

A Medical Professional's Right to His Moral Beliefs in Consideration to Unwanted Pregnancies:  
An Ethical Dilemma in the Field of Public Health

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In a landmark case decided upon in 1973, the U.S. Supreme Court ruled in *Roe versus Wade* that women had the legal right to abortion as per their constitutional rights to personal privacy. The case deemed abortion legal and regulations by state not applicable within the first trimester, regulated in the second trimester as per the best interests of the mother's health, and regulated or even prohibited in the third trimester as to best protect the fetus unless medically necessitated to protect the mother (United States Conference, n.d.). Since the ruling forty years ago, countless debates have ensued and interest groups have formed in an effort to either support or disband the 1973 decision. And, although *Roe v. Wade* permits women to make decisions about their own bodies, reproductive systems, and potential offspring there are in fact measures in place in the United States to protect the rights of medical professionals in regards to input they may have in these "personal" decisions. Conscience clauses deemed legal and appropriate by the American Medical Association, the American Nurse Association, and the American Pharmacists Association pay respect to the moral and ethical beliefs of medical professionals in denying to dispense emergency contraception (EC) or to perform medical procedures—such as abortion (Hemphill & Lillevik, 2006). With the rights of women protected under *Roe v. Wade* and the right to withhold emergency contraception or medical proceedings protected by various U.S. medical rights groups, there exists quite a conundrum: Is it ethical to allow the personal beliefs of a medical professional to trump the constitutional rights of a woman when it comes to her body and her reproductive organs?

Hemphill and Lillevik define a conscience clauses and refusal-to-provide clauses as "legal or ethical codicil which allows a health care provider the right to not participate in certain professional health care activities based on personally held moral, ethical or religious beliefs" (Hemphill & Lillevik, 2006, p.40). In order to best understand the ramifications of these clauses—as faced by women who would face them in the most extreme of situations—two sample scenarios have been included below. The first scenario exemplifies a pharmacist's conscience clause when faced with the sale of EC and the second addresses a doctor's refusal-to-

provide an abortion at a privately-funded hospital—in a case where it is decided upon by the woman, her husband, and her primary OBGYN. The scenarios are based on the laws and clauses and are not true stories in and of themselves.

*Scenario 1—*

Jill walks into a CVS the next town over from where she lives. It is a Saturday morning and she looks like she has been up half the night. She has bruises on her neck and restraint marks on her wrists too. After waiting in line at the pharmacy for what seems to Jill to be hours, she finally makes it to the front of the line. Weary and visibly upset, Jill asks the pharmacist to sell her Plan B One-Step, a form of emergency contraception that, if used properly and within 72 hours of unprotected sex, can prevent unwanted pregnancies (Plan B One-Step, 2013). The pharmacist gives Jill a troubled look and asks if this is what Jill really wants, insisting that Jill really weigh her options. Worrying that she may not get the pill, Jill starts crying. The pharmacist tells Jill that the morning after pill shouldn't be abused and is morally unfounded and she will not sell it to Jill on ethical grounds. She points to the pharmacist two cash registers over and tells Jill that although she herself will not sell Jill the pill, maybe the other pharmacist will be willing to do so. Jill grabs some tissues off of the counter and wanders to the back of the other line, worrying that if she is denied the sale of the pill again she may be forced to carry her rapist's baby.

*Scenario 2—*

Thirty-two year old Hannah went to her OBGYN for routine sonograms during her pregnancy. At the 20-week mark, Hannah's doctor tells her that the fetus does not seem to be growing normally and that she recommends Hannah go to the nearest hospital for an amniocentesis as soon as she can. Hannah makes an appointment at St. Mary's Hospital, just down the street. She undergoes the amniocentesis and learns that although Hannah has been carrying her pregnancy the same as her previous two, the doctors can already tell that Hannah's baby has severe chromosomal abnormalities and will be born with very serious special needs. Hannah asks for a few minutes alone and calls her primary OBGYN who then recommends Hannah discuss with her husband before making any rash decisions, but does recommend that aborting the pregnancy is a very realistic option for the couple. After talking to her husband Jack, the couple decides that abortion may be their only viable option since they already have two young children and many

bills to pay, not to mention a lack of familial support to aid in the raising and medical needs of their baby. Hannah and Jack call St. Mary's to schedule an abortion but the nurse's comments cause an upset. She tells the couple that although St. Mary's doctors are certified to perform abortions, they refuse to do so on moral grounds, based entirely on the religious affiliation of the hospital and affiliated doctors. Hannah thanks the nurse for her help and begins crying to her husband. Their insurance is not accepted by the surrounding hospitals and by the time they will be able to get an appointment at the nearest clinic it may be too late to perform a safe abortion.

