

COMMENT

THE BUSH ADMINISTRATION’S MIDNIGHT PROVIDER REFUSAL RULE: UPSETTING THE EMERGING BALANCE IN STATE PHARMACIST REFUSAL LAWS*

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I. INTRODUCTION

On July 6, 2002, college student Amanda Renz went to her local Wisconsin K-Mart to refill her prescription for oral contraceptives.¹ Neil Noesen, the only pharmacist on duty that day, asked Renz if she intended to use the prescription for contraceptive purposes. When she answered in the affirmative, Noesen informed her that his religious beliefs prevented him from dispensing contraceptives. He refused to refill her prescription or give her information on how to get the prescription filled elsewhere. When Renz later took her empty prescription package to Wal-Mart, the pharmacist on duty there called Noesen to obtain the original prescription, but he refused to assist in the transfer. Though Renz finally had the prescription filled two days later, she missed the first dose of her medication. After this experience, Renz filed a complaint against Noesen. The Wisconsin Department of Regulation and Licensing brought disciplinary proceedings against Noesen, ultimately reprimanding him and putting limitations on his pharmacist's license.²

In 2004, Gene Herr, an Eckerd pharmacist working outside of Dallas, refused to fill a rape victim's prescription for an emergency contraceptive, citing his religious belief that the medication caused abortion.³ As a result, Eckerd fired Herr based

1. *Noesen v. Wis. Dep't of Regulation & Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 385, 389 (Wis. Ct. App. 2008).

2. *Id.* at 389–90.

3. Liz Austin, *Pharmacist's Refusal Stirs Debate*, HOUS. CHRON., Feb. 29, 2004, at 34A. Though emergency contraceptives, also known as the "morning-after pill" or "Plan B," are now available to women over the age of eighteen without a prescription, the medication must be kept behind the pharmacy counter, giving pharmacists an opportunity to refuse to dispense it. See Press Release, FDA, FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older (Aug. 24, 2006), available at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108717.htm> (explaining how Plan B must be stored by pharmacies and how it may be obtained by customers); Brittany L. Grimes, Note, *The Plan B for Plan B: The New Dual Over-the-Counter and Prescription Status of Plan B and Its Impact upon Pharmacists, Consumers,*

on its policy prohibiting pharmacists from refusing to dispense medications on religious or moral grounds.⁴

These stories, along with many similar stories from around the country, indicate a growing debate over the propriety of laws protecting pharmacists who refuse to dispense medications to which they are religiously or morally opposed.⁵ Termed “conscience” or “refusal” laws, proponents argue that without them, employers and state medical boards may discriminate against religious pharmacists.⁶ In support of their argument, proponents point to the traditions of protecting religious freedom and personal autonomy in the United States.⁷ By contrast, opponents are outraged that such laws permit a pharmacist to interfere with a patient’s autonomy rights, as well as her constitutionally protected right to contraception.⁸ At its core, the debate pits two seemingly equal sets of rights against one another—the pharmacist’s autonomy and religious rights versus the patient’s autonomy and reproductive rights.

and Conscience Clauses, 41 GA. L. REV. 1395, 1420 (2007) (observing that pharmacists in states with laws mandating that all legal prescriptions be filled could potentially refuse to dispense Plan B because it no longer requires a prescription and thus falls outside of the purview of those laws).

4. Austin, *supra* note 3, at 34A.

5. See, e.g., Rob Stein, *Pharmacists’ Rights at Front of New Debate*, WASH. POST, Mar. 28, 2005, at A1 (reporting that a pharmacist in Milwaukee refused to dispense emergency contraceptives to married couple); Jim Ritter, *Planned Parenthood Protests over Morning-After Pill*, CHI. SUN-TIMES, Mar. 23, 2005, at 10 (reporting pharmacist at Osco pharmacy in downtown Chicago refused to fill a prescription for emergency contraceptives); Sarah Sturmon Dale, *Can a Pharmacist Refuse to Dispense Birth Control?*, TIME, June 7, 2004, at 22 (surveying stories of pharmacist refusals to dispense contraceptives); see also Noesen, 751 N.W.2d at 391–92 (affirming Wisconsin pharmacy board’s determination that a pharmacist failed to comply with the relevant standard of care by refusing to fill or transfer a patient’s prescription for oral contraceptives).

6. See Bryan A. Dykes, Note, *Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers*, 36 GA. L. REV. 565, 568 (2002) (“[L]egislation should allow health care providers to practice their skills in an integrated manner, maintaining their religious, philosophical, ethical, and moral integrity when they encounter requests or assignments that violate their conscience.”).

7. See *id.* (arguing that properly drafted conscience clauses can balance the autonomy rights of both health care providers and patients).

8. See Claire A. Smearman, *Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 ARIZ. L. REV. 469, 474 (2006) (arguing pharmacist refusals not only “interfere with the woman’s constitutionally protected right to determine whether and when to have a child,” but also “impos[e] [the pharmacists’] religious beliefs on others who do not share them”); ACLU, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 6 (2002), <http://www.aclu.org/FilesPDFs/ACF911.pdf> (advocating a framework in which policymakers consider the extent to which a provider’s refusal would burden those who do not share the provider’s beliefs); see also *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965) (holding the constitutional right to privacy affords married couples the right to use birth control); *Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972) (extending the right to use birth control to unmarried persons).

Federal and state laws protect doctors and nurses from discrimination if they refuse to perform abortions, but until recently few of these laws spoke directly to the issue of contraception.⁹ As the debate over reproductive rights has widened in recent years to focus more on contraception, pharmacists have sought the protection of these laws by defining pregnancy based on their religious views.¹⁰ Some religions dictate that a pregnancy begins at the moment an egg is fertilized.¹¹ By contrast, the medical community has determined that a pregnancy begins when a fertilized egg implants in the uterus.¹² Relying on a religious rather than medical definition of pregnancy, these pharmacists contend that certain contraceptives, including emergency contraceptives, IUDs, and birth control pills, may actually cause abortion due to their possible interference with the ability of a fertilized egg to implant in the uterus.¹³ Faced with increasing media attention to these matters, states have responded in different ways and with varying degrees of success to balance the rights of pharmacists

9. See discussion *infra* Part II.B–C (analyzing the history of refusal clauses).

10. See *Hearing on H.B. 4346 Before the State Government Administration Committee*, 2006 Leg., 94th Sess. (Ill. 2006) (statement of John A. Menges, Pharmacist, Walgreens), available at <http://www.pfli.org/mengestestimony0206.html> (“I am here today because I can not dispense any drug designed to end a human life. . . . For me human life begins when fertilization occurs.”).

11. See, e.g., U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES, pt. IV, Directive No. 45 (2001), available at <http://www.usccb.org/bishops/directives.shtml> (“Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which in its moral context, includes the interval between conception and implantation of the embryo.”); Smearman, *supra* note 8, at 490–91 (citing William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL’Y 455, 502–07 (2001)).

12. See Rachel Benson Gold, *The Implications of Defining When a Woman Is Pregnant*, GUTTMACHER REP. ON PUB. POL’Y, May 2005, at 7, 8, available at <http://www.guttmacher.org/pubs/tgr/08/2/gr080207.pdf> (“Between one-third and one-half of all fertilized eggs never fully implant. A pregnancy is considered to be established only after implantation is complete.”).

13. See Tony J. Kriesel, Recent Development, *Pharmacists and the “Morning-After Pill”: Creating Room for Conscience Behind the Counter*, 7 MINN. J. L. SCI. & TECH. 337, 342 (2005) (opining that acceptance of a fertilization-based definition of pregnancy compels the conclusion that the prevention of implantation caused by emergency contraception constitutes an abortion); Jennifer E. Spreng, *Pharmacists and the “Duty” to Dispense Emergency Contraceptives*, 23 ISSUES L. & MED. 215, 216 (2008) (citing certain post-fertilization effects of some contraceptives to support the claim that “oral contraceptives taken daily or on an emergency basis are abortifacients”). *But see* COMM. ON ETHICS, AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OPINION NO. 385, THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE 4 (2007), available at http://www.acog.org/from_home/publications/ethics/co385.pdf [hereinafter ACOG COMMITTEE ON ETHICS] (clarifying that emergency contraception prevents fertilization rather than implantation and lamenting the “misinformation and . . . prevalent belief that emergency contraception acts primarily by preventing implantation”).

and patients.¹⁴ This has resulted in a spectrum of laws—from Maine’s “must-fill” law, to South Dakota’s absolute protection of pharmacists, to more recent compromises in Illinois and California, termed “fill or refer” laws.¹⁵ In this way, the states have acted as laboratories, experimenting with policies acceptable to their populations.¹⁶ Recently, there has been an “emerging consensus”¹⁷ on the proper balance of accommodating religious beliefs while simultaneously protecting patient access to care.¹⁸ Indeed, both the House and Senate responded to this emerging consensus by proposing laws such as the Pharmacy Consumer Protection Act of 2005¹⁹ and the Access to Birth Control Act of 2007,²⁰ modeled on the Illinois and California

14. See Adam Sonfield, *Provider Refusal and Access to Reproductive Health Services: Approaching a New Balance*, GUTTMACHER POL’Y REV., Spring 2008, at 2, 4–5 (describing state laws aimed at balancing providers’ religious rights and patients’ access rights); Karissa Eide, Comment, *Can a Pharmacist Refuse to Fill Birth Control Prescriptions on Moral or Religious Grounds?*, 42 CAL. W. L. REV. 121, 126–36 (2005) (same); see also *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245, 1248–49 (W.D. Wash. 2007) (enjoining enforcement of Washington law imposing sanctions on pharmacies that permit pharmacists to refuse to fill legal prescriptions).

