. 21, 2004, at B1.

Medical Institute.<sup>127</sup> In addition, the private sector, including pharmaceutical companies, can conduct stem cell research. The potential exists, however, for ethically questionable practices, and federal guidelines would preemptively protect subjects, researchers, and patients.<sup>128</sup>

On March 9, 2009, President Obama issued a statement ordering that the limitations on embryonic stem cell research by the Bush Administration be lifted.<sup>129</sup> In July 2009, the NIH released the guidelines for stem cell research.<sup>130</sup> Despite certain constraints on stem cell research in the federal guidelines, it is clear that certain types of embryonic stem cell research will be federally funded, thus allowing this area of research to move forward at a faster clip. The influx of federal funding will allow scientists all over the country to conduct stem cell research and hopefully lead to the development of stem cell-based therapies for a variety of diseases. It is highly unlikely that the opponents of embryonic stem cell research will accept defeat. Rather, opponents to stem cell research will most likely continue to attempt to restrict access to therapies developed through stem cell research. Broadly worded pharmacist conscience clauses—already enacted in two states—provide an attractive avenue for opponents to stem cell research to restrict patient access to beneficial therapies.

### *C. The Controversy Surrounding Plan B as a Backdrop for Debate Regarding Drugs Developed Through Stem Cell Research*

The controversy surrounding Plan B provides a good background for understanding the interaction between the stem cell research debate and the arguments related to the potential expansion of pharmacist conscience clauses. Plan B, also known as the morning-after pill or EC, must be taken within a limited time frame after unprotected sex in order to prevent pregnancy. Plan B has no effect on an established pregnancy.<sup>131</sup> Originally a prescription drug, a woman was required to contact a physician after an episode of unprotected sex or contraceptive failure, receive a prescription, travel to a pharmacy, fill the prescription (assuming the pharmacist would fill it), and take the medication.<sup>132</sup> The risk of pregnancy increases the longer it takes for a woman to begin Plan B.<sup>133</sup>

In 2004, the scientific advisors at the FDA overwhelmingly recommended switching Plan B from a prescription drug to OTC, but in an unprecedented

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127. Alvin Powell, *From the Laboratory to the Patient*, HARV. UNIV. GAZETTE (Apr. 22, 2004), <http://www.news.harvard.edu/gazette/2004/04.22/99-StemOver.html> (last visited Aug. 27, 2010). See also Claudia Dreifus, *At Harvard's Stem Cell Center, the Barriers Run Wide and Deep*, N.Y. TIMES, Jan. 24, 2006, at F2 (noting that Howard Hughes Medical Institute is providing private funding for embryonic stem cell research at Harvard); Howard Hughes Medical Institute, *New Human Embryonic Stem-cell Lines to be Made Available to Researchers* (March 3, 2004), <http://www.hhmi.org/news/melton4.html> (last visited Nov. 11, 2010).

128. See generally, Sax, *supra* note 98, at 33-35 (promoting uniform guidelines).

129. Exec. Order No. 13505, *supra* note 9.

130. NAT'L INST. OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH, *supra* note 10.

131. Cantor & Baum, *supra* note 1, at 2009.

132. Alastair J.J. Wood, et al., *A Sad Day for Science at the FDA*, 353 NEW ENG. J. MED. 1197, 1197 (Sept. 22, 2005).

133. *Id.* ("The risk of pregnancy increases from 0.4 percent if contraception is initiated within 24 hours to 2.7 percent if it is initiated 48 to 72 hours after intercourse.")

decision, the agency rejected the advice of the scientific advisors.<sup>134</sup> This led to an enormous battle at the FDA with intense ethical debates and ultimately resignations, including the assistant commissioner for women's health and director of the Office of Women's Health at the FDA, Susan Wood.<sup>135</sup> Shortly after the decision not to move Plan B to OTC status, the commissioner of the FDA, Dr. Lester Crawford, also resigned.<sup>136</sup>

The advisory committee at the FDA recommended, in a vote of 23-4, to switch EC to OTC based on both safety and the importance of receiving the medication in a limited time frame.<sup>137</sup> In addition, studies showed that teenagers understood how to use Plan B and that its availability had no effect on their behavior.<sup>138</sup> The FDA responded with concerns that young teens may not comprehend the proper use of EC.<sup>139</sup> Some suggest that this reaction is just another example in a long line of Bush Administration tactics to oppose any line of defense that lessens risk associated with sex.<sup>140</sup> Indeed, the FDA delayed the decision stating that it was unsure how to restrict access to older age groups because it did not want to negatively influence the sexual behavior of teens.<sup>141</sup> Ultimately, in 2006, Plan B was approved for OTC, but only for women eighteen years of age and older.<sup>142</sup> In 2009, the age limit was lowered to women seventeen years of age and older.<sup>143</sup> In some states, a patient over the age of 17 does not need a prescription for Plan B from a doctor, but a pharmacist must dispense the drug to the patient.<sup>144</sup>

The arguments surrounding Plan B are an extension of the abortion debates

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134. Specter, *supra* note 108, at 60 ("The agency had never rejected a similar request against the advice of its scientific advisors and its own staff.").

135. Susan F. Wood, *Women's Health and the FDA*, 353 *NEW ENG. J. MED.* 1650, 1650 (2005) [hereinafter *Women's Health and the FDA*] ("Both the relevant advisory committees and the professional review staff at the FDA's Center for Drug Evaluation and Research had strongly recommended that nonprescription status be granted to Plan B emergency contraception (levonorgestrel), given its safety and the need for timely access for optimal efficacy.").

136. *Id.* at 1651.

137. Wood, et al., *supra* note 132, at 1197. See also *Women's Health and the FDA*, *supra* note 135, at 1650.

138. Jennifer Couzin, *Plan B: A Collision of Science and Politics*, 310 *SCIENCE* 38, 38 (2005) ("The results were unambiguous: Teenagers appeared to have no trouble understanding how to use Plan B, and its availability didn't change their behavior. Those results contributed to the near-unanimity among FDA scientists and the scientific community that the drug ought to move from prescription-only status to OTC.").

139. *Id.* at 39.

140. Specter, *supra* note 108, at 58-60 (providing a variety of examples including the failure of abstinence only education, cutting aid to groups that support abortions and condom use, failure of virginity "pledge" programs, and lack of support for vaccines).

141. Couzin, *supra* note 138.

142. Tomkowiak, *supra* note 8, at 1338 ("Finally, on August 24, 2006, the FDA approved Plan B for OTC sales, albeit only for women eighteen and older, who must show proof of age before purchasing Plan B.").

143. *FED. FOOD & DRUG ADMIN., Updated FDA Action on Plan B (levonorgestrel) Tablets*, (Apr. 22, 2009), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm149568.htm> (last visited Nov. 11, 2010).

144. See FDA, *FDA Approves Over-the-Counter Access for Plan B for Women 18 and Over*, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108717.htm>. ("Plan B will be stocked by pharmacies behind the counter because it cannot be dispensed without a prescription or proof of age.").

and “appears to reflect political meddling in the drug-approval process.”<sup>145</sup> These types of arguments are finding their way into all aspects of drug-related reproductive rights. As described in Part III, the pharmacist conscience clauses allow personal beliefs to hinder access to prescription drugs. A similar debate arose in the FDA process over Plan B. These viewpoints are also weighing in over stem cell research. Value-based debates appear to enter all fronts of medicine, science, and technology.

#### *D. Religious Beliefs as Applied to Stem Cell Research*

The religious opposition to abortion appears connected to the Bush Administration’s policy regarding stem cell research. In 2001, President Bush released a statement in opposition to federal funding to support the creation of new embryonic stem cell lines based on his personal “belief in the fundamental value and sanctity of human life.”<sup>146</sup> He also noted that his position on stem cell research is “shaped by deeply held beliefs.”<sup>147</sup> Moreover, opponents to stem cell research argue that the fertilized embryo used for starting material has the “potential” for life and should not be purposefully destroyed.<sup>148</sup> Interestingly, Karen Brauer, President of Pharmacists for Life International used the phrase “purposeful destruction” in an editorial in favor of conscience clauses.<sup>149</sup> The statements used in support of conscience clause legislation mimic the statements used to oppose stem cell research.

The Catholic Church opposes embryonic stem cell research. In the publication *Regarding the Instruction Dignitas Personae*, the Catholic Church classifies embryonic stem cell research as “gravely illicit.”<sup>150</sup> In a conclusory manner, this publication provides that “adult stem cells give more positive results than embryonic stem cells.”<sup>151</sup> This statement cannot be supported in light of the obstacles—such as lack of funding—to conducting embryonic stem cell research. The federal government recently lifted the practical ban on the federal funding of stem cell research. As mentioned above, it is impossible to know at this time whether adult stem cells may give better—or even different—results than embryonic stem cells.

