Harm or Mere Inconvenience? Denying Women Emergency Contraception

CAROLYN McLEOD

This paper addresses the likely impact on women of being denied emergency contraception (EC) by pharmacists who conscientiously refuse to provide it. A common view—defended by Elizabeth Fenton and Loren Lomasky, among others—is that these refusals inconvenience rather than harm women so long as the women can easily get EC somewhere else nearby. I argue from a feminist perspective that the refusals harm women even when they can easily get EC somewhere else nearby.

Conscientious refusals by health-care professionals have become a serious moral issue. One U.S. commentator names the issue the "San Andreas Fault of [U.S.] culture . . . How we decide this is going to have a long-lasting impact on our society" (Stein 2006). The impact, good or bad, will be most severe on parties who are directly involved in conflicts of conscience in health care: namely, patients who are denied standard services, and professionals who conscientiously object to providing them. There has been much discussion in bioethics about what is at stake when dealing with conflicts of conscience in health care for the professionals who object.[1] There has been comparatively little attention paid, however, to what's at stake for the patients who are denied treatment. Obviously, patients will not get the services they seek from the objecting professionals if these professionals are permitted to object. But as commentators often point out—in discussions about conscientious objection in *reproductive* health care in particular—the patients could simply go to another clinic or hospital to get the care they need, especially if they live in an area where the relevant services are available somewhere else. The conclusion we are invited to accept is that these patients are merely inconvenienced rather than harmed when they encounter a conscientiously objecting professional. I argue in this paper that this claim about inconvenience is seriously mistaken.

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The sorts of generalizations we can make about the impact on patients of being denied standard health-care services will depend, in part, on the service in question. I focus on the consequences for women of being denied access to emergency contraception (EC) by pharmacists. I choose this particular topic because the claim that these women are merely inconvenienced is common and is defended in print by some theorists (even some who have no moral qualms about EC). The best defense of this view that I know of comes from Elizabeth Fenton and Loren Lomasky (2005) (hereafter "F&L"). Contra F&L, I say that it is more plausible to conclude that women who are denied EC are harmed rather than merely inconvenienced,[2] *even if* they could get EC somewhere else nearby. Although my theory is specific to women who request EC, it has implications for how we understand the effects of conscientious refusals in reproductive health care on women more generally.

My discussion here is also relevant to deciding how we ought to resolve conflicts of conscience in reproductive health care. For it is easier to argue, as many bioethicists do, that the conscience of an objector in reproductive health care deserves substantial protection when the objector is only inconveniencing a patient rather than harming her. The moral conflict becomes more difficult to settle once we truly understand what the likely effects are of conscientious objections on female patients who want reproductive health care. I do not try to resolve these conflicts here; their dimensions, like those of the San Andreas Fault, are too vast to cope with in a short space. Rather, I simply deal with one side of these conflicts: that of women requesting care, and requesting EC specifically.

Mere Inconvenience for Most Women

Pro-life people who support pharmacists conscientiously objecting to EC tend to see women's ability to obtain EC as a matter of mere convenience, which allows them to deny the severity of conflicts of conscience in pharmaceutical practice. "Should one person's convenience trump another person's moral conscience? That's obnoxious, offensive and un-American," says one Catholic commentator (Laugminas 2005; cited in Vischer 2006, 93). Although they may not view such trumping as *obnoxious*, some liberal theorists who have no moral objection to EC agree that accessing it is a matter of convenience for most women; in being denied access, these women are inconvenienced, but not harmed. I have in mind in particular F&L (2005), but also Robert K. Vischer (2006).[3]

To be fair, F&L support some restrictions on the right of pharmacists to refuse conscientiously to provide EC, but they do not do so because they feel these refusals harm women. To explain why that is not their view, I will consider conditionals that they themselves do not construct but that they would

accept and that concern whether conscientious refusals by pharmacists harm women. Here are the conditionals:[4]

(1) If women who requested EC faced a true emergency, then being refused EC by a pharmacist would harm these women.
(2) If women who sought EC were entitled to get it from any pharmacist, because every pharmacist had a duty to dispense EC to any woman who makes a legitimate request for it, then being refused EC by a pharmacist would harm these women.
(3) If women who sought EC were entitled to get it from some pharmacists, because some but not all pharmacists have a duty to dispense EC, then being refused EC by one of the pharmacists who has this duty would harm these women.

F&L deny the antecedents of the first two conditionals (that women requesting EC face a true emergency and that every pharmacist has a duty to dispense). Moreover, they assume that the only way the consequent of harm could apply to *all* women who are refused EC is if the antecedent of either of these conditionals is true. (So there is harm to all of these women only if (i) there is a true emergency or (ii) each pharmacist has the above duty to dispense.) Since they believe that these antecedents are false, they must deny that all women who are refused EC are harmed as a result. At the same time, F&L accept that *some* women may be harmed by these refusals; for they would say that both the antecedent and consequent are true for conditional 3. I will argue that F&L employ an overly narrow conception of harm, though that even if this conception were correct, their reasoning against the claim that the refusals are always harmful is flawed.

But first, let me explain in some detail how F&L would respond to each conditional.