15. CAL. BUS. & PROF. CODE § 733 (West Supp. 2009) (allowing an individual pharmacist to refuse to dispense medications if the pharmacist has informed his employer of his objection in writing and requiring the pharmacy to ensure access to the medication); ME. REV. STAT. ANN. tit. 32, § 13795(2) (Supp. 2008) (providing that a pharmacist may refuse to fill a valid prescription “if unsatisfied as to the legitimacy or appropriateness of any prescription presented, the validity of any photographic identification or the identity of any patient presenting a prescription or any person acting on behalf of the patient”); S.D. CODIFIED LAWS §§ 22-1-2(50A), 36-11-70 (2006) (respectively defining “unborn child” as existing “from fertilization until live birth” and allowing a pharmacist to refuse to dispense medication “if there is reason to believe that the medication would be used to . . . [d]estroy an unborn child”); ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2009) (requiring pharmacies to ensure patient access to contraceptives when an individual pharmacist refuses); 02-392-19 ME. CODE R. § 11 (Weil 2009) (“A pharmacist may refuse to fill a prescription or dispense a drug only as permitted by [ME. REV. STAT. ANN. tit. 32, § 13795(2)].”).

16. Cf. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

17. Sonfield, *supra* note 14, at 6.

18. See Smearman, *supra* note 8, at 538–39 (expressing concern about refusal clauses in general but endorsing the Illinois approach); Robin Fretwell Wilson, *The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 61–62 (2008) (detailing states’ attempts to strike a proper balance and pointing out inherent fallacies).

19. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. § 2(a) (requiring that pharmacies receiving Medicare or Medicaid payments fill all valid prescriptions without “unnecessary delay or other interference”).

20. Access to Birth Control Act of 2007, S. 1555, 110th Cong. § 3(e) (imposing civil penalties on pharmacies that do not ensure patients have access to legal contraceptive prescriptions without delay); Access to Birth Control Act, H.R. 2596, 110th Cong. (2007) (companion bill).

compromises, which impose a duty to dispense on pharmacies but protect individual pharmacists' right to refuse.²¹

In December 2008, the Department of Health and Human Services (HHS) acted to disrupt this emerging consensus and throw state policies into question by promulgating a rule that purports to give all health care providers, including pharmacists, absolute protection from discrimination resulting from their refusal to participate in—or even refer—certain procedures, including abortion and, in certain cases, *any* activity to which the health care provider has a religious objection.²² Unlike state policies that have emerged over the past decade, the federal policy does not balance the patient's right to access with the provider's religious rights, but instead defers solely to the provider.²³ Thus, states that have enacted laws requiring pharmacies, but not individual pharmacists, to fill all valid prescriptions, or that require pharmacists to at least refer the patient to another pharmacy, are potentially in conflict with, and therefore preempted by, the federal rule.²⁴ By focusing on the issue from a federalism standpoint, rather than a privacy standpoint, this Comment will show that the Department of Health and Human Services is improperly interfering with the balance states have created between pharmacist and patient rights, and that the states are ultimately better suited to this task. This Comment begins with an overview in Part II of the refusal rights of health care providers, focusing on the history and expansion of federal refusal clauses over the past four decades. Part III examines the shift in the debate over refusal clauses from abortion to contraception, and how states have responded to the conflicting demands of pharmacists' rights and patients' rights. Part IV analyzes the new HHS Rule and the clashes between those rules and existing state laws, asserting that the federal rule preempts state laws that have already provided the most appropriate balance of rights between

21. Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005) (requiring all pharmacies receiving Medicare or Medicaid payments to fill all legal prescriptions); Access to Legal Pharmaceuticals Act, S. 809, 109th Cong. (2005) (same); H.R. 1652, 109th Cong. (2005) (companion bill, House of Rep.); CAL. BUS. & PROF. CODE § 733 (West Supp. 2009) (placing burden of filling prescriptions on the pharmacy instead of the pharmacist); ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2009) (same).

22. Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,073 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88) [hereinafter HHS Refusal Rule].

23. *Id.* at 78,074; see discussion *infra* Part IV.A–B.

24. See discussion *infra* Part IV.B–C; see also *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 541 (2001) (discussing preemption doctrine).

providers and patients. Part V demonstrates that in addition to striking a more proper balance, the states are better suited than the federal government to enact such laws when viewed from a federalism standpoint. Part VI concludes, recommending repeal of the rule by the federal government.

II. THE EVER-EXPANDING REFUSAL CLAUSE: A HISTORICAL PERSPECTIVE ON FEDERAL REFUSAL LEGISLATION

A. *A Basic Definition of a Refusal Clause*

When a health care provider, such as a pharmacist, refuses to provide services required by a legal or ethical duty, that provider potentially faces legal liability and disciplinary action from a state licensing board or employer.²⁵ The debate over laws protecting health care providers who decline to participate in certain health services based on a religious or moral objection begins with a clash over what these laws should be called.²⁶ Proponents refer to them as “conscience clauses” and argue that health care providers have a right to refuse to participate in activities that violate their religious or moral consciences.²⁷ Opponents, on the other hand, refer to these laws as “refusal clauses” to emphasize that they allow health care providers to refuse to perform what would otherwise be a legal or ethical duty.²⁸ In this Comment, they shall be referred to as “refusal clauses,” primarily because the term best describes the action taken by the health care provider and the function of these laws to protect that action. However, as explained in the next section, this should not be mistaken for a dismissal of health provider consciences.

25. See Dykes, *supra* note 6, at 573 (describing potential consequences of following conscience in the absence of refusal clause); see also Noesen v. Wis. Dep’t of Regulation & Licensing, Pharmacy Examining Bd., 751 N.W.2d 385, 392 (Wis. Ct. App. 2008). (affirming state pharmacy board’s decision to reprimand pharmacist for refusing to dispense or transfer a patient’s prescription for oral contraceptives in absence of a refusal clause).

26. See Smearman, *supra* note 8, at 474 (detailing the meaning behind the different terminology used on both sides of the debate); ACLU, *supra* note 8, at 6 (defining and outlining the debate).

27. Compare Dykes, *supra* note 6, at 568 (“With adequate conscience clause protection, health care providers can decline to participate in objectionable procedures without fear of discrimination or punishment.”), with Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 244 (Cal. Ct. App. 1989) (“Implicit in the allegations of . . . [the] complaint is the contention that appellant’s right to control her treatment must prevail over respondent’s moral and religious convictions. We agree.”).

28. ACLU, *supra* note 8, at 6.

B. Provider Freedom in the Abortion Context

Though the health care provider's right is sometimes characterized merely as a personal autonomy right not to participate in objectionable activities, a more proper view of "conscience" is a right to protect one's moral integrity.²⁹ An appeal to conscience would produce something akin to the following: if a person performs the objectionable action, she might not be able to look at herself in the mirror, sleep at night, or otherwise live with her decision.³⁰ The threat stems not only from the forced nature of the action itself but from the resulting harm to the person's moral identity.³¹ As such, "the right to refuse to participate in acts that conflict with personal ethical, moral, or religious convictions is accepted as an essential element of a democratic society."³²

In addition to this right, there is a long history of protecting individual religious freedom in the United States, and it is generally accepted that a person should not be subject to discrimination based upon his or her religious views.³³ In fact, a body of law has developed to exempt religious individuals from generally applicable laws that burden their religious practices.³⁴ However, this protection is expressly limited by the Supreme Court's requirement that the religious accommodation not impose a substantial burden on persons *not* benefiting from the accommodation.³⁵

Health care providers, including pharmacists, also expect to base their decisions on an exercise of professional judgment,

29. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 2.