The next logical step for supporters of conscience clause legislation would be to expand the reach of such legislation to medications derived from stem cell research.<sup>152</sup> Indeed, a state senator in Washington State already introduced an

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145. Wood, et al., *supra* note 132, at 1197.

146. Office of the Press Secretary of President George W. Bush, *Fact Sheet: Embryonic Stem Cell Research* (Aug. 9, 2001), <http://georgewbush-whitehouse.archives.gov/news/releases/2001/08/20010809-1.html> (last visited Nov. 11, 2010).

147. Discussion of President Bush, *supra* note 113.

148. Jason Scott Robert, *Model Systems in Stem Cell Biology*, 26 *BIO ESSAYS* 1005, 1005 (2004) (discussing the public debate over stem cell research).

149. Brauer, *supra* note 91.

150. THE VATICAN, *supra* note 95, at 8.

151. *Id.*

152. Cf. Martha S. Swartz, “Conscience Clauses” or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 *YALE J. HEALTH POL’Y L. & ETHICS* 269, 285, 296 (2006) (discussing the proposed expansion of conscience clauses to include new technologies based on stem cell research).

amendment to this effect.<sup>153</sup> Even if opponents to stem cell research lose the battle to private and public funding initiatives, the war can continue at subsequent levels. Once the FDA approves a drug developed through stem cell research, pharmacists in states with broad conscience clauses, such as Mississippi and Georgia, could invoke their personal beliefs and refuse to fill a prescription because they believe life was destroyed to create the therapy.<sup>154</sup>

The current scientific atmosphere is charged with energy for discovering new therapies and drugs based on stem cell research. Numerous areas are open to debate, including compensation for donors and the 2009 federal guidelines.<sup>155</sup> This Article argues that, among the many policy avenues that need to be addressed regarding stem cell research, one important area concerns patients' rights.

Because of the value-based nature of their arguments, proponents and opponents of stem cell research are at an impasse. In Part V, this Article argues that we should move away from a solely value-based dialogue and approach this discussion from a different perspective—that of normative economics.

#### V. THE APPLICATION OF WELFARE ECONOMICS TO PHARMACIST CONSCIENCE CLAUSE LEGISLATION

A wide breadth of literature applies economic analyses to provide guidance, support, or disagree with policy decisions. Law and economic scholarship focuses, in part, on whether various forms of economic rationale can provide guidance for law-makers. The phrase “law and economics” covers a large area of scholarship, some of which is applicable to conscience clauses. Recent scholarship by Louis Kaplow and Steven Shavell applies welfare economics—which focuses on individuals' well-being—to various areas of the law.<sup>156</sup> In their work, Kaplow and Shavell argue that the application of welfare economics provides superior results based on efficiency rather than using the traditional notions of fairness.<sup>157</sup>

As highlighted in Part III, the discussion regarding pharmacist conscience clauses weighs the religious beliefs of the objecting pharmacist against the ability of the patient to receive their valid prescription drug—that is, the discussion is focused on notions of fairness to each side. The debate appears to be at an impasse. Legal scholarship debating conscience clauses also focuses on notions of fairness<sup>158</sup>—including, but not limited to, first amendment jurisprudence, Title VII, women's rights, feminist legal theory, right to privacy, use of various litigation tactics, etc.<sup>159</sup> Applying these notions of fairness, legal scholars and advocacy

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153. S.B. 5878, 2003 Leg. (Wa. 2003).

154. As mentioned above, it is possible that certain groups may communicate with pharmacists regarding the invocation of conscience clauses to refuse to fill prescriptions. See, e.g., Pharmacists for Life International, *supra* note 19.

155. NAT'L INST. OF HEALTH GUIDELINES ON HUMAN STEM CELL RESEARCH, *supra* note 10.

156. See generally LOUIS KAPLOW & STEVEN SHAVELL, FAIRNESS VERSUS WELFARE (2002).

157. *Id.* at 105.

158. *Id.* at 39 n.48 (defining fairness to “refer to any principle that does not depend solely on the well-being of individuals” and stating that arguments based on “fairness-based analysis are broadly applicable to analyses based on justice or rights”).

159. See generally Smearman, *supra* note 26; Herbe, *supra* note 17, at 101; Tomkowiak, *supra* note 8; Teliska, *supra* note 32; Miller, *supra* note 37; Eisenstadt, *supra* note 32; Heather Rae Skeeles, *Patient*



groups propose a range of solutions, which run the gamut from absolute protection of objecting pharmacists from liability to alternative systems of seamless delivery to a statutory duty to fill all valid prescriptions. Kaplow and Shavell, in promoting the application of welfare economics, argue that advancing notions of fairness for policy determinations can actually reduce individuals' well-being; whereas welfare economics, by definition, is concerned with the aggregate well-being of individuals.<sup>160</sup>

This Article suggests that the courts or policymakers should apply an economic rationale to analyze pharmacist conscience clauses. Proponents of conscience clause legislation argue about whether it is fair for a pharmacist to have to fill prescriptions that may conflict with his or her personal or religious beliefs. Opponents argue that, for various reasons, it isn't fair if patients cannot receive their prescriptions. These arguments, however, fail to address or create a model that best serves society as a whole—that is, the arguments do not address the maximization of aggregate social utility.

#### A. Pharmacist Conscience Clauses Are Part of Tort Law

Legal scholarship in this area applies fairness and value-based arguments to support or oppose conscience clauses, but what the scholarship does not adequately address is that conscience clauses are part of tort law. Pharmacists can be held liable for professional negligence,<sup>161</sup> and courts from around the country recognize pharmacists as having a duty of care towards patients.<sup>162</sup>

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*Autonomy Versus Religious Freedom: Should State Legislatures Require Catholic Hospitals to Provide Emergency Contraception to Rape Victims?*, 60 WASH & LEE L. REV. 1007 (2003); Susan Burke Fogel & Lourdes A. Rivera, *The Current State of Abortion Law and Reproductive Rights: Saying Roe is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725 (2004); Cicconi, *supra* note 57; Charu A. Chandrasekhar, *Rx for Drugstore Discrimination: Challenging Pharmacy Refusals to Dispense Prescription Contraceptives Under State Public Accommodations Laws*, 70 ALB. L. REV. 55 (2006). See also Brown, *supra* note 20; Barfield, *supra* note 52 (stating the South Dakota Right to Life group pushed for the conscience clause law); Planned Parenthood Affiliates of New Jersey, *Fact Sheet: Emergency Contraception*, [http://www.plannedparenthoodnj.org/library/topic/emergency\\_contraception/factsheet](http://www.plannedparenthoodnj.org/library/topic/emergency_contraception/factsheet) (last visited Nov. 11, 2010) (“Individual pharmacists have refused to fill prescriptions for ECPs presumably based on the false assumptions that ECPs are abortifacients.”).

160. KAPLOW & SHAVELL, *supra* note 156, at 7, 44.

161. See Cicconi, *supra* note 57, at 724 (“By imposing liability on pharmacists who erroneously fill prescriptions, tort law obligates pharmacists to service patients by accurately filling their prescriptions.”).

162. See *McDaniel v. St. Clair*, 18 Va. Cir. 470, 473 (1990) (“The duty of the pharmacist is that of a health care professional and as such is a continuing duty, and the rule of continuing duty should be applied to pharmacists as it has been applied to other professions noted above”); *Downing v. Hyland Pharmacy*, 194 P.3d 944, 948 (Utah 2008) (“A pharmacist owes the consumer a duty of reasonable care with respect to the sale of drugs not authorized for sale by the FDA or the manufacturer”); *Nelms v. Walgreen Co.*, No. 02A01-9805-CV-00137, 1999 Tenn. App. LEXIS 437, at \*16-17 (Tenn. Ct. App. July 7, 1999) (affirming trial court’s ruling that the evidence supported a claim of ordinary negligence); *Cafarelle v. Brockton Oaks CVS, Inc.*, No. 94-0414A, 1996 Mass. Super. LEXIS 421, at \*8 (Mass. Dist. Ct. Apr. 1996) (“Because of the dangers involved in the drug business, due care for a pharmacist requires the highest degree of prudence, thoughtfulness, vigilance, and exact and reliable safeguards”); *Clair v. Paris Road Drugs, Inc.*, 573 So.2d 1219, 1225 (La. Ct. App. 1991) (“We also recognize that, because of the duties attendant to their profession, a high degree of care is placed on pharmacists.”). See