(1) If women who requested EC faced a true emergency, then being refused EC by a pharmacist would harm these women.

F&L would agree with this statement on the following grounds. Like other professionals, pharmacists are obligated to provide services in emergency situations (F&L 2005, 582). They would therefore be obligated to give women EC, and women would be entitled to receive it from them, if needing EC constituted a true emergency. When someone does not get that to which she is entitled, she is harmed. Denying women EC would therefore harm them.

However, F&L do not accept that women requesting EC face a true emergency or that it is legitimate for us to assume that they do. They write: "[S]o long as other sources are willing to step in, the case falls under the category of

convenience rather than emergency" (582). They go on to say that classifying the case as an emergency even when there are *no* other sources willing to step in is illegitimate. For, "whether averting an unwanted pregnancy can ever count as an emergency is precisely the crux of the parties' dispute. The pharmacist who insists on a right of conscientious refusal maintains that it is the nascent human life that is in dire jeopardy, not the prospective mother" (582). Thus, unless we are to decide the case in favor of the woman at the outset, we should avoid calling her situation an emergency. F&L suggest we should also acknowledge that the woman who is denied EC may not get pregnant anyway, or if she does, could have an abortion; and so there is no emergency in terms of her being forced to become a mother (582).

(2) If women who sought EC were entitled to get it from any pharmacist, because every pharmacist had a duty to dispense EC to any woman who makes a legitimate request for it, then being refused EC by a pharmacist would harm these women.

F&L would accept this conditional on the grounds that denying people that to which they are entitled harms them.

But F&L do not believe that every pharmacist has a duty to dispense EC to every woman who makes a legitimate request for it. They give two reasons: (1) as professionals, pharmacists enjoy the freedom to "choose whom to serve" (Arras 1988, 15),[5] at least in non-emergency situations; and this freedom is inconsistent with a duty to dispense (F&L 2005, 582). (2) As individual citizens, pharmacists have no duty to aid others, only a duty of noninterference (584).[6] This second, libertarian premise helps to bolster F&L's claim that women seeking EC are not entitled to get it from individual pharmacists on the grounds that there is an "individualized duty to treat" in pharmacy (Arras 1988, 18);[7] and hence, there could be no harm to these women that exists because of their being denied services to which they are entitled, again on these grounds.

F&L say that rather than being harmed, a woman who requests EC but is turned away is merely denied a benefit. In their words,

> [She] is . . . inconvenienced in pursuing her ends and may experience discomfort at being branded a moral transgressor, this at a time when she is especially vulnerable. Moreover, that vulnerability can be transformed, by refusal, into an unwanted pregnancy. But . . . these considerations nonetheless fall short of demonstrating the occurrence of an actionable harm. By refusing to enter into a transaction that the other party desires, one

> thereby *fails to provide a benefit* but [does] not . . . *inflict a liability* [that is, a harm] (F&L 2005, 583; their emphasis).

To continue with F&L's reasoning: one would inflict harm only if one were obliged to deal with the other party in a certain manner, yet refused to do so. But individual pharmacists are not obliged to accede to women's requests for EC. Thus, since women are not entitled to such aid from pharmacists, they are not harmed when pharmacists turn them away. The antecedent and the consequent of conditional 2 are both false.

> (3) If women who sought EC were entitled to get it from some pharmacists, because some but not all pharmacists have a duty to dispense EC, then being refused EC by one of the pharmacists who has this duty would harm these women.

F&L would accept this conditional for the same reasons that they would accept the last one. Moreover, they believe that *some* pharmacists are, or ought to be, duty-bound to dispense EC. The pharmacists they have in mind are those who work in rural areas or areas where it would be difficult for women to obtain EC unless some pharmacists were compelled to dispense it. There are two parts to F&L's argument here: Part 1 demonstrates that limiting the freedom pharmacists have to turn down potential clients can be legitimate, and Part 2 shows that such limits are appropriate only for some pharmacists.

Part 1 goes as follows: "When individuals confront one another as moral equals, they are not (barring exceptional circumstances) obliged to render more than simple noninterference with the projects of others" (F&L 2005, 585). But pharmacists and their clients are not "moral equals"; one is disadvantaged relative to the other. To explain, the regulatory regime that licenses pharmacists "restricts the liberty of . . . clients"—they cannot go to just anyone for drugs—yet it serves the liberty interests of pharmacists, who are shielded from competition, have greater employment security and income than they otherwise would, and so on (585). Pharmacists have a right to choose their clients; but "some limitation of [this] right . . . is justifiable compensation to [clients] for having their own domain of choice limited" (585). Pharmacists can therefore be compelled to cooperate with clients who seek services that the pharmacists themselves do not want to provide. The clients may be entitled to these services, in other words, even from pharmacists who object to them.

But Part 2 has F&L saying that "[p]harmacists' liberty interest in not being compelled to cooperate . . . with undertakings that they find morally distasteful should not be overridden if potential clients can easily avail themselves of other means for advancing their ends" (588). Thus, when women could easily go elsewhere to get EC they are not entitled to get it from an individual phar-

macist and so would not be harmed if one were to turn them away. Pharmacists working in geographical areas where EC is easy to come by therefore do not have a duty to dispense it, while pharmacists who are not in such areas do have this duty.