Although not based on true stories, situations identical to these scenarios may be happening every day in the U.S. because of the clauses already in place. Scenario one refers directly to the Pharmaceutical Conscience Clause, developed in 1998 by the American Pharmacists Association. "While physicians and nurses are primarily employed in hospitals and private practices, pharmacists are generally employed in the for-profit sector—with the majority of pharmacies (58 percent) operated by major discount retailers, and the remainder (42 percent) independently-owned drug stores" (Guttmacher Institute, 2006, pg.40). Therefore, pharmacists are bound to the demands and beliefs of various stakeholders to the company and must make decisions based not solely on medical professionalism or a customer's well-being. The Pharmaceutical Conscience Clause states that "APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal" (Instructions for Filling Out, n.d.). A policy report from the APhA explains the policy in layman's terms, stating that "[Pharmacists [should] be allowed to excuse themselves from dispensing situations which they find morally objectionable... ensuring that the patient will be referred to another pharmacist or be channeled into another available health system" (Guttmacher Institute, 2006, pg.42) Therefore, a pharmacist's personal beliefs—as well as the beliefs of the stakeholders in the company—on EC are protected so long as he points the woman in the direction of another location at which to access the pill. It is important to note that EC is not the same as an abortion but rather "[e]mergency contraception is used to prevent a pregnancy, not terminate a pregnancy, and is a general term used to describe several different types of birth control pills that are used in increased doses within 72 hours of unprotected intercourse" (Pharmacist Conscience Clauses, 2012). While some states have passed legislation

that legalizes the actions of the pharmacists, “[o]ther state legislators are introducing legislation that would require pharmacies to fill any legal prescription for birth control” which would indeed include all forms—emergency contraception included (Pharmacist Conscience Clauses, 2012).

Scenario two addresses both the conscience clause and also the refusal-to-provide clause. Here, doctors and other medical professionals can withhold medical treatment, and ultimately, refuse to perform an abortion if it goes against their own or the hospital’s moral standings. The theories that protect medical caregivers in these cases were established by the American Medical Association and the American Nurse Association to honor a medical individual’s “freedom to choose” or moral grounds” (Guttmacher Institute, 2006, pg.40). Some U.S. states have fought back against the law and may be on their way to overturning the AMA’s and ANA’s refusal allowances, though. New York’s Public Health Law § 2805, for example, “requires hospitals providing treatment for survivors of rape to provide survivors with written and oral information on emergency contraception, including its efficacy and availability. Hospitals are required to provide survivors with emergency contraception unless the individual requests otherwise” (Emergency Contraception State Laws, 2012). This means that medical professionals in New York hospitals are not allowed to fail to provide EC on ethical beliefs. The decision was ruled upon in a court case and trumps the clauses put forth in earlier times. Pennsylvania, on the other hand, follows a practice much more closely related to the conscience and refusal-to-provide clauses. Pennsylvania Code title 28 § 117.53, § 117.55 and § 117.57 state that “A hospital may choose not to provide [EC] onsite if doing so may be contrary to the stated religious or moral beliefs of the hospital. If a hospital claims a religious or moral exemption, that hospital must still . . . arrange for a victim who requests it to be transported to a facility which provides emergency contraception” (Emergency Contraception State Laws, 2012). Technically, all public, state-funded hospitals in the U.S. are legally required to perform abortions. The lines that distinguish a public hospital from a private hospital—that has the legal right to refuse to perform an abortion—are not always clear, though (The legal issues, n.d.).

Together, scenarios one and two—along with the legality intertwined in them—refer to a common theme: the morality of pharmacists and doctors in consideration with a woman’s right to her own body and to preventing unwanted or risky pregnancy. This becomes a public health concern when a woman’s rights and health are put on the line—a necessary evil deemed appropriate by the organizations in the U.S. that sanction conscience and refusal-to-provide

clauses. These clauses are trending all over the country, in fact, as “46 of 50 state governments have subsequently passed legislation designed to allow physicians, nurses and other health care providers to refuse to perform or assist in an abortion; and 43 states allow health care institutions (including 15 states private-only and one religious only) to refuse to allow abortions to take place on their premises” since *Roe v. Wade* (Guttmacher Institute, 2006, pg.40). Individuals debating these clauses wonder: “Where does the professional code of ethics pertaining to responsibility to the patient end and the individual morality of the pharmacist begin?” (Guttmacher Institute, 2006, pg. 41)

The matter becomes increasingly more of a public health issue when the medical professional’s actions pose a risk for the mother and fetus or child somewhere else along the line. Possible situations include pregnancy complications causing permanent health concerns for the mother; a child with costly disabilities born to a low-income family; maltreatment, abuse or victimization of the child; and potential cases of childism and transism (Willems, 2010). Willems defines transism as “transgenerational discrimination, i.e. transgenerational psychotraumatization [.] transgenerational transmission of psychosocial damage, leading to socioemotional and socioeconomic exclusion, due to a lack of empowerment of children, caregivers and communities” (Willems, 2002, pg. 71). This domino effect of abuse and neglect is likely to continue as its namesake states: over generations. These ensuing public health issues that come as a result of moral dilemmas in women’s reproductive health affect taxpayers when more money is needed to fund the monetary loads used for Medicare and Medicaid, disability pensions, abuse hotlines and crisis centers, foster care and case worker visits, and all other necessary programs and medical fees. This dilemma extends far beyond the scope of pregnancy and may ultimately affect all tax-paying Americans in some respect.

While this dilemma does pose many moral, ethical, personal, and monetary issues or troubles, there is no simple answer as to how to fix it. If the conscience clause and refusal-to-provide clause were completely eradicated after all of these years of being in place, many interest groups would likely come forward saying that the state has no right to tell pharmacists and other medical professionals when they are and are not allowed to consider their moral beliefs important. On the other hand, others do in fact want the current clauses eradicated because they feel that the separation of church and state in the U.S. should trump policies created by medical associations. The moral dilemma is infinite because ultimately, the personal is political and

judging who has more right to her rights—a woman over her reproductive system or a doctor over her religious and moral beliefs—is not black and white. The argument becomes a case of who has more funding and political swing, and can affect a change in favor of his own beliefs. Moral dilemmas exist everywhere in life. In the field of reproductive rights, however, they become something bigger than one could ever imagine.

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