Absent a conscience clause, pharmacists are liable for refusing to fill a prescription for a non-gatekeeper reason. At issue in *Noesen v. State of Wisconsin Department of Regulation and Licensing, Pharmacy Examining Board*,<sup>163</sup> for example, was whether the pharmacist, Noesen, violated the standard of care when he refused to fill or transfer a prescription.<sup>164</sup> In *Noesen*, patient Renz took her birth control prescription to K-Mart, where Noesen was the on-duty pharmacist.<sup>165</sup> Noesen questioned Renz as to whether she needed the prescription for “contraceptive purposes.”<sup>166</sup> When Renz replied in the affirmative, Noesen advised her of his objection and refused to fill the prescription.<sup>167</sup> Ranz took her empty prescription package to Wal-Mart and the pharmacist at Wal-Mart called Noesen to transfer the prescription; Noesen refused.<sup>168</sup> Ranz successfully filled her prescription two days later—but only after missing her first dose.<sup>169</sup> Renz filed a complaint and administrative proceedings were instituted against Noesen.<sup>170</sup> The appellate court affirmed the Board’s conclusion that “Noesen violated the standard of care applicable to pharmacists when he refused to fill or transfer a patient’s prescription for an oral contraceptive.”<sup>171</sup>

Conscience clauses, in providing blanket protection from liability, acknowledge that pharmacists would otherwise be subject to liability. Arkansas’s statute, for example, provides: “No such institution, employee, agent, or physician shall be held liable for the refusal.”<sup>172</sup> Likewise, Florida’s statute provides: “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.”<sup>173</sup> As described in detail below, the conscience clauses effectively create a no-liability regime.

### *B. Application of Welfare Economics to the Basic Theory of Liability and Deterrence in a Unilateral Tort Model*

Kaplow and Shavell’s scholarship defines how welfare economics applies to

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*also* *Dee v. Wal-Mart Stores, Inc.*, 878 So.2d 426, 427 (Fla. Dist. Ct. App. 2004) (“When a pharmacy fills a prescription which is unreasonable on its face, even though it is lawful as written, it may breach this duty of care”); *Powers v. Thobani*, 903 So.2d 275, 278 (Fla. Dist. Ct. App. 2005) (“[F]actual circumstances exist under which negligence liability can be imposed on a pharmacy for failing to use due and proper care in filling prescriptions, even if the prescription is filled in accordance with the physician’s instruction.”).

163. 751 N.W.2d 385 (Wis. Ct. App. 2008).

164. *Id.* at 388.

165. *Id.* at 389.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Noesen*, 751 N.W.2d at 389.

170. *Id.*

171. *Id.* at 388.

172. ARK. CODE ANN. § 20-16-304(5) (West 2010).

173. FLA. STAT. ANN. § 381.0051(6) (West 2001); *see also*, MISS. CODE ANN. § 41-107-5(1) (West 2010).

tort law.<sup>174</sup> The application of welfare economics to evaluate social policy involves two steps: (1) apply a positive analysis to determine the effects of the policy; and (2) engage in a normative analysis to determine the policy's social desirability.<sup>175</sup> "The hallmark of welfare economics is that policies are assessed exclusively in terms of their effects on the well-being of individuals."<sup>176</sup> In promoting the application of welfare economics over the use of fairness, Kaplow and Shavell explain:

[A]ny notion of fairness would be subject to our criticism: employing welfare economics always entails choosing the rule under which everyone is better off than under each of the alternatives; hence, any deviation from the attempt to enhance individual's well-being—in whatever setting—entails the result that everyone must be worse off. This conclusion is true whether the notion of fairness rests on a need for compensation, a demand for punishment, a desire to realize corrective justice, or any other basis. Moreover, this conclusion is true for any mixed view, under which weight is given both to a notion of fairness and to individuals' well-being; as long as any weight is a notion of fairness, one will sometimes be led to choose a different legal rule from that under welfare economics, and in every such instance, all individuals will be made worse off.<sup>177</sup>

Thus, welfare economics analyzes the net maximization of social well-being.

In his recent scholarship, Shavell describes the application of welfare economics to tort law in a unilateral accident model. Shavell's analysis describes how to minimize the sum of the costs of care and of expected accident losses, which equal the total social costs.<sup>178</sup> A unilateral accident occurs when only the injurer's exercise of care affects the accident risk.<sup>179</sup> A close approximation of this is where an automobile hits a pedestrian; it is unilateral because the pedestrian's actions are minor and have almost no effect on reducing risk.<sup>180</sup> In this type of situation, the optimal social welfare occurs where the level of care minimizes the total social costs.<sup>181</sup> The three scenarios under which to discuss the optimal social welfare in a unilateral accident model are: (1) no-liability; (2) negligence; and (3) strict liability. A theoretical analysis of the social costs under these three regimes demonstrates how each scenario affects social welfare.

First, Shavell provides an analysis of the *level of due care* of the injurer, e.g.,

174. See generally KAPLOW & SHAVELL, *supra* note 156.

175. Louis Kaplow & Steven Shavell, *Fairness Versus Welfare*, 114 HARV. L. REV. 961, 977 (2000-01) [hereinafter *Fairness Versus Welfare*]; see also E.J. MISHAN, COST-BENEFIT ANALYSIS 386 (2d ed. 1976) (discussing the use of Pareto improvement in the application of welfare economics: "A Pareto improvement takes place if some economic rearrangement makes one or more people better off without making anyone worse off").

176. *Fairness Versus Welfare*, *supra* note 175.

177. KAPLOW & SHAVELL, *supra* note 156, at 105.

178. STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 177-99 (2004) [hereinafter FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW].

179. *Id.* at 178. See also *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947) (defining what is known as the Learned Hand theory of liability: "[I]f the probability be called P; the injury, L; and the burden, B; liability depends upon whether B is less than L multiplied by P: i.e., whether B [is less than] PL").

180. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 178.

181. *Id.* at 178-79.

the driver of the automobile, in the unilateral model.<sup>182</sup> Under a no liability regime, injurers will not exercise any level of care because, although there are costs, there is no benefit to the injurer to exercise care.<sup>183</sup> At the other end of the spectrum, under a strict liability regime, injurers must pay for all accident losses that they cause.<sup>184</sup> Here, the injurers will exercise the level of care that is identical to the social goal of minimizing total social costs.<sup>185</sup> Under a negligence regime, the injurer will be liable only for accident losses caused by the injurer where the injurer failed to exercise a level of due care as defined by the courts.<sup>186</sup> Thus, the injurer would not take care above the level of due care as defined by the courts or a statute because there is no advantage for the injurer to do so.<sup>187</sup>

Second, Shavell provides an analysis of the *level of activity* of the injurer in a unilateral tort model.<sup>188</sup> Under a no liability regime, the injurer engages in the amount of activity that gives them the greatest utility without consideration of the social costs.<sup>189</sup> In a strict liability regime, the injurer will choose the optimal level of activity because he or she will enjoy the benefits of the activity, but still has to pay the social costs.<sup>190</sup> Under a negligence regime, injurers “will engage in their activity whenever the utility they derive net of the cost of care is positive.”<sup>191</sup> For social welfare to be maximized, an injurer must choose a level of due care and select a level of activity that “appropriately balances the utility he obtains against the additional risks he creates and the costs of care.”<sup>192</sup> The law will establish the standard of care so that the injurer can calculate and appropriately balance his or her behavior.

Although it appears from the above analysis that strict liability will always lead to the maximum social welfare in a unilateral situation, this is not always the case. The defect of the negligence rule, which can lead to excessive activity levels, must depend on the magnitude of the losses caused by the activity.<sup>193</sup> That is, if an activity is extremely hazardous—such as blasting—then strict liability is appropriate because of the high risk of harm despite the use of all reasonable care.<sup>194</sup> If, however, the activity creates a low risk of accident losses when reasonable care is taken, then the importance of excessive activity under a negligence rule will be minimal.<sup>195</sup>

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182. *Id.* at 178-82.

183. *Id.* at 179.

184. *Id.* at 179-80.

185. *Id.* at 179-80.

186. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 180.

187. *Id.*

188. *Id.* at 193-99.

189. *Id.* at 195.

190. *Id.* at 196.

191. *Id.*

192. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 194.

193. *Id.* at 197.

194. *Id.* at 197-98; *cf.* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 20 (2010) (defining the application of strict liability).

195. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 197-98.

C. *Pharmacist Conscience Clauses—An Economic Approach*

Described below is an argument that pharmacist conscience clauses can be analyzed under a unilateral tort model.<sup>196</sup> To analogize pharmacist conscience clauses to Shavell's unilateral tort model: The injurers are the refusing pharmacists and the victims are the patients who are not able to receive their prescription from the pharmacist. The refusing pharmacist is the injurer because when an individual decides to become a pharmacist they know an integral part of that job is to fill valid prescriptions.<sup>197</sup> If a person does not want to fill prescriptions, then they never have to become a pharmacist.<sup>198</sup> The harm only flows from the refusing pharmacist to the patient when the pharmacist refuses to fill a prescription.