To summarize F&L's view, in being denied EC some women may be harmed, but not those who could easily get EC from another pharmacist. The latter would be harmed by these refusals only if they faced a true emergency or were entitled to get the drug from any pharmacist. But neither of these conditions holds. And therefore, at most these women are inconvenienced.

Harm to Many Women

F&L are much too quick, however, in asserting that it is a mere inconvenience for many women to be denied EC. I will show why they are not convincing when they argue that the antecedents of the first two conditionals do not obtain. But first I will introduce another conditional, which allows that harm to women from being denied EC is common. Here, and elsewhere, I interpret harm differently from F&L (while acknowledging that they are not crystal clear on what their own interpretation is). Let me begin by discussing this difference.

F&L appear to be concerned with harms that are also wrongs (i.e., those where a person is deprived of that to which she is entitled). There are at least two reasons for this. (1) When F&L discuss harm explicitly,[8] they are responding to the objection that because refusals to provide EC harm women, pharmacists should not have the right to make them. But harm to women would be a reason to deny this right to refusal only if the harm were also a wrong. The objector to whom F&L are replying therefore must be using "harm" in this normative sense (Feinberg 1984). To give a viable response, F&L need to prove that there is no normative harm and therefore need to focus on this sort of harm. Thus, it makes sense to assume that when they refer to "harm," they mean normative harm: harm that is also a wrong. (2) F&L do not believe that it is possible for women who are refused EC to be harmed by this action without being wronged by it.[9] If these women are not entitled to the drug, then the refusing pharmacist denies them a benefit but does not harm them.[10]

The first point to make here is that not all harms are wrongs, as I am sure F&L would agree. To illustrate, I harm you, but do not obviously wrong you, if I cause grievous injury to you while warding off a violent attack by you. The "semantic envelope of 'harm'" (to borrow a phrase from F&L 2005, 584) contains more than just states or conditions that are wrongs.

The second point is that this semantic envelope as F&L describe it (albeit vaguely) is too narrow. Many of us would include within it circumstances that F&L would summarily exclude because of their libertarian intuitions about harm: for example, being driven out of business by someone who sets up

shop across the street and lures away all of one's customers, or being reduced to tears because someone implies unjustly that one is a reprehensible person. To say that people in such situations are harmed seems perfectly coherent to me, which is why I will adopt a broader conception of harm than F&L do. I allow that in doing so, however, much of what I will say about harm to women from being denied EC will not persuade those who conceive of harm as F&L do.

Although "harm" is semantically broader in scope than F&L acknowledge, it is not so broad as to include all forms of disappointment or unpleasantness. Joel Feinberg makes this second point nicely in his theory of harm. He describes harm in a non-normative sense as a "setback to an interest" (Thomson 1986, 383). An interest, he says, is something in which we have a *stake*, meaning that we are better or worse off depending on the condition of this thing (e.g., our reputation, our family) (Feinberg 1984, 33, 34). People typically do not have a stake in not being disappointed or more generally displeased (43). For most people, their "psyches are sturdy" enough that they "can take a certain amount of disappointment without [their] interests being affected, that is, without suffering harm" (43).

But not everyone is so sturdy. Moreover, everyone can experience disappointment that is great enough or repeated often enough that it rises to the level of harm in Feinberg's sense (Thomson 1986, 383). Disappointment of this sort interferes, if only temporarily, with one's ability to act in one's interests, because of the mental disturbance or suffering that it causes (Feinberg 1984, 46). An example is disappointment over losing an important contract at work that makes it impossible for one to continue being at work, or disappointment over being told for the hundredth time that one is not as smart as one's brother, which makes one so angry (!) that one cannot concentrate on anything important for a while.

I will show that in all likelihood, for many women, the disappointment of being denied EC by a pharmacist rises to the level of harm. Whether this harm is normative or non-normative—that is, whether pharmacists also wrong women when they deny them EC—is something I want to leave open.[11] Following Feinberg (and unless I specify otherwise), I will hereafter use "harm" to mean a non-normative setback to interests. Moreover, I will assume that just as mere disappointment is not harm on Feinberg's view, mere inconvenience is not harm either. Since something that is a mere inconvenience is only "*slightly* troublesome or difficult" (OED; my emphasis), it alone cannot set an interest back (although repeated inconveniences could do that). Thus, if being denied EC is harmful in Feinberg's sense, then it cannot be a mere inconvenience.

With this discussion of harm in mind, consider another conditional. (To be perfectly clear, "harm" in this conditional does not necessarily mean wrong, as it does in the other conditionals.)

(4) If being denied EC interfered with women's interests, or more specifically with their ability to continue seeking EC or to maintain their moral identity or sense of security, then the denial would harm them.

The antecedent of this conditional probably does obtain for many women, in part because of the oppressive social structure that women inhabit. The cause of the harm may be this structure, not only the pharmacist who refuses to accede to a woman's request for EC.