30. *Id.*

31. *Id.*

32. Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2009 (2004); *see also* Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician–Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 68 (1994) ("Integrity of conscience and professional judgement [sic] are moral rights of physicians. Society and patients have an obligation to respect them.").

33. *See, e.g.*, Civil Rights Act of 1964, Pub. L. No. 88-352, § 703(a)(1), 78 Stat. 241, 255 (codified at 42 U.S.C. § 2000e-2(a)(1) (2006)) (prohibiting employers from discharging or otherwise discriminating against "any individual with respect to his compensation, terms, conditions, or privileges of employment, because of . . . religion").

34. *See, e.g.*, *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005) (upholding the constitutionality of the Religious Land Use and Institutionalized Persons Act of 2000 as a permissible government accommodation of religion).

35. *Id.*; *see* Melissa Duvall, Comment, *Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women?*, 55 AM. U. L. REV. 1485, 1506–09 (2006) (arguing state refusal laws run afoul of the Establishment Clause where they give pharmacists an absolute right to refuse and impose no obligation to accommodate a woman's right to access legal prescriptions).

rather than have their decisions imposed by law.³⁶ Thus, health care providers' rights should not be dismissed outright; however, it is equally improper to ignore the limitations on the right to refuse, which arise out of patients' competing interests.

All persons have an autonomy interest in making their own medical decisions.³⁷ In addition, when it comes to a woman's reproductive health choices, the right to privacy is implicated.³⁸ A woman's privacy and autonomy interests, however, are given more weight in the decision to prevent a pregnancy than in the decision to terminate a pregnancy. With regard to abortion, the Supreme Court has held that women do not have an absolute right to access abortion services; rather, they have a right to do so without an "undue burden" imposed by the government.³⁹ On the other hand, a woman's right to access contraceptives is not similarly circumscribed. The Supreme Court has held that citizens have a right to access contraceptives and "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."⁴⁰ Early refusal clauses were constructed within the framework of the abortion debate, which has created many of the problems with pharmacist refusal clauses today.⁴¹ The next section will examine these early refusal clauses.

C. *The Church Amendment: The Birth of Federal Abortion Refusal Clauses*

Almost as soon as the ink was dry on the Supreme Court decision declaring a woman's right to choose to terminate her pregnancy before viability, Congress enacted the first federal

36. See Wilson, *supra* note 18, at 46. Though pharmacists are traditionally viewed as mere dispensers of medication, the pharmacist is not a mere automaton. Rather, the pharmacist has a duty to exercise professional judgment to ensure that patients use drugs properly and understand the risks that a drug may pose to a particular patient. Smearman, *supra* note 8, at 509.

37. Dennies Varughese, Comment, *Conscience Misbranded!: Introducing the Performer v. Facilitator Model for Determining the Suitability of Including Pharmacists Within Conscience Clause Legislation*, 79 TEMP. L. REV. 649, 656 (2006) (citing Carey v. Population Servs. Int'l, 431 U.S. 678, 687 (1977)).

38. *Id.* (citing Griswold v. Connecticut, 381 U.S. 479, 483–86 (1965)).

39. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874 (1992); see also Harris v. McRae, 448 U.S. 297, 315–17 (1980) (holding that the Hyde Amendment, which eliminated most federal funding for abortions, did not create an unconstitutional obstacle to abortion).

40. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

41. See *infra* Part III (discussing the way pharmacists have redefined contraception as abortion to fit within abortion refusal clauses).

refusal clause.⁴² With this law, Congress sought to clarify that individual health care providers at facilities receiving federal funds are under no obligation to perform a legal abortion or sterilization if such a procedure violates their moral or religious views.⁴³ The first federal refusal clause, known as the Church Amendment,⁴⁴ was proposed in direct response to a 1972 temporary injunction requiring that a Catholic hospital allow a sterilization procedure to be performed on its premises.⁴⁵ In issuing this injunction, a Montana district court reasoned that because the hospital received federal funds, it was a state actor and therefore could not deprive the plaintiff of her constitutional right to a sterilization procedure.⁴⁶ The Amendment then garnered the necessary support after the Supreme Court announced its decision in *Roe v. Wade*.⁴⁷

The Church Amendment really contains two provisions: a conscience provision and a nondiscrimination provision. The conscience provision of the Church Amendment allows individuals and health care entities to refuse to perform sterilizations or abortions if the procedures are against their religious beliefs.⁴⁸ The nondiscrimination provision forbids entities receiving certain federal funds from punishing individuals for exercising this right of refusal.⁴⁹

In addition to the requirements above, the following conscience provision was added to the Church Amendment in 1974 as part of the National Research Service Award Act of 1974:

No individual shall be required to perform or assist in the performance of *any part of a health service program or research activity* funded in whole or in part under a program administered by the Secretary of Health [and Human Services] if his performance or assistance in the

42. Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401, 87 Stat. 91, 95 (codified as amended at 42 U.S.C. § 300a-7 (2006)).

43. 42 U.S.C. § 300a-7 (2006); see also Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 144–50 (2003) (tracing the legislative backlash following the *Roe* decision).

44. The amendment was named after its sponsor, Senator Frank Church of Idaho. Eisenstadt, *supra* note 43, at 144–45.

45. 119 CONG. REC. 9595 (1973) (statement of Sen. Church); see also Taylor v. St. Vincent's Hosp., 369 F. Supp. 948, 948–51 (D. Mont. 1973) (finding the Health Programs Extension Act of 1973 prohibited the court from exercising jurisdiction over the case and therefore dissolving the previously granted temporary injunction), *aff'd*, 523 F.2d 75, 76–78 (9th Cir. 1975).

46. Taylor, 369 F. Supp. at 950 n.1.

47. See Eisenstadt, *supra* note 43, at 145–46.

48. 42 U.S.C. § 300a-7(d) (2006).

49. 42 U.S.C. § 300a-7(c) (2006).

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performance . . . would be contrary to his religious beliefs or moral convictions.⁵⁰

This section, however, does not contain as broad a nondiscrimination clause as the provisions regarding sterilization and abortion:

No entity which receives . . . a grant or contract for biomedical or behavioral research under any program administered by the Secretary of Health [and Human Services] may . . . discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel . . . because he performed or . . . refused to perform or assist in the performance of any [lawful health service or research] activity on the grounds that his performance or assistance in the performance of such service or activity would be contrary to his religious beliefs or moral convictions⁵¹

In sum, the Church Amendment mandates that public officials and courts allow individuals to refuse to provide sterilization or abortion services that conflict with their religious convictions, without fear of discrimination.⁵² Additionally, the Amendment broadly states that no individual “shall” be forced to perform any activity that is part of a health service program or research activity if that activity contravenes his or her religious beliefs.⁵³ However, the only actor prohibited from discriminating on this basis is an “entity” doing biomedical or behavioral research with funds from HHS, and thus the prohibition does not extend to all entities receiving federal funding.⁵⁴ Despite the potentially broad construction of this provision, the Church Amendment has been largely understood (at least until recently) to pertain only to sterilization and abortion.⁵⁵

50. Pub. L. No. 93-348, § 214, 88 Stat. 342 (1974) (codified as amended at 42 U.S.C. § 300a-7(d) (2006)) (emphasis added).

51. Pub. L. No. 93-348, § 214, 88 Stat. 342 (1974) (codified as amended at 42 U.S.C. § 300a-7(c)(2) (2006)).

52. 42 U.S.C. § 300a-7(b)-(c) (2006); *see also* Taylor v. St. Vincent's Hosp., 523 F.2d 75, 77 (9th Cir. 1975) (affirming protection of religious hospital's right to refuse to perform sterilization pursuant to the Church Amendment).

53. 42 U.S.C. § 300a-7(d) (2006).

54. 42 U.S.C. § 300a-7(c)-(d). The Church Amendment does not define the term “entity.” *Id.*

55. *See, e.g.*, 119 CONG. REC. 9595 (1973) (statement of Sen. Church) (“The amendment would simply clarify the intent of Congress with respect to the significance of accepting Federal funding as it might apply to the question of performing abortions or sterilizations in religious[ly] affiliated hospitals”); Taylor, 523 F.2d at 77 (acknowledging the “need to protect . . . denominational hospitals with religious or moral scruples against sterilizations and abortions” (internal quotation marks omitted)); Eisenstadt, *supra* note 43, at 145-47 (explaining that the initial concerns spurring the

Because the Church Amendment protects only individuals or entities that receive federal funding, states began enacting their own refusal clauses, modeled on the federal law, to protect health care providers not covered by the Church Amendment.⁵⁶ By 1978, more than forty states had enacted some form of refusal clause relating to abortion, sterilization, and, in at least one instance, contraception.⁵⁷ After this flurry of legislative activity in the 1970s, the issue of refusal clauses largely lay dormant until the 1990s.