Here, the injurers (i.e., refusing pharmacists) and victims (i.e., patients) are distinct groups and the well-being of each group may be different.<sup>199</sup> These two groups will have different preferences—the pharmacists may prefer a rule of no liability,<sup>200</sup> whereas the victims may prefer a rule of strict liability.<sup>201</sup> The economic goal is to maximize social utility. Under this model, what is gained by the patients is lost by the pharmacists who would choose the liability protection for refusing to fill prescriptions.<sup>202</sup>

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196. This Article descriptively applies welfare economics to pharmacist conscience clauses in a unilateral tort model to demonstrate how welfare economics can be applied to the debate. The Author acknowledges that other models may be utilized to analyze pharmacist conscience clauses through the use of welfare economics. The purpose here, however, is to demonstrate that an economic approach—as opposed to fairness arguments—offers an attractive alternative to the current debate.

197. See Cicconi, *supra* note 57, at 723. Cf. Harrington, *supra* note 40, at 804-09 (discussing whether there is a duty of the pharmacist to dispense medication).

198. This Article does not fully consider whether this may raise an autonomy issue. Instead, this Article views the decision not to become a pharmacist as equal to reasons why many people do not enter certain professions. For example, some groups are opposed to blood transfusions; thus, one may suspect that people in these groups do not become surgeons. The main point is that individuals know, *ex ante*, requirements for certain professions. If an individual does not or cannot satisfy the basic requirements of a profession, then that individual knows that they should consider a different profession.

199. KAPLOW & SHAVELL, *supra* note 156, at 118.

200. Indeed, not all pharmacists will prefer this as many pharmacists may be against conscience clause legislation. Another point where there is room for debate, is whether a pharmacist's preference to refuse to fill prescriptions could be considered an objectively bad preference and therefore the preference will have no value in an economic calculation. For example, in *NEW FOUNDATIONS OF COST-BENEFIT ANALYSIS*, Matthew Alder and Eric Posner provide an example of an objectively bad preference (here, a preference that "homosexuals not be helped through AIDS research") that would most likely not be considered by an agency applying a cost-benefit analysis. MATTHEW ALDER & ERIC POSNER, *NEW FOUNDATIONS OF COST-BENEFIT ANALYSIS* 129-30 (2006). Similarly, under conscience clause legislation, a pharmacist may escape liability for refusing to fill a prescription for HIV medications because the pharmacist is personally opposed to helping homosexuals. Thus, a debate about determining a value to assign to the objecting pharmacist's preferences should consider the above when applying a normative economic approach to conscience clause legislation. See *id.* at 139 ("We could imagine, for example, guidelines holding that preferences that are based on animus against racial minorities, women, and homosexuals would not be counted.").

201. KAPLOW & SHAVELL, *supra* note 156, at 118.

202. Again, an argument could be that the objecting pharmacist's preference should not be considered or given a low value. For example, if the analysis determines that a preference against, for example, people who oppose medication for persons infected with HIV is due to opposition to homosexuality and is considered an objectively bad preference, then this preference may be assigned a value of \$0. Or, perhaps, if a preference is not considered objectively bad, then the analysis could focus

Pharmacist conscience clauses operate to shield a refusing pharmacist from any and all liability should the pharmacist refuse to fill a prescription due to a personal or religious belief. These clauses can be descriptively analogized to the no care standard described above in the unilateral driving model. Under the pharmacist conscience clause regime, a refusing pharmacist will not exercise any level of care because there is no benefit to the injurer in doing so, even though there would be costs to the patient. Further, under the pharmacist conscience clause regime, a refusing pharmacist will engage in the amount of activity that gives them the greatest utility without any consideration of the social costs, such as failure to give a patient a time-sensitive prescription. “[A] regime of no liability, one that does not satisfy the notions of fairness that we consider, will be best for all individuals when liability does not influence precautions and is costly to administer.”<sup>203</sup> Here, pharmacist conscience clauses are not best for individuals’ well-being because liability does influence precautions. Under the no liability regime of a pharmacist conscience clause, the refusing pharmacist will not take any precautions to fill prescriptions that are against their religious beliefs, regardless of the cost to the patients, harm will occur, and the patients will bear the costs.<sup>204</sup>

Upon the theoretical demonstration that pharmacist conscience clauses can be analogized to a no-care regime, and may not maximize the well-being of individuals, the question becomes whether pharmacists should be held liable under negligence or strict liability for refusing to fill a valid prescription.<sup>205</sup>

Strict liability is most likely not the appropriate measure for the injurer’s liability with respect to pharmacist conscience clauses because this is not a situation where substantial risk is created despite the exercise of due care.<sup>206</sup> Strict liability is traditionally reserved for those activities—such as blasting—that cannot be made safe with any reasonable exercise of due care and the activity can be classified as one not of common usage.<sup>207</sup> An appropriate level of due care—i.e., liability for refusing to fill a valid prescription based on the pharmacist’s religious beliefs—can be assigned to support a negligence regime. That is, a court can establish a standard of due care that considers the gatekeeper functions of the

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on the costs associated with the affected person in obtaining the medication versus delaying or prohibiting obtaining the medication. See ALDER & POSNER, *supra* note 200, at 140 (describing how to handle objectively bad preferences in cost-benefit analysis). In their book, Adler and Posner acknowledge the potential problems with monetizing the costs and benefits of regulations given parties’ preferences. *Id.* at 149.

203. KAPLOW & SHAVELL, *supra* note 156, at 105 (footnote omitted).

204. *Cf. id.* at 102 (discussing a regime of no liability in a reciprocal accident paradigm).

205. The Author acknowledges that a stylistic model was applied for this determination. That is, that the failure of the patient to receive the medication is the main variable used to analyze the individual’s well-being. This restrictive assumption, however, allows for a simple model and is helpful to illustrate the problems associated with conscience clauses. See *id.* at 32 n.33. Further, this Article does not consider the distributional effect of moving money from the injurer to the victim as a variable that should influence the analysis. See FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 654-55 (explaining why “legal rules should generally not be chosen on the basis of their distributional effects”). This model assumes that the cost of precaution is lower than the cost associated with inducing the injurer to take care. See KAPLOW & SHAVELL, *supra* note 156, at 102-03.

206. See, e.g., FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 202.

207. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 20 (2010) (defining elements of abnormally dangerous activity).

pharmacist. Pharmacists can exercise the due care to meet the professional standards of their gatekeeper medical functions.

The negligence rule for pharmacists may be favored under welfare economics because a level of due care can be established that maximizes social welfare. The professional standard of care can be established by reference to a national standard or the state licensing provisions.

If the level of care is established by statute or regulation, state licensing boards can utilize an economic analysis to establish the standard of care that will be applied by the courts. Factors to be considered in the analysis to establish the professional standard of care in order to minimize social costs include: the likelihood of harm, the probable extent of harm, the number of individuals at risk, and the ease in which those causing injury can alleviate risk.<sup>208</sup> That is, the state licensing board can consider the above analysis and factors when establishing the requirements of professional conduct. This is important because some state licensing provisions are vague and may not effectively guide a court. For example, the statute governing pharmacists in Kansas provides: "Nothing in this section shall be construed as preventing a pharmacist from refusing to fill or refill any prescription if in the pharmacist's professional judgment and discretion such pharmacist is of the opinion that it should not be filled or refilled."<sup>209</sup> Under the Kansas provision, a court would likely have a difficult time discerning the standard of care for determining when it is reasonable for a pharmacist to refuse to fill a prescription. The statute is not clear as to what is encompassed within "professional judgment and discretion." Pharmacists, as professionals, are trained in pharmacology. As long as the drug does not pose any pharmacological risk to the health and safety of the patient, then should anything other than professional judgment be considered? State policymakers can apply welfare economics to define professional conduct in such a way that a court can apply the specific standard of care to a pharmacist who is facing a claim of professional negligence. Alternatively, it may be that state licensing boards prefer to have matters regarding professional conduct adjudicated in administrative proceedings, with review by appellate courts.<sup>210</sup> In either case, the state licensing board can apply welfare economics to define professional and unprofessional conduct.<sup>211</sup>

Another dimension to consider is whether the victims could or should exercise any level of care. If a patient receives a prescription from their physician and travels to a pharmacy to fill it, it does not seem as though the victim can adjust their behavior to avoid accident losses. Here, the pharmacists and pharmacies are in the

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208. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 191 (discussing determination of due care).

209. KAN. STAT. ANN. § 65-1637 (2009).

210. *See, e.g., Noesen*, 751 N.W.2d 385; *cf. ALDER & POSNER, supra* note 200, at 2 ("To simplify greatly, cost-benefit analysis (CBA) requires the regulatory agency to sum up the costs and benefits of a proposed regulation, and issue the regulation if the benefits exceed the costs.").