Let me explain, first by linking pharmacists' refusals to women's oppression. My claim here is not that these pharmacists have sexist attitudes toward women, but that their refusals could easily reinforce sexism as well as racism. There are roughly two ways in which this could happen. One is that pharmacists' objections highlight the sexist or racist stigma that women face upon requesting EC. Studies reveal that there is a serious stigma attached to obtaining EC for women (Free et al. 2002; Fairhurst et al. 2004; Shoveller et al. 2007; Wu et al. 2007), and some studies connect the stigma directly to social stereotypes about women's sexuality (e.g., Shoveller et al. 2007). The relevant stereotypes are that women who are sexually promiscuous are of low character[12] —they are "sluts" or "whores"—and women, more so than men, who have unprotected sex are "irresponsible" or "careless."[13] Stereotypes about the sexuality of minority women, including the "myth of the lascivious Black woman" (Roberts 1997, 11), are also relevant. In response to stereotypical views about women's sexuality, young women especially worry about being thought of as "that kind of woman" when they ask for EC (Shoveller et al. 2007, 15). It is not hard to see how, if their request gets denied on moral grounds by a *pharmacist* (a respected member of society), their reluctance to obtain EC would increase. The pharmacist's objection would make them feel like a bad person for wanting or needing EC. A woman who is bad in this context is promiscuous and/or does not take seriously her responsibility as a woman to use contraception or to use it properly. Although the pharmacist may not intend to send this message about her, his moral objection could do so regardless. Actions or statements have meaning against a certain social background (e.g., of myths about women's sexuality); their meaning does not necessarily come from what one intends.

Objecting pharmacists could try to control the meanings that their objections have by explaining what grounds them; but it is clear neither that pharmacists should be having discussions of this sort with clients, nor that they would succeed in eliminating a sexist or racist message from their speech. Although they could tell the woman who requests EC that their concern is not with her sexual behavior, but with the nascent human life that she would jeopardize if she took EC, professionalism might dictate that they avoid having such conversations with clients (i.e., ones in which they provide unsolicited

details about their personal moral beliefs). In giving this explanation for their objection, they might reinforce sexism anyway. For out of the explanation, a new stereotype could rear its head: good women are maternal and do not put the lives of children, especially their own offspring, at risk. Thus, their client could go from feeling like a whore to feeling like a baby killer, and a female one to boot.

Conscientious refusals can contribute to oppression in a further way, one that applies to women who are not concerned with how requesting EC might influence people's thoughts about their sexuality, their degree of moral responsibility, or their maternal instincts. That they live in a society in which pharmacists—the gatekeepers to EC in the United States[14]—are permitted to refuse to give them EC could confirm to them, along with other factors (such as inadequate protection from sexual assault and poor access to abortion services), that their society does not respect them as women. It does not value their ability to govern their own bodies and their own lives. The subjective impact of conscientious refusals on women who feel such disrespect will be severe. Assuming that most women who request EC feel entitled on some level to get it,[15] these women may also be large in number.

Exploring the connection between conscientious refusals and oppression allows us to see which interests of women can be "set back" when they are refused EC, and thus, why many women can be harmed by these refusals. These interests appear above in conditional 4 and include women's autonomy in obtaining EC (their reproductive autonomy), their moral identity (as a good or fine person), and the sense of security that goes along with living in a society that respects them.

Conscientious refusals threaten women's reproductive autonomy if they accentuate the stigma associated with EC so much that out of shame or embarrassment, women stop trying to obtain it (Stein 2005; Shoveller et al. 2007). Empirical evidence suggests that the stigma alone is enough to prevent some women from ever asking for EC. For these women, it is easier "not to think about the risk of pregnancy, which might not occur, than to endure the stigmatization over the need for [EC]" (Free et al. 2002, 1394, 1395). Other women who fear being stigmatized overcome their fear to ask for EC. But would they keep trying to get it after being refused it for moral reasons—and by a health-care professional? To soldier on would presumably require more bravery and self-assurance than some of these women can muster, particularly those who feel the stigma intensely because of their age and those who are stigmatized more than others because of their minority status. Put simply, women who experience a conscientious refusal that deters them from accessing EC, because of the stigma attached to doing so, are harmed in not being able to exercise their reproductive autonomy. Of course, the impact on their autonomy will be especially severe if they get pregnant because of not

taking EC and have to have an abortion or suffer through a "forced gestation" (Little 1999).

Alternatively or in addition, conscientious refusals can impair the interest that a woman has in maintaining her moral identity. The refusals have this effect if they trigger in the woman's mind norms about women's sexuality that she has internalized. The mental image, brought on by the conscientious refusal, of her being "that kind of woman" could linger despite her best efforts to erase it. And if it does linger, then her hold on her moral identity as a different kind of woman—a responsible kind—has loosened. We do have reports of women feeling humiliated, "like [they] had to defend what kind of person [they are]," when they are refused EC.[16] Being humiliated—or "branded a moral transgressor" (F&L 2005, 583)—is harmful in Feinberg's sense if it damages something in which one has a stake. I conjecture that what is at stake for some women when they are refused EC is a continuous grip on their moral identity, and that oppressive norms about women help to explain why this is the case.