D. Recently Expanding Federal Refusal Clauses

A number of factors, including the rise of the managed care system and the central role of religious hospitals in that system, converged in the 1990s to bring refusal clauses back into the forefront of national attention.⁵⁸ Since the 1970s, refusal clauses have evolved from narrow exemptions permitting individuals and certain institutions to refuse to perform abortions and sterilizations to broader exemptions encompassing a growing class of individual health care providers and institutions and wider circumstances in which they can refuse.⁵⁹

passage of the Church Amendment pertained to abortion and sterilization); Jody Feder, *Federal and State Laws Regarding Pharmacists Who Refuse to Dispense Contraceptives*, in CRS REPORT FOR CONGRESS 1 (Cong. Research Serv., CRS Report RS22293, 2005), available at http://www.policyarchive.org/bitstream/handle/10207/4243/RS22293_20051007.pdf (“Until recently, most conscience clause laws were designed to allow medical practitioners to opt out of providing abortion-related services.”).

56. See ACLU, *supra* note 8, at 1 (noting that after the Church Amendment was passed many states “soon followed suit” by enacting refusal clauses pertaining to abortion, sterilization, and contraception).

57. *Id.* A typical statute, such as Ohio’s refusal clause, provides that no hospital or individual is required to perform, permit, or participate in medical procedures that result in abortion, and that such a refusal cannot be a basis for civil liability or disciplinary action. OHIO REV. CODE ANN. § 4731.91 (LexisNexis 2006). By contrast, the Arkansas refusal clause, enacted in 1973, allows a pharmacist or physician to refuse to “furnish any contraceptive procedures, supplies, or information.” ARK. CODE ANN. § 20-16-304(4) (2005).

58. See Smearman, *supra* note 8, at 477 (“The issue [of refusal clauses] gained renewed attention beginning in the mid-1990s with the managed care explosion and the emergence of Catholic hospitals as a significant power in the provision of health care.” (footnotes omitted)); Rachel Benson Gold, *Conscience Makes a Comeback in the Age of Managed Care*, GUTTMACHER REP. ON PUB. POL’Y, Feb. 1998, at 1, available at <http://www.guttmacher.org/pubs/tgr/01/1/gr010101.pdf> (“[T]he managed care revolution is yielding a crop of new conscience laws[,] . . . which are broadening traditional conscience-law concepts . . .”); Susan Berke Fogel & Lourdes A. Rivera, *Saying Roe Is Not Enough: When Religion Controls Health Care*, FORDHAM URB. L.J. 725, 727 (2004) (“The growing influence of . . . [religiously controlled] health systems has resulted in a proliferation of refusal clauses . . .”); see generally Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1446–47 (1995) (examining the rise of religious hospitals in the era of managed care and the conflicts between hospitals’ religious beliefs and legal duties to treat).

59. See Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP. ON PUB. POL’Y, Aug. 2005, at 7, 7–9, available at

In 1996, the Coats Amendment further modified the Public Health Service Act by expanding the class of individuals protected under the federal refusal clause to prohibit governments from discriminating in the accreditation and certification of medical schools and physicians.⁶⁰ In pertinent part, the Coats Amendment provides:

The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity⁶¹ to discrimination on the basis that . . . the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to *provide referrals* for such training or such abortions⁶²

Specifically, the Coats Amendment prohibits governments from basing accreditation of “postgraduate physician training programs” on whether such a program provides or refuses to provide training in abortion techniques.⁶³ The Coats Amendment is important because it protects not only those individuals who wish not to *perform* abortions but also those who wish to take their objection a step further and refuse to *refer* patients to another doctor or facility.⁶⁴

The Weldon Amendment, which Congress has added to the Department of Health and Human Services Appropriations Act every year since 2004,⁶⁵ provides:

None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity⁶⁶

<http://www.guttmacher.org/pubs/tgr/08/3/gr080307.pdf>; Varughese, *supra* note 37, at 651 (“[T]he application of conscience clauses has liberally evolved to include reproductive health, end-of-life care, and right-to-die issues.”); Fogel & Rivera, *supra* note 58, at 746 (“[R]efusal clauses have been expanded beyond issues of individual beliefs to apply to entire corporate health systems.”).

60. Coats Amendment, Pub. L. No. 104-134, § 515, 110 Stat. 1321, 1321-245 (1996) (codified as amended at 42 U.S.C. § 238n (2006)).

61. The Amendment defines “health care entity” to include individual physicians, postgraduate physician training programs, and participants in programs of training in the health professions. 42 U.S.C. § 238n(c)(2) (2006).

62. 42 U.S.C § 238n(a) (2006) (emphasis added).

63. 42 U.S.C § 238n(b) (2006).

64. 42 U.S.C § 238n(a)–(b) (2006).

65. Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508(d)(1), 121 Stat. 1844, 2209 (2007); Revised Continuing Appropriations Resolution, 2007, Pub. L. No. 110-5, § 2, 121 Stat. 8, 8; Dep’t of Labor Appropriations Act of 2006, Pub. L. No. 109-149, § 508(d)(1), 119 Stat. 2833, 2879–80 (2005); Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 507(d)(1), 118 Stat. 2809, 3163 (2004).

66. “Health care entity” is defined to include “an individual physician or other

to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or *refer* for abortions.⁶⁷

Unlike the previous nondiscrimination clauses, the Weldon Amendment adds sanctions for noncompliance: the termination of funds appropriated by HHS.⁶⁸ Like the Coats Amendment, the Weldon Amendment relates solely to abortion; however, the Weldon Amendment is significant because it expands the covered entities to include not only individual doctors and hospitals but also insurance plans and any other type of health care facility.⁶⁹

Thus by 2008, federal refusal clauses had expanded in two ways from the Church Amendment: first, to include not only individual health care providers but also managed care organizations and insurance companies; and second, to include not only the actual performance of an objectionable procedure but also the referral of such a procedure. Federal policy, at least with regard to abortion, has come down firmly on the side of protecting the provider. However, federal refusal clause legislation remains focused on abortion. The next section will examine the way some pharmacists have begun refusing to dispense contraceptives by arguing that they are protected by federal refusal clauses, and how states have responded to protect patient rights.

III. SHIFTING THE ABORTION DEBATE TO PHARMACIST REFUSALS

At the end of the twentieth century, new pharmaceuticals, such as Mifepristone, a pill that induces abortion, and emergency contraception, a pill containing high doses of oral contraceptives

health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." Consolidated Appropriations Act, Pub. L. 108-447, § 508(d)(2), 118 Stat. 2809, 3163 (2005).

67. Consolidated Appropriations Act, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2005) (emphasis added).

68. *Id.*

69. Consolidated Appropriations Act, Pub. L. No. 108-447, § 508(d)(2), 118 Stat. 2809, 3163 (2005); see Jody Feder, *The History and Effect of Abortion Conscience Clause Laws*, in CRS REPORT FOR CONGRESS 3 (Cong. Research Serv., CRS Report RS21428, 2006), available at http://www.policyarchive.org/bitstream/handle/10207/3696/RS21428_20060227.pdf ("[T]he new conscience clause law is broader because it allows Medicaid and Medicare-funded health plans to refuse to provide counseling and referral for abortion-related services, whereas earlier conscience clause laws permitted providers to opt out only of the actual provision of such services."); see also Tresa Baldas, *Fighting Refusal to Treat*, NAT'L L.J., Feb. 7, 2005, at 1 (examining the breadth of and legal challenges to the Weldon Amendment).

to prevent pregnancy, brought pharmacists into the debate over the right to refuse to dispense such medications.⁷⁰ At the same time, a shift occurred in the debate over reproductive rights, as the pro-life movement expanded its agenda beyond simply advocating against abortion to include advocating a “culture of life”—reducing the need for abortion by reducing the incidence of premarital sex.⁷¹ This segment of the pro-life movement seeks to accomplish this objective by making contraceptives more difficult to obtain, based on the belief that access to contraceptives encourages people to engage in sex.⁷² This section will first examine the rights of pharmacists and patients in the refusal context and the method of balancing those rights developed by the medical community. Next, this section will explore the methods the states have come up with to balance those rights.

A. *Provider Freedom and Patient Rights in the Contraception Context*

The 1965 landmark decision *Griswold v. Connecticut* ensured the nationwide legality of prescription contraceptives.⁷³ The Supreme Court has since held that citizens have a right to access contraceptives, and “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁷⁴ Patients today have expectations when it comes to their medical care, including: access to prescribed medications, respect for their personal autonomy and privacy, and confidence that their medical needs will guide their care.⁷⁵ Specifically, patients expect

70. Holly Teliska, Recent Development, *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, 234–35 (2005) (recounting the debate among pharmacy scholars over dispensing emergency contraception).