211. It is unclear whether it is more cost effective to have the courts perform analyses based on the facts in front of them or to have each state conduct a cost benefit analysis when determining the state licensing regulations. A full scale cost-benefit analysis may be too expensive for a state to consider because at some point it becomes so expensive there are diminishing returns. *ALDER & POSNER, supra* note 200, at 109.

best—if not the only—position to avoid the losses.<sup>212</sup> The injurers are the only party that can take the precaution to fill all valid and legal prescriptions in order to minimize total social costs.<sup>213</sup>

Under the above analysis, the application of welfare economics demonstrates that negligence is the appropriate regime. Another advantage to the application of welfare economics to analyze conscience clause legislation is transparency in decision-making.<sup>214</sup> Liability for refusal to fill valid prescriptions allows the pharmacists to know, *ex ante*, the consequences of not serving as a gatekeeper and refusing to fill the prescription due to religious or personal beliefs.<sup>215</sup>

The theoretical model outlined above demonstrates that pharmacist conscience clauses create a no-liability regime that fails to maximize individuals' well-being.<sup>216</sup> An empirical model could be created to predict the economic costs resulting from conscience clause legislation. Rural communities, for example, may have high costs associated with a pharmacist's refusal to fill a prescription. Low income persons in rural communities may not have access to transportation or the ability to take time away from work to travel to neighboring communities to fill prescriptions.<sup>217</sup> Notably, it is states such as South Dakota and Mississippi—with higher percentages of low income and rural communities—that have conscience clause legislation.<sup>218</sup> The 2000 Census data shows that both South Dakota and Mississippi are largely rural states.<sup>219</sup> A recent government survey looking at state-by-state poverty levels calculates that 13.9% of citizens in South Dakota are under the poverty level and 19.9% of citizens in Mississippi are below the poverty level.<sup>220</sup> Citizens in these states will potentially face a higher degree of difficulty when attempting to fill prescriptions initially refused by their local pharmacist.

By assigning values in the economic calculus, and employing the economic tests of Pareto improvement or Kalder-Hicks, conscience clause legislation can be evaluated to determine if it maximizes individuals' well-being as compared to an absence of such legislation. A potential Pareto improvement can be obtained

212. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 189.

213. *Id.* Social costs are defined as the sum of the costs of care and of expected accident losses. *Id.* at 177-99.

214. *See, e.g.*, ALDER & POSNER, *supra* note 200, at 135 (“CBA enhances transparency by forcing agencies to use a common metric for justifying their decisions.”).

215. KAPLOW & SHAVELL, *supra* note 156, at 49 (“[N]otions of fairness often ignore important aspects of *ex ante* behavior.”).

216. FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW, *supra* note 178, at 663; *see also* MISHAN, *supra* note 175, at 412-13 (maintaining that cost-benefit analysis is a useful technique for determinations of social policy, although it has certain limitations).

217. Tomkowiak, *supra* note 8, at 1349-50.

218. Teliska, *supra* note 32, at 241 (looking at the legislative trend in pharmacist refusal clauses in South Dakota).

219. *Id.* at 244-46 (discussing the results of the 2000 Census); *see also* U.S. Census Bureau, *State and County Quick Facts*, <http://quickfacts.census.gov/qfd/states/28000.html> (last visited Nov. 11, 2010) (for census information).

220. U.S. Census Bureau, *Percent of People Below Poverty Level in the Past 12 Months (For Whom Poverty Status is Determined): 2008*, [http://factfinder.census.gov/servlet/ThematicMapFramesetServlet?\\_bm=y&-geo\\_id=01000US&-tm\\_name=ACS\\_2008\\_3YR\\_G00\\_M00601&-ds\\_name=ACS\\_2008\\_3YR\\_G00\\_&-\\_MapEvent=displayBy&-\\_dBy=040&-\\_lang=en&-\\_sse=on](http://factfinder.census.gov/servlet/ThematicMapFramesetServlet?_bm=y&-geo_id=01000US&-tm_name=ACS_2008_3YR_G00_M00601&-ds_name=ACS_2008_3YR_G00_&-_MapEvent=displayBy&-_dBy=040&-_lang=en&-_sse=on) (last visited Nov. 11, 2010).



where the “gains *can* be so distributed as to make everyone in the community better off.”<sup>221</sup> Some law and economics scholars refer to the potential Pareto improvement as the Kalder-Hicks test, which relaxes the rigor of the strict Pareto test by analyzing whether the benefits gained from a particular project or regulation are enough that they can compensate the losers and still have some left over for themselves—although no actual compensation is required.<sup>222</sup>

In sum, the theoretical application of welfare economics to the protection from liability under the conscience clause—which is analogous to a no-duty regime under tort law—does not appear to be supported by the normative economic approach of welfare economics due to a failure to maximize individuals’ well-being.

#### D. A Pre-Emptive Response to Deontological Concerns

In brief, this section addresses potential critiques of the application of welfare economics to resolve the pharmacist conscience clause issue. Some legal scholars question the application of economic analysis to policy questions that arguably contain moral factors or moral evaluations.<sup>223</sup> In their scholarship, Eyal Zamir and Barak Medina explain:

[D]eontological theories view the goodness of outcomes as a morally relevant factor, but not as the only inherently important one . . . . They contain constraints on attaining the best outcomes and at the same time allow people to (sometimes) pursue their own interests and the interests of people dear to them or belonging to their group, even if such a pursuit conflicts with attaining the overall good.<sup>224</sup>

Scholarship in this area analyzes the conflict between economic efficiency analysis, which looks to individuals’ well-being, and deontological analysis, which maintains that an individual’s interest should be pursued even if it conflicts with obtaining the overall maximization of social welfare.<sup>225</sup>

Applied to pharmacist conscience clauses, a deontological argument could be that a refusing pharmacist’s religious views that birth control or drugs developed through stem-cell research are morally wrong and that no dollar or utility value can or should be applied to this personal viewpoint in order to conduct an economic

221. See MISHAN, *supra* note 175, at 386, 390; see also ALDER & POSNER, *supra* note 200, at 6. Our argument is that CBA is best defended as a *welfarist* decision procedure. Cost-benefit analysis is justified as a decision procedure to the extent that it advances overall well-being—that is, the well-being of the public generally, if not necessarily every member of the public—relative to alternative decision procedures, including the null case of doing nothing.  
*Id.*

222. ALDER & POSNER, *supra* note 200, at 10-11, 22.

223. See Richard S. Markovits, *On the Relevance of Economic Efficiency Conclusions*, 29 FLA. ST. U. L. REV. 1, 26-34 (2001) (arguing deficiencies of the application of economic-efficiency analysis); Eyal Zamir & Barak Medina, *Law, Morality, and Economics: Integrating Moral Constraints with Economic Analysis of Law*, 96 CAL. L. REV. 323, 329-43 (2008) (critiquing consequentialism).

224. Zamir & Medina, *supra* note 223, at 343.

225. A large body of scholarship addresses the conflict between consequentialism and deontology. This debate is beyond the scope of this Article. This section of the Article is meant to show that a strict application of deontology does not necessarily negate the promotion of a negligence regime. Further, welfare economics can consider the preferences of pharmacists.

analysis. One response to this argument is that the application of welfare economics to determine whether pharmacist conscience clauses maximize individuals' well-being does not violate an individual's religious beliefs. Any adult who is opposed to birth control or drugs developed through stem cell research is not required to take the medication. That is, the application of welfare economics to pharmacist conscience clauses does not violate an individual's autonomy with respect to his or her personal feelings and values associated with these drugs. If a person is opposed to these types of drugs, he or she does not have to take the medication. Thus, the individual who is opposed to certain drugs can act in a way that maintains his or her moral integrity by choosing not to become a pharmacist and not to take certain drugs.<sup>226</sup> In this way, an objecting person's autonomy is preserved.<sup>227</sup> The preservation of autonomy, however, does not give an individual the right to impose his or her religious beliefs onto someone else.

Further, the decision to become a pharmacist is volitional. There is no requirement that any individual has to become a pharmacist. Ex ante, a person considering whether to become a pharmacist knows that part of the profession is dispensing FDA-approved drugs. Society could not function if every profession allowed exemptions for any and all moral beliefs.<sup>228</sup> As an analogy, it would be difficult to allow exemptions for a surgical resident, who is also a Jehovah's Witness, which allow the resident to refuse to provide a patient with a needed blood transfusion due to the resident's personal or religious beliefs.<sup>229</sup> It is unlikely

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226. See, e.g., Zamir & Medina, *supra* note 223, at 344 ("While consequentialism judges acts according to whether they bring about the best state of affairs, deontology judges acts according to whether the actors conduct themselves in ways that maintain their moral integrity.").