Finally, conscientious refusals put a woman's sense of security at risk, in particular when they confirm to her that her society does not respect her ability to decide what happens to her own body. To sense disrespect of this sort from whoever is in power is to feel vulnerable. Women clearly have an interest in not feeling this way, but rather in being secure in knowing that their society respects their bodily integrity, particularly surrounding pregnancy. Conscientious refusals that violate this interest harm women.

Thus, I believe I have shown that harm to women from being denied EC can occur and is likely to occur. This conclusion clearly applies to women who could get EC somewhere else nearby, for the relevant disruption to women's autonomy, moral identity, and sense of security does not depend on their overall level of access to EC. Two further issues about this harm that I want to address briefly are whether the harm would exist if women were not oppressed and whether it could occur for reasons other than those I have considered.

First, would women's disappointment in being denied EC rise to the level of harm in a society that does not oppress them? I doubt that it would (although I admit to having trouble fully imagining such a society). My doubt stems from the fact that a moral objection to a woman requesting EC would not have the same social meaning in this society as it does in ours. It could not reinforce in the woman's mind either that she is a careless slut or that she is a second-class citizen. Perhaps there would still be stigma associated with EC—that is, gender-neutral stigma about being careless with contraception—but this stigma could be significantly weaker than the sexist or racist stigma we have now, and also women presumably would be better able to cope with it and prevent it, along with the pharmacist's objection, from setting their interests back, simply because they would no longer be psychologically oppressed (Bartky 1990). But I speculate, and do so too freely perhaps. I

prefer to concentrate, as I have thus far, on actual women: that is, female human beings who do not enjoy equality with men and whose sexuality is stereotyped in negative ways.

Second, there are ways other than those I have considered in which conscientious refusals to provide EC can contravene women's interests and therefore harm them. For example, the refusals can damage their interests in general by making them so angry at the pharmacist or at their society that they are distracted from doing what is important to them. Still, I assume that the most serious ways in which conscientious refusals can harm women are those I have discussed.

Although harm to the above interests (in reproductive autonomy, a moral identity, and a sense of security) is serious, it may nevertheless be permissible. In other words, pharmacists may do nothing wrong in causing it. The operative word here is "may," however. It is plausible to think that a right to conscientious refusal in pharmacy ought to be restricted, or even ought not to exist, because of the potential for such harm (alone or coupled with the privileges that pharmacists enjoy). The right could infringe on an entitlement women have not to be harmed in the above ways. And if that were true, then the harm would be a wrong.

Some people will want to insist that the harm I have discussed is irrelevant to the debate over a pharmacist's right of conscience. They will point to the fact that objecting pharmacists are not the sole and perhaps not even the main cause of this harm. Surely we ought not to impose restrictions on a pharmacist's right of conscience because of harm caused by stereotypes that the pharmacists may not even accept! My response to this objection is twofold. First, it is not obvious that restricting the behavior of health-care professionals for such reasons is illegitimate. I argue elsewhere that as part of their larger duty to respect patient autonomy, these professionals have a duty to do what they can to counteract harmful effects that stereotypes can have on patient autonomy (McLeod 2002).

Second, if we ignore the kind of harm I have discussed (as F&L do), then we fail to deal with the conflict between the objecting pharmacist and the woman as it actually exists: that is, as a conflict between two people who are morally unequal not only because the pharmacist is privileged by a licensing scheme, but also because the woman is oppressed in society. F&L write, "pharmacist and prospective client do not stand to each other as any two random agents endeavoring to secure their various ends as they make their way through the world" (F&L 2005, 585). They assume this is true, in cases where the prospective client is seeking EC, only because one of the "two random agents" is a pharmacist. However, surely it is true also because one of them is a woman. Moreover, we appreciate this fact only by attending to how conscientious refusals to provide EC can harm women *as women*.

In general, once we situate conscientious refusals to provide EC within their social context, it becomes plausible to assume, regardless of whether EC is readily available elsewhere, that conscientious refusals harm rather than merely inconvenience women. F&L fail to see the harm not only because they conceive of harm too narrowly in their discussion, but also because when they analyze the refusals, they take them out of their social context, particularly the context of oppression toward women.

I said that I wanted to leave open the question of whether harm to women from these refusals is normative (i.e., a wrong). But if F&L are correct that no individual pharmacist has a duty to dispense EC to women who could easily get it elsewhere, then by refusing to give EC to these women, pharmacists do not wrong them; whatever harm the women might suffer could not be a wrong. So let me end by showing that F&L are not convincing when they deny the antecedents of conditionals 1 and 2, and are therefore not convincing when they suggest that refusals cannot wrong women who have other means of obtaining EC. Their mistake again is to fail to consider the social circumstances of women who request EC.

Emergency Contraception?

Recall the first conditional:

(1) If women who requested EC faced a true emergency, then being refused EC by a pharmacist would harm these women.

F&L suggest that while emergencies are "measured in minutes,"[17] "women have up to 72 hours after unprotected intercourse to secure medicine to block pregnancy" (F&L 2005, 582). Even if the timing were tighter than that, however, F&L would say that we cannot insist on "emergency" as the appropriate label, because it implies that unwanted pregnancies are a serious problem.[18] How we ought to characterize these pregnancies is again "precisely the crux of the parties' dispute" (582). Thus, according to F&L, we cannot legitimately claim that obtaining EC is an emergency for women who request it.