71. See Cristina Page, *The Fight to Stop Contraception*, CAPITAL TIMES (Madison), June 6, 2008 (describing rise of anti-contraceptive protests outside women’s clinics and the shift in pro-life agenda) (on file with Houston Law Review).

72. See, e.g., Michael New, *Abortion Advocates’ Making Contraception an Election Issue May Backfire*, LIFENEWS.COM, Aug. 5, 2008, <http://www.lifenews.com/nat4102.html> (advocating a “culture of life” in which “the best strategy for reducing abortion is to reduce the incidence of premarital sex”); see also KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 172 (1984) (“[P]ro-life people believe that the availability of contraception is what encourages teens to have sex in the first place, so they feel that sex education and contraception simply add fuel to the fire.”).

73. *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965) (holding constitutional right to privacy gives married couples the right to use birth control); see also *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (extending this protection to unmarried persons).

74. *Eisenstadt*, 405 U.S. at 453.

75. See Wilson, *supra* note 18, at 45–46 (2008) (outlining patient and provider expectations).

that their providers' decisions will be based upon prevailing medical knowledge, rather than on personal religious beliefs.⁷⁶ As even proponents of refusal clauses acknowledge, "a health care provider's autonomy cannot be exercised in a way that violates a patient's autonomy in making her own choices."⁷⁷ But, "neither should the patient's autonomy be exercised in a way that would trump the values and choices of the health care provider as a human being."⁷⁸

It is apparent from this discussion that there must be a way to balance the rights of patients and providers to ensure that providers are not forced to take action that will violate their moral integrity, while ensuring that women have access to legal and constitutionally protected prescriptions. Unlike in the abortion context, neither providers nor patients have an absolute right to have their needs met at the expense of the other.⁷⁹ Therefore, policymakers must determine the proper balance after weighing the concerns on each side of the argument.⁸⁰

Though there are many possible solutions, including requiring pharmacies to post notices of their policies or requiring transfers or referrals,⁸¹ one solution that is increasingly embraced by the states is similar to the one endorsed by the American Pharmacists Association. Health care providers, including pharmacists, have a duty to respect patient autonomy and to avoid imposing their views on patients who do not share their religious beliefs.⁸² These duties arise out of the provider's choice to enter the profession, a choice that requires providers to abide by professional norms.⁸³ To further these

76. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 3–4 (proposing scientific integrity as one potential limitation on conscientious refusal).

77. Varughese, *supra* note 37, at 658.

78. Dykes, *supra* note 6, at 567; *see also supra* Part II.B (reviewing provider rights).

79. *See supra* notes 37–40 and accompanying text (discussing right to privacy in abortion and contraceptive contexts).

80. *See* Wilson, *supra* note 18, at 60–61 (discussing considerations for policymakers). *But see* Jed Miller, Note, *The Unconscionability of Conscience Clauses: Pharmacists' Consciences and Women's Access to Contraception*, 16 HEALTH MATRIX 237, 269–70 (2006) (arguing refusal clauses are unconstitutional because they are not narrowly tailored to advance a compelling state interest).

81. *See* Miller, *supra* note 80, at 270–72 (discussing notice requirements and mandatory patient transfer as potential solutions).

82. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 3–4 (outlining the professional and ethical responsibilities of physicians to their patients when conscientious refusal creates a conflict); AM. PHARMACISTS ASS'N, CODE OF ETHICS FOR PHARMACISTS (1994), <http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisp lay.cfm&ContentID=2903> [hereinafter APHA CODE OF ETHICS].

83. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 3 (emphasizing the set of moral

ends, the American Pharmacists Association and American Medical Association have developed guidelines for pharmacists (and other health care providers) who face decisions affecting their conscience.⁸⁴

B. Professional Standards

Pharmacists must comply with professional standards set forth by their state's laws regulating pharmacist conduct.⁸⁵ Typical state statutes require pharmacists to comply with the prevailing standard of care, which is largely informed by the ethical standards set forth by the American Pharmacists Association (APhA).⁸⁶ The APhA's ethical standards require pharmacists to "respect[] personal and cultural differences among patients" and to "place[] concern for the well-being of the patient at the center of professional practice."⁸⁷ While respecting patient autonomy is key, the APhA has also adopted a policy of accommodating an individual pharmacist's right of conscientious refusal, so long as the patient's needs can still be met.⁸⁸ The policy, formulated in 1998, reads as follows:

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. When this policy is implemented correctly, and proactively, it is seamless to the patient, and the patient is not aware that the pharmacist is stepping away from the situation. In sum, APhA supports the ability of the pharmacist to step away,

values and duties that physicians accept upon entering the medical profession, "which must precede a provider's personal interests").

84. APhA CODE OF ETHICS, *supra* note 82; AM. MED. ASS'N, PRESERVING PATIENTS' ABILITY TO HAVE LEGALLY VALID PRESCRIPTIONS FILLED (June 20, 2005), available at <http://www.ruralhealthweb.org/index.cfm?objectid=3F82625F-1185-6B66-88D365ACFC0FB6B2>.

85. See Teliska, *supra* note 70, at 236 ("[S]tate pharmacy boards develop specific guidelines for their state-licensed pharmacists to follow").

86. See Noesen v. Wis. Dep't of Regulation & Licensing, Pharmacy Examining Bd., 751 N.W.2d 385, 391 (Wis. Ct. App. 2008) (declining to establish the relevant standard of care but citing potential sources in Wisconsin law and publications of APhA); APhA CODE OF ETHICS, *supra* note 82 (stating that the principles set forth in the Code of Ethics "are established to guide pharmacists in relationships with patients, health professionals, and society").

87. APhA CODE OF ETHICS, *supra* note 82.

88. AM. PHARMACISTS ASS'N, ISSUE BRIEF: FEDERAL CONSCIENCE CLAUSES 3 (2009), <http://www.pharmacist.com/AM/Template.cfm?Section=Issues&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=20005>.

not in the way, and supports the establishment of an alternative system for delivery of patient care.⁸⁹

Basically, the APhA encourages its members to follow a “dispense or refer policy” so pharmacists are not forced to violate their conscience, but patients are not affected by a pharmacist’s decision to conscientiously refuse service.⁹⁰

C. *The Problem*

As the examples in the introduction show, the real problem arises where pharmacists believe that following the APhA policy in and of itself constitutes a violation of their conscience. Indeed, there is an increasing movement among religious health care providers (not just pharmacists) to view a referral as essentially the same as actually committing the objectionable act.⁹¹ For example, Karen Brauer, the President of Pharmacists for Life, explained that referring a customer to a fellow pharmacist to obtain emergency contraceptives “is like saying ‘I don’t kill people myself but let me tell you about the guy down the street who does.’”⁹² To support their decision not to follow APhA policy, these pharmacists have pointed to federal refusal clauses, which protect health care providers who refuse to refer or counsel patients for abortion.⁹³ This is a problem because a patient’s right to contraception must be balanced with a provider’s conscience right. This is unlike the abortion context, where Congress and the Supreme Court have established that the provider’s conscience right trumps the patient’s privacy right.⁹⁴ Additionally, pharmacies (not just individual pharmacists) have sought the protection of abortion refusal clauses, pointing to the expansion of federal refusal clauses to protect a wide range of entities.⁹⁵

89. *Id.* (emphasis added).

90. *Id.*; see also Teliska, *supra* note 70, at 239 (arguing that the APhA policy is “inconsistent with the Code of Ethics, which obligates pharmacists to focus foremost on patients’ needs”).

91. See Spreng, *supra* note 13, at 274 (noting that some pharmacists view referring a patient to another pharmacist to dispense an abortifacient as tantamount to an act against human life).

92. Sophia Rowlands, *Chapter 417: Contraceptives and Conscience Find Compromise in California*, 37 MCGEORGE L. REV. 166, 171 (2006).

93. See discussion *infra* Part II.C–D (analyzing federal refusal clauses).

94. See *supra* notes 37–41 and accompanying text (discussing weight of patients’ rights of access in contraception and abortion contexts).

95. See *supra* Part II.D (examining expansion of federal refusal clauses to include entities as well as individuals); see also Wilson, *supra* note 18, at 61 (“[S]ociety should be more concerned for the conscientious objections of individuals than of facilities, which lack a moral being and consequently cannot suffer metaphysical consequences

D. State Refusal Clauses and “Fill or Refer” Rules

Most states implemented refusal clauses similar to the Church Amendment during the 1970s in order to protect doctors and nurses from discrimination for refusing to perform or assist in abortions or sterilizations.⁹⁶ Only four states—Georgia, Mississippi, Arkansas, and South Dakota—expressly give pharmacists a similar right to refuse.⁹⁷ Pharmacists in other states increasingly base their right to object on a redefinition of certain types of contraceptives as abortion or as agents capable of causing abortion.⁹⁸ As a result, states with general *Roe*-era refusal clauses are coming up with innovative ways to ensure that women have access to legal contraceptives while respecting pharmacists’ personal freedom. This section will examine the laws implemented by Illinois and California to illustrate two of these approaches.