227. Some may argue that the autonomy of the pharmacist is restricted, for example, even if it is in choosing a profession. The Author thanks a colleague for raising this important issue. However, this problem can be addressed in a cost benefit analysis. To make an analogy, restrictions on places where persons are allowed to smoke affect a smoker's autonomy and ability to enjoy smoking. For a non-smoker, however, the restrictions on smoking may increase their enjoyment. As described in E.J. Misham's treatise on cost-benefit analysis, the smoker and non-smoker are not on equal footing: "In accordance with the liberal maxim, the freedom of any man, say, to smoke what he wants and where he wants is conceded-but along with the critical proviso that his smoking take place in circumstances which do not reduce the welfare of others." MISHAM, *supra* note 175, at 447. This rationale can be applied to pharmacist conscience clauses. One argument could be that even if the autonomy of choosing a profession is restricted because a pharmacist can be held liable for refusing to fill a prescription for a non-medical reason, the refusing pharmacist is not on equal footing with the patient that is refused their prescription because there is a reduction in the welfare of the patients.

228. Zamir & Medina, *supra* note 223, at 347. Zamir and Medina discuss the consequentialist response to the application of moderate deontology to personal moral theory versus the application to legal policymakers:

[I]t has been argued that the distinctions central to at least some versions of deontology, such as the doing/allowing and intending/foreseeing, are not relevant in the public sphere. This is because, unlike a private person, the state bears responsibility for the well-being of all, and because the motivations for collective and institutional decisions are often unclear and even conflicting.

*Id.* Zamir and Medina, however, do not support this argument. See *id.*

229. *Jehovah's Witnesses*, WIKIPEDIA, [http://en.wikipedia.org/wiki/Jehovah's\\_Witnesses](http://en.wikipedia.org/wiki/Jehovah's_Witnesses) (last visited Aug. 27, 2010) ("Jehovah's Witnesses are best known for their door-to-door preaching, distribution of literature such as *The Watchtower* and *Awake!*, and for their refusal of military service and blood transfusions even in life-threatening situations."). See also *Jehovah's Witness*, ENCYCLOPEDIA BRITANNICA, <http://www.britannica.com/EBchecked/topic/302393/Jehovahs-Witness> (last visited Nov. 11, 2010).

that a hospital or residency program would be required to accommodate the refusing resident's personal beliefs about blood transfusions. Indeed, this hypothetical supports the application of Title VII to employers such that employers are only required to accommodate an employee's religious beliefs so long as the accommodation is *de minimis*. Further, religious beliefs do not trump all other considerations. In addressing this issue, the Supreme Court has stated that states must adopt laws with a secular purpose.<sup>230</sup>

Deontological concerns may address the following problem. Suppose a small-town pharmacist, who is opposed to stem cell research, refuses to fill any prescriptions for a new medication for diabetes because the drug was developed through stem cell research. On the other hand, suppose 100 patients in this same small town are not able to obtain their diabetes medication. This scenario creates a deontological constraint. Whose moral position is more important? The pharmacist who doesn't want to fill the prescription or the patients who suffer—and maybe even die—because they cannot receive their medication?<sup>231</sup> Even if it is just one patient who cannot receive his or her medication, who is in a worse position—the patient or the pharmacist? Welfare economics can address this problem, to some extent, because the preferences of each side can be included in the calculation.<sup>232</sup>

A final note on this Article's brief response to potential philosophical concerns is that the law seeks to obtain practical results.<sup>233</sup> It is not that the religious concerns of the refusing pharmacists shouldn't be acknowledged, it's that the preferences of the pharmacists who want legal protection from liability for refusing to fill prescriptions should not bootstrap lawmakers and judges in cases where a refusing pharmacist interferes with a patient's right to FDA-approved medications.<sup>234</sup> Individuals' religious rights are protected under the First Amendment, but this does not mean the law must conform to every religious

230. See, e.g., *Edwards v. Aguillard*, 482 U.S. 578 (1987) (defining elements of the *Lemon* Test and reviewing Establishment Clause jurisprudence). Another argument, as discussed previously in Part V.C., could be made that the objecting pharmacist's preference is an objectively bad preference.

231. See, e.g., Kenneth W. Simmons, *Deontology, Negligence, Tort, and Crime*, 76 B.U. L. REV. 273, 292 n.68 (1996) (criticizing consequentialist arguments, but acknowledging potential deontological constraints).

232. Cf. ADLER & POSNER, *supra* note 200, at 156-57 (addressing deontological criticisms of cost-benefit analysis and conceding that cost-benefit analysis does not track deontological values. The authors state that cost-benefit analysis "is not a superprocedure" and that deontological "considerations (to the extent they exist) need to be brought to bear on agency choice through decision rules other than [cost-benefit analysis]").

One way to calculate the pharmacist's preference is to utilize the marginal value of the preference. That is, the first time a pharmacist refuses may have one value, but the second, third, etc. time may have less value. The Author thanks a colleague for suggesting the use of marginal value to calculate the pharmacist's preference.

233. See Michel Rosenfeld, *Pragmatism, Pluralism and Legal Interpretation: Posner's and Rorty's Justice Without Metaphysics Meets Hate Speech*, 18 CARDOZO L. REV. 97, 104-05 (1996) (discussing the difference between philosophy and law and stating that the law "must aim for workable solutions that make a real difference in the empirical world"). Cf. GUIDO CALABRESI & PHILIP BOBBIT, *TRAGIC CHOICES* 86-87 (1978) (discussing the application of nonmarket mechanisms to tragic choices).

234. Cf. Rosenfeld, *supra* note 233, at 111 (describing Posner's approach to pragmatism).

thought of any individual.<sup>235</sup> According to the theoretical application of welfare economics as described above, a negligence regime maximizes individuals' well-being.<sup>236</sup> As professionals—whether a doctor or a pharmacist—the best interest of the health and safety of the patient, according to standard medical practices, should be followed.

*E. Current Alternative Proposals Do Not Maximize Individuals' Well-Being*

As discussed in Part V, Section C, the common law, or state licensing provisions, can establish that the standard of care for pharmacists is to fill all valid and legal prescriptions—that is, the level of care is defined by the gatekeeper functions of the profession. A court may decide that the refusal to fill a prescription for religious reasons fails to meet the standard of care and hold a pharmacist liable for this refusal. Put differently, a pharmacist would fail to meet the professional standard of care should a pharmacist refuse to fill a prescription for any non-medical reason. The common law approach to tort liability should accomplish the goal of maximizing individuals' well-being in light of this standard.

Other proposals, as described below, promote alternative approaches to ensure that patients receive their prescription drugs. These proposals, however, contain certain practical problems that potentially make them less ideal than the common law negligence approach.

*1. Seamless Delivery*

One proposed policy is to place the burden on the pharmacy to require seamless delivery of all medications without the patient knowing that a particular pharmacist personally objects to use of the drug.<sup>237</sup> Described as 'stepping away' rather than 'stepping in the way,' this policy requires that a pharmacy establish a system where at least one pharmacist is on duty at all times who will fill all prescriptions.<sup>238</sup> A recent bill proposed in Pennsylvania would place the onus on pharmacies to ensure the seamless delivery of stocked drugs.<sup>239</sup> California enacted

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235. *Cf. id.*

236. This Article does not propose that an economic approach to any question of law will always be correct. It is possible and conceivable that an economic approach will have a result that is diametrically opposed to the preservation of certain rights. Arguably, any approach to law has limitations. *Cf. id.* at 122 (describing Posner's approach as looking to "the United States Constitution to curtail the most objectionable political redistributions and to rule out the most ethically reprehensible uses of wealth-maximization in common law adjudication").

237. Smearman, *supra* note 26, at 538 ("By requiring each pharmacy, rather than each pharmacist, to dispense the contraceptives, the regulation leaves room for the pharmacy to adopt procedures to accommodate an individual pharmacist who wishes to step aside when another pharmacist is available to fill the prescription.").

238. *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Comm. on Small Bus.*, 109th Cong. 11-12 (2005) (statement of Linda Garrelts MacLean, Clinical Assistant Professor of Pharmacotherapy, Washington State University). See also Greenberger & Vogelstein, *supra* note 4, at 1558 (proposing solutions); Tomkowiak, *supra* note 8, at 1348 (discussing so-called transfer provisions).

239. Access to Legal Pharmaceuticals Act, H.B. 2217, 189th Gen. Assemb. (Pa. 2005); Access to Legal Pharmaceuticals Act, S 1089 (Pa. 2006).

a statute addressing seamless delivery.<sup>240</sup> Likewise, legislation aimed at ensuring all valid prescriptions are filled by the pharmacy, as opposed to the pharmacist, has been introduced at the federal level.<sup>241</sup> These pieces of legislation attempt to adopt a middle ground whereby a prescription would be filled without delay and a patient would never know that a particular pharmacist may personally object to dispensing the medication.