But this argument is unconvincing. First, EC's "contraceptive efficacy decreases dramatically during [the] seventy-two hour window" (Davidoff 2006, 20); the drug is most effective if used twelve to twenty-four hours after unprotected intercourse (Greenberger and Vogelstein 2005). "[E]ffective contraceptive relief is [still] not measured in minutes" (F&L 2005, 582), although it is measured in hours, and the relevant hours may be small in number. I am not persuaded that emergencies have to be measured in minutes rather than hours (or even days) anyway. If we knew that a bomb was set to go off in a

public place in seventy-two hours—or even seventy-two days—then we would have an emergency on our hands.

Second, if we accept along with F&L that averting an unwanted pregnancy is not an emergency, then are we not taking the perspective of the objecting pharmacist, rather than being neutral between the pharmacist and the woman? I do not see how we can be neutral, because we are faced with two discrete alternatives: either EC is *emergency* contraception or it is not. Also, we could take sides on this issue without settling the whole matter of whether pharmacists can ever refuse to provide EC. They could still refuse, in some circumstances at least, if avoiding an unwanted pregnancy were an emergency; they could do it when there is a back-up pharmacist in the pharmacy who could deal with the emergency at hand (Wicclair 2006, 239).

Let me review why the risk of unwanted pregnancy is often serious enough that being faced with it *is* an emergency for women. Pregnancy can jeopardize a woman's life, her physical or mental health, or her future as she envisions it. Pregnancy endangers the life of women with certain health conditions (Greenberger and Vogelstein 2005, 1557); for some women, it represents a "period of risk" for physical abuse by husbands or partners (Saltzman et al. 2003); it jeopardizes the mental health of women who are pregnant due to rape and who experience the pregnancy as a nine-month continuation of the rape; it ruins the future plans of many women, who know they could not go through the intimacy of gestation and then give their child up for adoption (Little 1999), and who realize they will be the child's primary caretaker; and for some women it means that they will be dependent on a partner who treats them badly. In brief, what is at stake for many women with unwanted pregnancy is nothing short of life, health, freedom, or respect. Given how essential these goods are, should we not conclude that a situation in which one or more of them is at risk is an emergency?

Still, some people would object to the idea that unwanted pregnancy is so terrible that a substantial risk of one occurring counts as an emergency. What about the "nascent human life" that could flourish if the pregnancy were allowed to proceed? What about the possibility of the woman having an abortion? I will evaluate these points, but only briefly, since my purpose is simply to cast doubt on F&L's view that EC is not *emergency* contraception. The pharmacist who is opposed to EC believes that a nascent human life could be "in dire jeopardy" (F&L 2005, 582).[19] Even assuming this is true, however, unlike the pregnant woman, the embryo does not have a personal future that is at stake with the decision about whether to give her EC (McInerney 1990). Furthermore, its life is completely dependent on the woman's and will continue to be so (if it survives) for months or years. We cannot simply choose its life or its future over hers. Thus, even if EC threatened a nascent human life, it could still be an emergency for women to obtain EC.

What about the objection that the woman could simply have an abortion if she gets pregnant after not being able to access EC? To put it mildly, this suggestion is distasteful. The decision to terminate a pregnancy is emotionally difficult for many women. Also, abortion is not readily available for many of them,[20] it is out of the question for some, and in any case it is a painful form of surgery. To imply, as F&L do, that because "subsequent abortion is available" to women who cannot get EC, there is no emergency is to fail to take seriously what it means to be a woman contemplating an abortion (F&L 2005, 582). It is also to fail to understand that emergencies can exist even when there is only a chance of something bad happening. A small house fire is arguably an emergency. To question this by noting that the house may not burn down, and that even if it does, one could rebuild at a later date, is ludicrous. Similarly, to insist that being at risk for an unwanted pregnancy is not an emergency because the pregnancy may not occur, and even if it does, the woman could have an abortion, is absurd.

In short, I am unconvinced that women requesting EC are not in an emergency situation and therefore that pharmacists do not have a duty to dispense EC as part of their larger duty to provide care in emergency situations. Pharmacists may very well have this duty, which means that the harm caused by pharmacists' refusals to provide women with EC may very well be a wrong.

An Individualized Duty to Dispense EC

Recall the second conditional:

> (2) If women who sought EC were entitled to get it from any pharmacist, because every pharmacist had a duty to dispense EC to any woman who makes a legitimate request for it, then being refused EC by a pharmacist would harm these women.

F&L's main reason for rejecting the individualized duty mentioned in the antecedent of this conditional is that, like other professionals, pharmacists have the freedom to choose whom to serve. While for the sake of argument, I will assume that this claim about pharmacists is correct,[21] I will object to the way that F&L interpret this freedom. They take this freedom to be so extensive that it eliminates the possibility of there being an individualized duty to treat. Following John Arras, I suggest instead that the freedom is constrained by the duty, which exists *prima facie*.