Illinois has an expansive general refusal clause. The Health Care Right of Conscience Act protects doctors, nurses, medical students, and other health care personnel who refuse to “perform, assist, counsel, suggest, recommend, refer or participate in any way” in services that violate their “sincerely held set of moral convictions arising from belief in and relation to God.”⁹⁹ In 2005, in response to a well-publicized account of a pharmacist turning away a woman seeking emergency contraception, Illinois Governor Rod Blagojevich issued an emergency rule requiring pharmacies to accept and fill prescriptions for all contraceptives “without delay” and establishing a toll-free number for Illinois residents to report

for their choices.”).

96. See *supra* notes 56–57 and accompanying text (providing examples of the typical state refusal clauses).

97. ARK. CODE ANN. § 20-16-304(4) (2005) (“Nothing in this subchapter shall prohibit a . . . pharmacist . . . from refusing to furnish any contraceptive procedures, supplies, or information . . .”); S.D. CODIFIED LAWS § 36-11-70 (2004) (allowing a pharmacist to refuse to dispense medication if there is reason to believe that the medication would be used to “[d]estroy an unborn child”); S.D. CODIFIED LAWS § 22-1-2(50A) (2004 & Supp. 2009) (defining “unborn child” as existing “from fertilization until live birth”); MISS. CODE ANN. §§ 41-107-3 to 107-5 (West 2007) (providing that a health care provider has the right not to participate in a service that violates his or her conscience, and defining “health care provider” as “including, but not limited to . . . [a] pharmacist”); GA. COMP. R. & REGS. § 480-5-.03(n) (2009) (“It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs.”).

98. Varughese, *supra* note 37, at 660 (“To substantiate their right to refuse, pharmacists point to a new scientific debate, framed best ‘as a conflict about when a pregnancy begins,’ generated by infusing religious orthodoxy into traditional scientific principles of reproductive physiology.” (quoting Teliska, *supra* note 70, at 235)).

99. 745 ILL. COMP. STAT. ANN. 70/3(a), 70/4 (2008).

refusals.¹⁰⁰ The rule, which became permanent on August 25, 2005, provides that “[u]pon receipt of a valid, lawful prescription for a contraceptive, a retail pharmacy . . . *must dispense the contraceptive . . . to the patient . . . without delay*, consistent with the normal timeframe for filling any other prescription.”¹⁰¹ The term “contraceptives” in the Illinois rule includes all FDA-approved contraceptives, including emergency contraceptives.¹⁰² The rule further provides:

If the contraceptive . . . is not in stock, the pharmacy must obtain the contraceptive under the pharmacy’s standard procedures [I]f the patient prefers, the prescription must be transferred to a local pharmacy of the patient’s choice Under any circumstances an unfilled prescription for contraceptive drugs must be returned to the patient if the patient so directs.¹⁰³

Thus, the Illinois rule puts the burden on the pharmacy, rather than on the individual pharmacist, to meet the needs of the patient. Indeed, Illinois courts have ruled that the Health Care Right of Conscience Act protects individual pharmacists who exercise their conscientious refusal.¹⁰⁴ As one commentator noted, “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.”¹⁰⁵ More recent Illinois regulations make it clear that a pharmacy can choose not to carry *any* contraceptives, but if a pharmacy carries ordinary birth control pills, it must also carry emergency contraceptives.¹⁰⁶ In

100. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1) (2009); 29 Ill. Reg. 5586 (Apr. 15, 2005) (“Recent instances of a pharmacy’s refusal to dispense legally prescribed contraceptives has resulted in delay and/or prevention of women from meeting their most basic health needs [T]he refusal to dispense contraceptive prescription drugs without providing reasonable alternatives for the protection of the patient constitutes a threat to the public interest, safety, or welfare.”).

101. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1) (2009) (emphasis added).

102. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(5) (2009); *Vandersand v. Wal-Mart Stores, Inc.*, 525 F. Supp. 2d 1052, 1054 (C.D. Ill. 2007) (“As quoted . . . [in ILL. ADMIN. CODE tit. 68, § 1330.91(j)], the term ‘contraceptives’ . . . includes all FDA-approved contraceptives, which includes Emergency Contraceptives.”).

103. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(1) (2009).

104. *Vandersand*, 525 F. Supp. 2d at 1057.

105. Smearman, *supra* note 8, at 538. A group of pharmacists and pharmacies challenged the rule, claiming it violates the Illinois Health Care Right of Conscience Act, as well as their religious freedom. *See Morr-Fitz, Inc. v. Blagojevich*, 901 N.E.2d 373, 377 (Ill. 2008). Thus far, the Illinois Supreme Court has ruled that the plaintiffs present a justiciable claim, but no ruling has issued on the merits. *Id.* at 392–93.

106. ILL. ADMIN. CODE tit. 68, § 1330.91(j)(2) (2009) (directing each pharmacy to “use

promulgating these regulations, Illinois has chosen a balance that respects individual pharmacists' religious beliefs while ensuring that women still have access to legal medication, both ordinary contraceptives and emergency contraceptives, by placing the duty to dispense on the pharmacy, not the pharmacist.

Unlike Illinois, California has a narrower abortion refusal clause, which allows doctors, nurses, hospital employees, and certain hospitals to refuse to participate in abortions based on moral or religious objection.¹⁰⁷ In 2006, California passed a law that requires licensed pharmacists to dispense all legal prescriptions, unless: (1) the pharmacist believes it is illegal or would adversely affect the patient's medical condition; (2) the medication is not in stock; or (3) the pharmacist has given prior written notice of religious or moral objection to the pharmacist's employer so that that employer may make a "reasonable accommodation" to "establish protocols that ensure that the patient has timely access to the prescribed drug"—basically, either to have another pharmacist on duty to fill in for those prescriptions, or to require the objecting pharmacist to refer the patient to another pharmacy.¹⁰⁸ This comports with the APhA's standard advocating a "dispense or refer" policy.¹⁰⁹ If a pharmacist does not comply with the requirements of this law, he or she will be subject to disciplinary action.¹¹⁰ Additionally, if an employer is unable to make a "reasonable accommodation"—for example, if the pharmacy is unable to employ more than one pharmacist or the objecting pharmacist refuses to refer prescriptions—it may be permissible to fire the pharmacist.¹¹¹ However, some argue that requiring pharmacists to "go on record with their beliefs and burdening employers with accommodating those beliefs could foster a hostile work environment and even

its best efforts to maintain adequate stock of emergency contraception to the extent that it continues to sell contraception"); see Sonfield, *supra* note 14, at 5 ("[T]he regulation prohibits a pharmacy from making an arbitrary distinction between emergency contraception and ordinary birth control pills, as they share the same mechanism of action.").

107. CAL. HEALTH & SAFETY CODE § 123420 (West 2006).

108. CAL. BUS. & PROF. CODE § 733(a)–(b) (West Supp. 2009).

109. See *supra* Part III.C (describing APhA's refusal policy).

110. CAL. BUS. & PROF. CODE § 733(a) (West Supp. 2009).

111. See Lora Cicconi, Comment, *Pharmacist Refusals and Third-Party Interests: A Proposed Judicial Approach to Pharmacist Conscience Clauses*, 54 UCLA L. REV. 709, 725–28 (2007) (analyzing reasonable accommodation law in pharmacist refusal context); Rowlands, *supra* note 92, at 172 (noting opponents' concern that objecting pharmacists may not be protected if an employer is unable to make reasonable accommodation without undue hardship upon notice of objection).

jeopardize jobs and employment opportunities for objecting individuals.”¹¹²

Unlike Illinois and California, which relieve the individual pharmacist of the burden of dispensing medications to which they object by placing that burden on the pharmacy, some states require individual pharmacists to dispense medications, regardless of their personal beliefs.¹¹³ However, a federal district court granted a preliminary injunction staying the enforcement of a similar Washington statute, which required individual pharmacists to either fill or “refuse and refer” the prescription to another pharmacist or pharmacy, because it impermissibly targeted religious individuals in violation of the Free Exercise Clause of the Constitution.¹¹⁴

The contours of acceptable accommodations of pharmacist refusals have emerged in recent years through state legislation and administrative rulemaking. These largely comport with the professional standards put forth by the APhA, which demand that patients’ rights to legal prescriptions be met while respecting individual pharmacists’ rights to object based on religious or moral views about contraception. In addition to these laws and rules, state pharmacy boards, including the Texas State Pharmacy Board, are increasingly making statements to reiterate the professional standard put forth by the APhA.¹¹⁵ The next section will show how this “emerging consensus” has been disrupted by a federal rule promulgated by the Department of Health and Human Services.