At first glance, this appears to be a suitable compromise to all sides. Notions of fairness are satisfied: a pharmacist retains the right of refusing to dispense, yet the patient still receives the medication. In practice, however, seamless delivery is problematic.<sup>242</sup> First, it assumes that all pharmacies, including rural ones, will financially be able to support having multiple pharmacists on duty, if needed. Second, a pharmacy could decide that it only wants to have one pharmacist on duty at any given time and will therefore only hire a pharmacist who will fill all prescriptions. Potentially, a pharmacist with religious objections could argue that this constitutes religious discrimination—albeit this is probably a weak argument.<sup>243</sup> Third, logistical problems exist. For example, the pharmacist that will fill all prescriptions may be sick one day, or may need time away for personal reasons. Under this scenario, any particular pharmacy would need multiple back-up pharmacists to ensure the seamless delivery of drugs. Fourth, a pharmacy may determine that the requirement to always have one pharmacist on duty that will fill all prescriptions is too onerous and simply decide not to stock the controversial medications. For example, albeit under different circumstances, Wal-Mart decided not to carry EC.<sup>244</sup> Wal-Mart ultimately changed its policy, after pressure by state officials to sell EC.<sup>245</sup> No reason exists, however, not to believe that other pharmacies—particularly independent pharmacies in small towns—would opt to avoid the conflict altogether and refuse to carry certain drugs. Fifth, seamless delivery may be a particularly difficult solution in states that have laws giving pharmacists the legal authority to prescribe and dispense EC.<sup>246</sup> In these scenarios, patients are interviewed and counseled by a pharmacist. If the pharmacist agrees the patient meets the clinical criteria for EC, the pharmacist can write and fill the

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240. Cicconi, *supra* note 57, at 710 (describing California law).

241. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. §2(a) (2005). *See also* Cicconi, *supra* note 57, at 720 (2007) (describing the proposed federal legislation).

242. *See, e.g.*, Smearman, *supra* note 26, at 537 (footnote omitted) (“While the policy of ‘referrals and seamless access’ adopted in the APhA refusal clause has facial appeal, in practice it has proved impracticable because community pharmacists often work alone.”).

243. Herbe, *supra* note 17, at 93-94 (discussing how a plaintiff would be unlikely to overcome the defense of undue burden required in order to make a religious discrimination claim under Title VII of the Federal Civil Rights Act of 1964).

244. John Maniaci, Editorial, *Wal-Mart’s Phony Morality*, CHI. SUN-TIMES, July 11, 1999, at 19.

245. Michael Barbaro, *In Reversal, Wal-Mart Will Sell Contraceptive*, N.Y. TIMES, Mar. 4, 2006, at C4.

246. *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Comm. on Small Bus.*, 109th Cong. 11-12 (2005) [hereinafter *Freedom of Conscience Hearings*] (statement of Linda Garrelts MacLean, Clinical Assistant Professor of Pharmacotherapy, Washington State University). Professor MacLean stated that Alaska, California, Hawaii, Maine, New Hampshire, New Mexico, and Washington allow pharmacists to prescribe EC and that in 2005 similar legislation was introduced in Illinois, Kentucky, Maryland, Massachusetts, New Jersey, New York, Oregon, Texas, and Vermont. *Id.*

prescription.<sup>247</sup> This system is an important step forward for women who need EC because of the time-sensitivity of effectiveness of the medication. It also, however, expands the role of the pharmacist and potentially increases all the burdens discussed above on a pharmacy to ensure that a pharmacist is on duty at all times to prescribe and dispense all medications.

Seamless delivery also feeds into the problem associated with expansion of conscience clauses as applied to drugs developed through controversial biomedical research. Some pharmacists may not be willing to fill prescriptions for assisted suicide, while others object to birth control, while others in the future may object to newly discovered drugs developed through stem cell research. Pharmacies may end up in a quagmire and find it too difficult to have pharmacists on duty at all times to dispense drugs for all medications. This makes the decision not to carry controversial medications a more attractive choice for these pharmacies.

The seamless delivery proposal exemplifies where a policy decision solely consisting of notions of fairness does not necessarily maximize individuals' well-being. Upon an examination of the potential practical problems that can be encountered with a system of seamless delivery, it appears that the patients continue to be the injured party and the refusing pharmacists continue as the injuring party, resembling the problems associated with a no-liability regime as described above.

Welfare economics would not support seamless delivery because it reduces individuals' well-being. That is, proponents of seamless delivery consider the preferences of the pharmacist who does not want to face liability for refusing to fill a prescription. The objecting pharmacist's preference, however, has a detrimental impact on the well-being of the patients who will have de facto difficulty in filling prescriptions, as described above.<sup>248</sup> Thus, the aggregate benefit to social welfare of having prescriptions filled will greatly exceed any gain to the refusing pharmacist.<sup>249</sup> In sum, the practical problems with seamless delivery mimic the no-liability regime of conscience clauses—a policy that is not supported by welfare economics.

## 2. Duty-to-Fill Legislation

Duty-to-fill legislation requires all pharmacies and pharmacists to dispense legal prescriptions.<sup>250</sup> This type of legislation allows the pharmacists to know, ex ante, the potential consequences of their actions should they refuse to fill a prescription due to personal or religious beliefs.<sup>251</sup> That is, the duty-to-fill legislation allows the pharmacists to select the level of care to take—knowing the

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247. *Id.*

248. *See, e.g.,* KAPLOW & SHAVELL, *supra* note 156, at 427:

[A] complete welfare economic analysis of many of the preferences that are generally believed to be objectionable will not ordinarily lead one to favor policies that satisfy such preferences. The reason is that the detrimental effects of so doing—reductions in other individuals' well-being and often, in the long run, the well-being of those with the objectionable preferences—will tend to outweigh the benefits of satisfying such preferences.

249. *Id.* at 429.

250. *See Freedom of Conscience Hearings, supra* note 248.

251. KAPLOW & SHAVELL, *supra* note 156, at 49.

consequences of their actions.<sup>252</sup>

Although the application of welfare economics in the above theoretical model demonstrates that a common law negligence regime can maximize individuals' well-being, some states have reacted to the idea that a pharmacist may escape liability for refusing to fill prescriptions by enacting rules that statutorily establish liability for refusing pharmacists. Under the theoretical model of pharmacist liability as proposed in this Article, statutory duty-to-fill legislation is not needed unless: (1) the states refuse to repeal already enacted pharmacist conscience clause legislation; (2) the states continue to enact conscience clause legislation; or (3) the courts or state licensing boards do not want to apply welfare economics to determine the standard of care.<sup>253</sup> In any event, a discussion of duty-to-fill legislation is warranted in consideration of the existence any of the above scenarios.

As mentioned earlier, some states have duty-to-fill rules. Illinois, for example, issued an emergency duty-to-fill rule after a pharmacist in downtown Chicago refused to fill a prescription for a contraceptive.<sup>254</sup> The Governor stated that "[o]ur regulation says that if a woman goes to a pharmacy with a prescription for birth control, the pharmacy is not allowed to discriminate against who they sell it to and who they don't . . . . No delays. No hassles. No lectures. Just fill the prescription."<sup>255</sup> Specifically, the Governor said he was taking a stand against a growing trend of anti-choice pharmacists.<sup>256</sup> This policy is a way to ensure that all legal prescriptions are filled,<sup>257</sup> however, it does not require the pharmacy to carry the medication at issue.

Opponents of duty-to-fill legislation argue that it turns pharmacists into robots that are required to fill all prescriptions, without respect to their gatekeeper function.<sup>258</sup> They argue that pharmacists would have to fill all legal prescriptions without delay regardless of whether the pharmacist detects potential allergies or

252. *Id.* ("Accordingly, ex ante behavior, all of its possible outcomes, and the potential effects of legal rules thereon are central features that are examined under welfare economic analysis").

253. Perhaps duty-to-fill legislation, or similar legislation that grants regulatory authority in the same vein, would satisfy the philosophical concerns raised in Part V, Section D. Scholarship in the area notes that an economic approach to law may be in friction with an automatic wealth-maximizing outcome. In these cases, policymakers may turn to regulations. *See, e.g.,* Rosenfeld, *supra* note 233, at 118, observing:

In practice, however, one cannot remain within the frictionless world of perfect markets in which law is merely facilitative and where outcomes are automatically wealth-maximizing. Instead, frictions are inevitable, littering the path to wealth-maximization with serious obstacles, making it necessary to appeal to regulative law, and raising for the first time significant questions concerning distributive justice.