Arras would reject F&L's wide interpretation of the freedom to choose whom to serve, according to which professionals can "turn down potential clients with whom they feel uncomfortable working either for moral or other reasons" (Arras 1988, 582). According to Arras, physicians "may choose whom

to serve, but their *reasons* for refusing patients are not a matter of moral indifference, as some accounts tend to depict them" (15; his emphasis). Out of moral indifference to unhealthy people and out of concern for their own lifestyle, for example, physicians cannot refuse to take people on as new patients who are unhealthy and whom they feel would take up too much of their time. Or out of moral indifference to the vulnerable and out of concern for their own social status, they cannot eliminate services from their practice that give them no glory. Arras argues that each individual health-care professional has a "role-specific duty to care for the vulnerable" (i.e., people who are vulnerable because of their health status; 15; see also Clark 2005; Wicclair 2006; Card 2007). Many of us would agree, as evidenced by our reaction to the hypothetical professional who in choosing his patients shows a stunning indifference toward people with health-care needs.

My point here is not that pharmacists and other health-care professionals lack the freedom to choose whom to serve (which would preclude them from making any conscientious objections), but rather that any such freedom must be tempered by a duty to care for the vulnerable. In deciding whether to provide services, health-care professionals need to consider that they have this duty and that refusing to provide service could therefore be inappropriate. Of course, denying it could also be appropriate or permissible, however, because the duty itself (i.e., to care for the vulnerable) could require that they refuse some requested services (i.e., those that would be harmful in the circumstances) or their concern for the vulnerable could legitimately be overridden by other concerns (though presumably only moral concerns, one of which could be their own conscience).

I think health-care professionals' freedom to choose whom to serve is further constrained by the fact that they alone do not get to decide whether it is appropriate for them to deny services to patients. If they refuse to accede to a patient's request for moral reasons, then it is open to their professional association or government to say that their reasons are inadequate.[22] For example, if a pharmacist's conscience and concern for her own moral identity comes into conflict with a woman's need for EC, and the pharmacist decides on grounds of conscience not to serve her, then those in power could challenge this decision. Contrary to what F&L suggest, her freedom to choose whom to serve is actually quite narrow (no matter whether she is one among many pharmacists in a one-mile radius or the only pharmacist in a 100-mile radius).

This account of both the freedom of health-care professionals to choose their patients and of an individualized duty to treat is plausible, but F&L ignore it, which makes their argument about these same issues unpersuasive. I have shown that every pharmacist could very well have a *prima facie* duty to dispense EC to any woman who needs it. The duty could be part of a larger duty to care for the vulnerable in their capacity as health-care professionals, or it

could exist on the grounds that having access to contraception and being spared the harm of being refused it are central to women's welfare. Either way, with this duty in place, the moral situation of an individual pharmacist who does not want to dispense EC is more complicated than F&L make it out to be. The pharmacist would be in a moral conflict situation, rather than merely a situation of having a certain desire and deciding how to act on it.

Regardless of what the moral situation is of the individual pharmacist, however, a moral conflict does occur when a pharmacist conscientiously refuses to provide EC to a woman who needs it; the conflict arises if not for the individual pharmacist, then for government or the pharmaceutical profession. How they, or we, ought to resolve the conflict depends on what is at stake for the different parties to it. I have argued that what is at stake for many women who are denied EC is their reproductive autonomy, their moral identity, their sense of security, or all of these. Also it is reasonable to assume, based on a plausible conception of harm, that these women are therefore harmed, rather than merely inconvenienced, by these refusals. Bioethicists such as F&L cannot presume to solve the problem of conscientious refusals to EC without comprehending the impact that these refusals likely have on women in societies such as ours. This impact, in a word, is harm.

Notes

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1. The attention is almost exclusively on these professionals. For example, Mark Wicclair asks, "What is at stake when a . . . pharmacist advances a conscience-based objection"; he responds by describing what is at stake only for the pharmacist (Wicclair 2006, 226–28). Others who focus on the interests of the objecting professional are Childress (1979), Blustein (1993), and Benjamin (1995); see also Wicclair (2000).

2. Another possibility is that they are wronged, but are neither harmed nor inconvenienced. The assumption here is that there are wrongs that are not harms. (Later on, I discuss the opposite: harms that are not wrongs.) People are wronged but not harmed, at least "*on balance*," if they mostly benefit from a wrong (e.g., their land is improved by having someone trespass on it [Feinberg 1984, 35]; his emphasis). Since it would be rare that on balance, a woman would benefit from being denied EC, I will not consider any further the possibility that in general, women are wronged but not harmed by this experience.

3. According to Vischer, having to "drive across town" to obtain EC is a "market-driven inconvenience" (Vischer 2006, 113).

4. I have left out this conditional: if women who were denied EC were browbeaten or otherwise harassed by the pharmacist, then they, the women, would be harmed. F&L would agree with this conditional too (F&L 2005, 584). They also appear to believe that

at most *some* women are browbeaten or harassed, and harmed by conscientious refusals for this reason. I will leave such cases aside (as F&L do) and focus on ones in which there is a simple conscientious refusal, with no harassment or even attempts at moral persuasion. My reasons here are twofold: (1) we simply do not know how common harassment and moral persuasion are in this context; and (2) it is worthwhile demonstrating that even simple refusals cause harm.