112. Rowlands, *supra* note 92, at 172 (2006) (citing Letter from Amy J. Koons, Leg. Liaison, Capitol Res. Inst., to Cal. State Senate, Bus., Prof., and Econ. Dev. Comm. (Apr. 19, 2005)).

113. See, e.g., ME. REV. STAT. ANN. tit. 32, § 13795(2) (Supp. 2008) (granting pharmacists the discretion to refuse to fill a valid prescription “if unsatisfied as to the legitimacy or appropriateness of any prescription presented, the validity of any photographic identification or the identity of any patient presenting a prescription or any person acting on behalf of the patient”); 02-392-19 ME. CODE R. § 11 (Weil 2009) (“A pharmacist may refuse to fill a prescription or dispense a drug only as permitted by [ME. REV. STAT. ANN. tit. 32, § 13795(2)].”).

114. *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245, 1264–66 (W.D. Wash. 2007). *But see* Marci Hamilton, *Why a Federal District Court Was Wrong to Apply Strict Scrutiny to a Washington State Law Requiring Pharmacies, but Not Individual Pharmacists, to Fill “Plan B” Prescriptions*, FINDLAW, Nov. 15, 2007, <http://www.pharmacist.com/AM/Template.cfm?Section=Issues&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=20005> (arguing that strict scrutiny was an improper standard in deciding *Stormans, Inc. v. Selecky*).

115. Sonfield, *supra* note 14, at 5; see, e.g., Texas State Board of Pharmacy, Plan B, <http://www.tsbp.state.tx.us/planb.htm> (last visited Sept. 19, 2009) (“If a pharmacist is unable to sell a medication or fill a particular prescription for any reason, he [or] she should refer the patient to another pharmacist at the pharmacy, if possible, or refer the patient to a pharmacy where the patient may obtain the medication.”).

IV. DECEMBER 2008 HHS REFUSAL RULE:
UPSETTING THE BALANCE OF PATIENT AND
PROVIDER RIGHTS ESTABLISHED BY STATE LAWS

Though toned down from an earlier version leaked to the media in July 2008, which purported to define abortion in such a way as to include many methods of contraception, this midnight administrative rule represents a last ditch attempt to restrict access to abortion and contraceptives, even where states have attempted to protect such access.¹¹⁶ As we have seen, federal laws protect health care providers' rights of conscience with regard to abortion services.¹¹⁷ The HHS Refusal Rule diverges from current federal law and conflicts with certain state laws because it protects pharmacists' *and* pharmacies' rights to refuse to fill *or refer* prescriptions that violate their religious or other moral convictions.¹¹⁸ The rule, formally proposed in August 2008, is highly controversial and sparked over 200,000 comments in opposition.¹¹⁹

Though federal refusal clauses have been on the books since 1973,¹²⁰ in 2008, HHS was purportedly concerned that federal nondiscrimination laws were being broken.¹²¹ Thus, HHS sought to "clarify] the scope of [existing] protections" and to "provide[] for the implementation and enforcement of federal nondiscrimination statutes protecting the conscience rights of health care entities."¹²² The rule contains new definitions,

116. Compare HHS Refusal Rule, *supra* note 22, at 78,072, 78,098 with U.S. Dep't of Health & Human Servs., Draft, at 16–17, available at <http://www.rhrealitycheck.org/emailphotos/pdf/HHS-45-CFR.pdf> (last visited Sept. 19, 2009) [hereinafter Leaked Draft]; see also PLANNED PARENTHOOD, GEORGE W. BUSH'S WAR ON WOMEN: A PERNICIOUS WEB (on file with author) (chronicling the Bush Administration's reduction of access to family planning based on pro-life ideology).

117. See *supra* Part II (discussing federal abortion refusal clauses).

118. HHS Refusal Rule, *supra* note 22, at 78,097–98.

119. Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274, 50,282 (Aug. 26, 2008); Scott Swenson, *Overwhelming Opposition Floods HHS Refusal Clause Proposal: 200,000+*, RH REALITY CHECK, Sept. 26, 2008, <http://www.rhrealitycheck.org/blog/2008/09/26/overwhelming-opposition-floods-hhs-refusal-clause-proposal-200000>; see National Women's Law Center, *What Are Some Key Organizations Saying About the Proposed HHS Rule?*, <http://www.nwlc.org/pdf/keyorgsonhhsrule.pdf> (last visited Sept. 19, 2009) (summarizing letters written by various organizations in opposition to the rule).

120. See *supra* Part II.C (discussing federal refusal laws enacted since 1973).

121. Press Release, U.S. Dep't of Health & Human Servs., HHS Secretary Calls on Certification Group to Protect Conscience Rights (Mar. 14, 2008), available at <http://www.hhs.gov/news/press/2008pres/03/20080314a.html> (discussing Health and Human Services Secretary Mike Leavitt's concern that a new policy by the American College of Obstetricians and Gynecologists would force physicians to violate their conscience).

122. HHS Refusal Rule, *supra* note 22, at 78,074, 77,090.

prohibitions on health care entities that receive federal funds, and a requirement that those entities certify their compliance with the rule, or face a possible loss of federal funds.¹²³ This section will show that the HHS Refusal Rule, unlike the carefully balanced state rules emerging in recent years, sides solely with the provider, rather than balancing the rights of the provider and patient. Further, although the rule is couched primarily in the terms of the federal refusal statutes—meaning it purports to apply to abortion and sterilization only—the rule reaches the subject of state refusal clauses by failing to provide a definition of abortion and by specifically including pharmacies.¹²⁴

A. *The Content of the Rule*

The crux of the HHS Refusal Rule is the certification requirement, 42 C.F.R. § 88.5, which requires all organizations and individuals receiving funds from HHS, including state and local governments, to certify in writing that they will not:

discriminate against any physician or other health care professional in the employment, promotion, termination, or extension of staff or other privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions.¹²⁵

The rule defines “assist in the performance” to mean “participate in any activity with a *reasonable connection* to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity.”¹²⁶ The rule makes it clear that this includes not just the actual performance of such an activity, but also the “referral, training, and other arrangements for the procedure, health service, or research activity.”¹²⁷ “Health care entity” and “entity” have the same definition, and include:

123. *Id.* at 78,090–92; *see also* Letter from Rick Pollack, Executive Vice President, Am. Hosp. Ass’n, to Michael O. Leavitt, Sec’y, U.S. Dep’t of Health & Human Servs. (Sept. 23, 2008), *available at* <http://www.aha.org/aha/letter/2008/080923-cl-conscience-clause.pdf> (“Compliance failures bring with it severe penalties—loss of federal funds.”).

124. *See, e.g.*, HHS Refusal Rule, *supra* note 22, at 78,072 (describing federal refusal laws as “prohibit[ing] discrimination on the basis of one’s objection to, participation in, or refusal to participate in, specific medical procedures, *including* abortion or sterilization” (emphasis added)).

125. *Id.* at 78,099.

126. *Id.* at 78,097 (emphasis added).

127. *Id.*

an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility.¹²⁸

HHS responses to comments on the definition of “entity” clarify that pharmacists and pharmacies are included in the definition, as does the chart in the economic impact analysis, which lists both pharmacy schools and chain and independent pharmacies.¹²⁹

The other portions of the rule restate the provisions of the federal refusal clauses, emphasizing that no entity or state or local government receiving HHS funds may discriminate against individuals or entity health care providers for refusing to “assist in the performance” of abortion.¹³⁰ Because the definition of abortion is left open, this may include certain types of contraceptives.¹³¹

Further, the last provision of the rule, which is to be codified at 42 C.F.R. § 88.4(d), goes beyond abortion and sterilization to prohibit “[a]ny entity, including a State or local government, that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services,” from requiring “any individual to perform or assist in the performance of *any part of a health service program or research activity* funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions.”¹³² The rule defines “health

128. *Id.*

129. *Id.* at 78,076, 78,094. In the administrative rulemaking context, an agency must give notice of a proposed rule and give serious weight to comments from the public before it can enact a final rule. *See* 5 U.S.C. § 553 (2006) (outlining notice and comment requirements for rulemaking by administrative agencies). Here, HHS received over 200,000 comments, *see supra* note 119, so a significant portion of the final rule is dedicated to responding to these comments. *See* HHS Refusal Rule, *supra* note 22, at 78,074–95. However, HHS changed little between the Proposed Rule and the Final Rule, and many of its responses were mere lip service to the serious concerns of citizens and organizations. *See* Kate Naseef, *HHS Issues Final Rule to Protect Providers’ Conscience Rights; Opponents Seek Reversal*, BUREAU OF NAT’L AFFAIRS: HEALTH LAW REPORTER, Dec. 25, 2008, <http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-7MMJK5?OpenDocument> (“A few changes were made to the proposed rule, but the final rule is mostly the same.”).