Duty-to-fill legislation or a related regulation is similar to a "rule-utilitarianism" approach. *See also* GUIDO CALABRESI & PHILIP BOBBIT, *TRAGIC CHOICES* 86-87 (1973) (discussing the application of nonmarket mechanisms).

254. Pallasch, *supra* note 62 ("Gov. Blagojevich issued an emergency rule Friday compelling pharmacists to dispense contraceptives even if they believe the drugs kill the unborn.").

255. *Id.*

256. *Id.*

257. Tomkowiak, *supra* note 8, at 1350-55 (recommending "duty to dispense" laws).

258. *Freedom of Conscience Hearings*, *supra* note 248. ("If the pharmacist's role were merely to dispense lawfully prescribed medicines, that robot or automation would fit the bill.").

adverse drug-related interactions.<sup>259</sup> This argument in opposition to duty-to-fill legislation is a red herring. It does not impact the importance of applying pharmacological knowledge of drug allergies and interactions. Indeed, as these concerns were presented to the Illinois Governor and the Illinois Department of Financial and Professional Regulation, they issued a clarification statement that the duty-to-fill rule was not to interfere with a pharmacist's responsibility to conduct a utilization review.<sup>260</sup>

The language of duty-to-fill legislation can easily be drafted to ensure the gatekeeper function of a pharmacist is not compromised. The Pharmacy Consumer Protection Act of 2005, introduced in the Federal Senate, for example, directly addresses the obligation to fill valid prescriptions, while protecting the gatekeeper function:

The pharmacy ensures that each valid prescription is filled with unnecessary delay or other interference, consistent with the normal timeframe for filling prescriptions [and] . . . [n]othing in this section shall prohibit a pharmacy from refusing to dispense a prescribed item, in accordance with standard pharmacy practice, if there is a valid medical concern that such prescribed item will cause problems due to therapeutic duplications, drug-disease contraindications, drug interactions (including serious interactions with prescription or over-the-counter medications), incorrect dosage or duration of drug treatment, drug-allergy interactions, or drug abuse or misuse. Any refusal to dispense a prescribed item must be based on generally accepted practice among health care providers.<sup>261</sup>

In this way, the professional gatekeeper function is protected and the patient receives the prescribed medication.<sup>262</sup>

If, however, states refuse to repeal pharmacist conscience clause legislation and continue to pass pharmacist conscience clause legislation, the federal government may need to enact duty-to-fill legislation to pre-empt state behavior. That is, the state conscience clause legislation will carve out an exception to the common law approach of the application of a professional standard of care. If this is the case, then the current duty-to-fill legislation proposed at the federal level should contain additional safeguards.

Although a step in the right direction, duty-to-fill legislation must place an obligation on a pharmacy to carry any controversial medication. The duty-to-fill legislation proposed in the Federal Senate, for example, includes a provision that the pharmacy must ensure that it orders an item that is not in stock or transfer the prescription.<sup>263</sup> Any duty-to-fill legislation, however, should include language that a pharmacy cannot refuse to stock or order drugs due to any personal or religious beliefs. This proposed addition maximizes individuals' well being because the

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259. *Id.*

260. *Id.*

261. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. §§ 2(a), (c) (2005). This legislation places the burden on the pharmacy and it may face similar practical problems as discussed with seamless delivery in Part V.E.1.

262. *Cf.* Smearman, *supra* note 26, at 510-11 (discussing why the duty to warn has not shifted from physician to pharmacist and stating that “[c]ourts addressing this issue emphasize that pharmacists are not qualified to evaluate the soundness of a physician’s choice of a drug regimen for a patient”).

263. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. §2(a) (2005).



pharmacies could also be the injuring party.

This is an important point because Catholic hospitals are the largest group of non-profit hospitals and are often the only hospital in rural areas.<sup>264</sup> Many Catholic hospitals adhere to religious doctrines when establishing policies, including performing abortions or providing EC to rape victims.<sup>265</sup> A study of Catholic hospitals showed that only 28% provided EC to rape victims.<sup>266</sup> This is an alarming statistic considering the American Medical Association considers EC to be standard care for a rape victim.<sup>267</sup> By amending any duty-to-fill legislation to set the standard of care to include a requirement that a pharmacy must stock or order all FDA approved medications, both the pharmacy and the pharmacist can face liability for refusing to fill a valid prescription due to any non-medical reason.

Further, any duty-to-fill legislation should include a private cause of action.<sup>268</sup> If the states continue to adopt, enact and/or enforce pharmacist conscience clause legislation, then the federal government will need to enact duty-to-fill legislation to pre-empt state behavior. In this way, both the government and the citizens can monitor the proper enforcement of this legislation.

In some respects, a pharmacist conscience clause that stops any patient—male or female—from filling a prescription exemplifies and amplifies that patients are injured by this legislation. To date it is women who are overwhelmingly affected by conscience clause legislation because it is women who fill prescriptions for contraceptives and EC.<sup>269</sup> Historically, women gained equal rights through the Equal Protection and Due Process Clauses.<sup>270</sup> Once men are refused prescriptions for diabetes, Alzheimer's, Parkinson's, and heart disease, the debate surrounding conscience clause legislation will raise issues that are no longer based on reproductive rights, women's rights, or only affect a subset of the population. These types of difficulties can be included in the normative application of welfare economics.

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264. Eisenstadt, *supra* note 32, at 137 (describing the expansion of Catholic hospitals); Skeeles, *supra* note 155, at 1011 (“Catholic hospitals constitute the largest group of health care providers in the United States”); Smearman, *supra* note 26, at 485.

265. Eisenstadt, *supra* note 32, at 138 (describing how hospitals follow religious doctrine when instituting policies); Fogel & Rivera, *supra* note 159, at 740-41 (describing how a broad range of services are unavailable at religious hospitals).

266. Weiss, *supra* note 18, at 4 (describing the study of rape victims' access to EC in emergency rooms).

267. American Medical Association, ACCESS TO EMERGENCY CONTRACEPTION 27 (2008), available at [http://www.ama-assn.org/ama1/pub/upload/mm/386/vio\\_policy\\_comp.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/386/vio_policy_comp.pdf) (last visited Nov. 11, 2010).

268. The Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005) contains a private cause of action. The findings for this legislation, however, could potentially be limited to contraception. A bill that is passed should include all FDA approved medications and contain a private cause of action for an aggrieved individual.

269. Tomkowiak, *supra* note 8, at 1347 (“Likewise, one hundred percent of the patients directly affected by pharmacist refusal clauses are women.”). See also Vokes, *supra* note 16, at 402-03 (2006) (“Nearly one third of all women in the United States who use some sort of contraception method are on birth control pills; over eleven million women use birth control as their regular method of contraception.”).

270. See, e.g., American Civil Liberties Union, *Tribute: The Legacy of Ruth Bader Ginsberg and WRP Staff*, (Mar. 7, 2006), <http://www.aclu.org/womensrights/gen/24412pub20060307.html> (last visited Nov. 11, 2010).

## VI. CONCLUSION

The ramifications of conscience clause legislation run far beyond the number of instances of refusals to fill prescriptions or the desire to accommodate pharmacists who are personally against specific medications. This type of legislation could be expanded to many other drugs and areas of research and it does not have a net benefit to social welfare.

An analysis of pharmacist conscience clauses is particularly ripe at this time as the Obama Administration recently announced its support for the federal funding of embryonic stem cell research. Expansive pharmacist conscience clause legislation could protect pharmacists who refuse to fill prescriptions for drugs developed through stem cell research.

Legal scholarship in this area debates the fairness of conscience clauses. The debate appears to be at an impasse and is, in any event, unsatisfying. This Article proposes the application of welfare economics as the guiding principle in policy determinations and presents an alternative approach to the current debate surrounding pharmacist conscience clauses.

The theoretical application of welfare economics demonstrates that pharmacist conscience clause legislation may not maximize individuals' well-being. A common law approach, whereby a pharmacist may be held liable for refusing to fill a prescription for a non-medical reason, most likely can reach the appropriate balance to minimize total social costs. If however, states refuse to repeal pharmacist conscience clause legislation or states continue to pass pharmacist conscience clause legislation, duty-to-fill legislation, which places a statutory duty on pharmacies or pharmacists to fill valid prescriptions, may be needed. If this is the case, duty-to-fill legislation should include a provision that pharmacies cannot refuse to carry any FDA approved medication due to any religious or personal objections.

Importantly, duty-to-fill legislation does not alter any of the professional responsibilities and gatekeeper functions of a pharmacist. The pharmacist's job to ensure the prescription is valid and legal remains. The expertise required for drug allergies or interactions is still a critical component of the profession. Interesting to note in this debate is that the word science is within the word *conscience*.