5. This language, employed by Arras, comes from the *Principles of Medical Ethics* of the American Medical Association (2001). Principle VI of this document reads: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service" (cited in Clark 2005, 67). F&L assume that pharmacists have this same right.

6. It is unclear whether this second claim is a moral or a legal one. In endnote 5, F&L acknowledge arguments to the effect that everyone has a duty to be a Minimally Decent Samaritan (Thomson 1971) and that those who are "specially qualified" to provide the necessary aid (e.g., health-care professionals) may be required to be more than just minimally decent (Clark 2005, 79). But F&L dismiss these arguments on the grounds that they refer to moral duties rather than to legal or professional duties, as though F&L were not concerned with moral duties. In other parts of their paper, however, they seem obviously concerned with moral duties, including parts where they discuss a duty to aid: for example, they say that a "failure to render aid is [not] *morally* on all fours with the infliction of harm" (F&L 2005, 583, my emphasis).

7. The duty to treat is "individualized" if it falls on the shoulders of each and every health-care professional. It is not individualized if it falls instead to the profession or to government. See Arras 1988, 11.

8. That is, when they distinguish between failing to benefit someone and harming her.

9. This is true so long as the refusal is a simple one (see n. 4). Browbeating by the pharmacist could harm the woman, in F&L's view, although they do not explain why. Presumably, they would say it could interfere with her liberty interests.

10. F&L have a libertarian view of harm according to which harm results not from failing to provide people with resources to improve their situation or to prevent it from getting worse, but from interfering with their negative liberty. Moreover, the interference must undermine their ability to act freely in the relevant circumstances; it is not enough to erect barriers to people's freedom that they can or should be able to surmount. Moral disapproval of people's actions would count as such a barrier (F&L 2005, 584).

11. I *must* leave it open, in fact, if I am to avoid trying to solve the problem of whether these refusals are permissible. (Recall, I have the more modest objective of determining what is at stake for women with these refusals.) I *will* leave this door open by showing that F&L are not persuasive when they claim that denying women EC does not "harm" (i.e., wrong) them.

12. There is a strong link in the public mind between EC and sexual promiscuity. For example, people worry that increased access to EC will increase sexual promiscuity among women (a worry that is unfounded; see Wu et al. 2007).

13. As Anna Stubblefield says, "women are typically expected to bear the burden of contraception. Pregnancy 'happens to them,' therefore they must 'protect themselves'" (Stubblefield 1996, 82).

14. On pharmacists' role as gatekeeper in the United States, see Card 2007, 8. On August 24, 2006, the FDA approved nonprescription status for the EC levonorgestrel (Plan B) for all users except for those under the age of 18. "[W]omen age 18 years and older must be able to prove their age to a pharmacist who keeps the drugs behind the counter" (Card 2007, 8).

15. Evidence of this feeling of entitlement comes from a study showing that overall, American women strongly oppose the right of pharmacists and other health-care professionals to refuse out of conscience to provide them with reproductive services (Miller 2000).

16. This quotation comes from Rebecca Polzin, who was repeatedly denied birth control by her local pharmacist (Schuman 2006). See also Lambert 2005 and Gee 2006.

17. "Unlike someone in cardiac arrest or lying by the side of the road with a spurting artery, effective contraceptive relief is not measured in minutes" (F&L 2005, 582).

18. The assumption here is that emergencies exist only when *immediate* action is necessary to avert a situation that is *serious* (OED). I would modify this definition as follows: emergencies exist when prudence dictates that we engage in immediate action to avert a situation that is serious.

19. The literature as a whole mentions two ways in which EC could jeopardize the life of this entity: (1) by terminating a pregnancy; or (2) by preventing the implantation of a fertilized egg. There is no evidence that currently available forms of EC (i.e., levonorgestrel—"Plan B"—and similar hormonal regimens) interfere with an established pregnancy (Card 2007, 10). And there is controversy over whether these forms can have post-fertilization effects: for example, Card cites evidence to the contrary (11; Croxatto et al. 2004), while Baergen and Owens claim that "available data on Plan B do not rule out the possibility of a postfertilization mechanism of action" (Baergen and Owens 2006, 1279).

20. For example, in Canada there are significant barriers to abortion access for women, including the fact that as of 2006, only 15.9% of Canadian hospitals provided abortion services (Shaw 2006).

21. The claim is controversial for two reasons. (1) Pharmacists may not qualify as professionals, and therefore may not have the freedoms that professionals enjoy. Baergen and Owens reject this view but explain why someone might hold it (Baergen and Owens 2006). (2) Pharmacists, or health-care workers in general, may not have the freedom to choose whom to serve because they are purveyors of a public accommodation (i.e., health care); as such, they may be morally and legally required to offer the accommodation to everyone despite whatever moral objections they have in doing so (Anderson 2005). This point, while valuable, goes against the general understanding within medicine that medical professionals have some freedom to choose their own patients (see n. 5).

22. On the assumption that conscience protects our *moral* values or *moral* standing, it is also open to professional associations or governments to insist that pharmacists' reasons are not moral reasons, and therefore their conscience is not at stake even if they say otherwise.

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