130. *See* HHS Refusal Rule, *supra* note 22, at 78,097–98; *supra* Part II.C–D (analyzing federal refusal clauses).

131. *See supra* notes 12–13 and accompanying text (discussing the blurring of contraception and abortion in some religious groups).

132. HHS Refusal Rule, *supra* note 22 at 78,097–98 (emphasis added).

service program” to include “any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the Department.”¹³³ Unlike the Church Amendment, the rule expands the class of entities prohibited from discriminating against persons who object to non-abortion activities beyond just those doing biomedical or behavioral research to include those participating in *any* health service program.¹³⁴

Thus, though HHS attempted to portray the rule as merely a clarification and enforcement of existing federal law, the plain text of the rule extends the provisions of existing federal refusal legislation, affording the same protection to health care providers and entities objecting to contraception as to abortion.¹³⁵

B. Historical Context: Shedding Light on the Meaning of the Rule

According to HHS, the origins of the rule are to be found in a November 2007 Opinion by the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics.¹³⁶ In that opinion, the ACOG Committee on Ethics reviewed the right of health care providers to conscientiously refuse to provide care and came up with a set of recommendations to “maximize respect for health care professionals’ consciences without compromising the health and well-being of the women they serve.”¹³⁷ Key among the recommendations made in that opinion were: (1) the duty of health care providers to give patients notice of their personal moral commitments; (2) the duty to disclose accurate and unbiased information based on medical science; and

133. *Id.* at 78,097.

134. *See supra* notes 51–54 and accompanying text (explaining provisions of the Church Amendment).

135. *See supra* notes 121–22 and accompanying text (discussing HHS’s professed motives).

136. *See* Press Release, U.S. Dep’t of Health & Human Servs., Regulation Proposed to Help Protect Health Care Providers from Discrimination (Aug. 21, 2008), *available at* <http://www.hhs.gov/news/press/2008pres/08/20080821a.html> (“[M]any in the health care industry . . . are unaware of these provider conscience rights. For example, an ethics opinion put forth several months ago by the American College of Obstetricians and Gynecologists appeared to disregard these laws.”); *see also* ACOG COMMITTEE ON ETHICS, *supra* note 13, at 5 (recommending ethical guidelines that balance health care professionals’ consciences with the health and welfare of the women they serve); Rachel Walden, *Leavitt Misrepresents to Justify Proposed Regulation*, RH REALITY CHECK, Aug. 26, 2008, <http://www.rhrealitycheck.org/blog/2008/08/25/leavitt-misrepresents-justify-proposed-regulation> (questioning Secretary Leavitt’s characterization of the ACOG opinion as disregarding federal law).

137. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 5.

(3) the duty to refer patients in a timely manner in the case of a conscientious refusal.¹³⁸ Also in November 2007, the American Board of Obstetrics and Gynecology (ABOG) issued its 2008 Bulletin on the requirements for the maintenance of board certification.¹³⁹ This bulletin states that a physician's board certification could be revoked for, among other things, a violation of ACOG or ABOG rules or ethical principles.¹⁴⁰ By reading these two documents together, one could come to the conclusion, as did HHS Secretary Michael O. Leavitt, that by refusing to refer a patient for an abortion, a board certified physician could lose his or her certification.¹⁴¹ Reaching this conclusion, Secretary Leavitt wrote a letter to ABOG and ACOG expressing his concern that this could lead to discrimination in violation of federal refusal law, not by ABOG itself (ABOG is a private institution that does not receive HHS funds), but by institutions covered by the federal refusal clauses that, in turn, require their physicians to be board certified.¹⁴² In response, ABOG executive director Norman Gant wrote back clarifying that the recommendations included in the ACOG Committee Opinion are not a binding portion of ACOG's code of ethics, and therefore would not be considered in a decision to grant or revoke a particular physician's board certification.¹⁴³ Despite this assurance from ACOG in March 2008, HHS Secretary Leavitt used the certification issue as a primary

138. *Id.*

139. AM. BD. OF OBSTETRICS & GYNECOLOGY, INC., BULLETIN FOR 2008 MAINTENANCE OF CERTIFICATION 7 (2007), available at <http://www.abog.org/pdf/MOC2008.pdf> [hereinafter ABOG BULLETIN]. ABOG is an independent, nonprofit organization that certifies obstetricians and gynecologists in the United States. ABOG, <http://www.abog.org/about.asp> (last visited Sept. 19, 2009). Unlike a license from a state medical board, which is required to legally practice medicine, a board certification is a private, voluntary process that "attests . . . that the [doctor] possesses special knowledge and professional capability." ABOG BULLETIN, *supra*, at 7.

140. ABOG BULLETIN, *supra* note 139, at 10.

141. ACOG COMMITTEE ON ETHICS, *supra* note 13, at 5 ("Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request."); Press Release, U.S. Dep't of Health & Human Servs., HHS Secretary Calls on Certification Group to Protect Conscience Rights (Mar. 14, 2008), available at <http://www.hhs.gov/news/press/2008pres/03/20080314a.html>.

142. Press Release, U.S. Dep't of Health & Human Servs., *supra* note 141.

143. See Letter from Norman Gant, Executive Dir. of Am. Bd. of Obstetrics & Gynecology, to Michael O. Leavitt, Sec'y, U.S. Dep't of Health & Human Servs. (Aug. 22, 2008) (responding that HHS misinterpreted its policy, stating that ABOG "has taken no stand, pro or con, against individual physicians who choose to or choose not to perform abortions or to refer patients to abortion providers" and clarifying that the "issue is not a consideration in . . . certification"); see also ACOG, CODE OF PROFESSIONAL ETHICS OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS 1 (2008), http://acog.org/from_home/acogcode.pdf (defining ethical foundations for the practice of obstetrics and gynecology).

argument in favor of the proposed rule in August 2008, stating, “[t]his became a topical matter when the [ACOG] issued guidelines that could . . . necessitate a doctor to perform abortions to be considered competent.”¹⁴⁴ When viewed against the background of the Bush Administration’s policies as a whole toward reproductive rights, and in conjunction with the draft leaked in July 2008, this misunderstanding—some say willful misrepresentation—reveals the true motives of HHS.¹⁴⁵

A draft HHS Refusal Rule, leaked to the media in July 2008, chronicled recent state laws requiring pharmacies to fill prescriptions for contraceptives and requiring employers providing prescription drug benefits to cover contraception.¹⁴⁶ The draft discussed the proposed definition of abortion, claiming that the medical community recognized two definitions of pregnancy—at the time of fertilization and at the time of implantation—then sided with the definition at the time of fertilization.¹⁴⁷ The draft defined abortion as “any of the various procedures—including the prescription and administration of any drug or the performance of any procedure or any other action—that results in the termination of the life of a human being in utero between conception and natural birth, whether before or after implantation.”¹⁴⁸ Though the final version of the rule dropped this controversial definition,¹⁴⁹ HHS declined to alleviate concerns over this language by clarifying that contraceptives are excluded from the definition of abortion. Instead, HHS stated that “such questions over the nature of abortion and the ending of a life are highly controversial and strongly debated. The Department believes it can enforce federal . . . laws without an abortion definition.”¹⁵⁰ The final rule leaves the door open for providers to define contraception as abortion based on their

144. Walden, *supra* note 136.

145. *Id.*; PLANNED PARENTHOOD, *supra* note 116.

146. Leaked Draft, *supra* note 116, at 8–10; NAT’L WOMEN’S LAW CTR., PROPOSED HHS RULE ATTACKS WOMEN’S ACCESS TO BIRTH CONTROL 1 (July 2008), http://www.nwlc.org/pdf/july08_abortionproposal_factsheet.pdf.

147. Leaked Draft, *supra* note 116, at 16–17. *But see supra* note 12 and accompanying text (discussing medical definition of pregnancy).

148. Leaked Draft, *supra* note 116, at 17.

149. *See supra* notes 12–13 and accompanying text (discussing dispute over definition of abortion); *see also supra* notes 37–40 and accompanying text (describing different privacy interests in contraception versus abortion).

150. HHS Refusal Rule, *supra* note 22, at 78,072, 78,077; *see also* Letter from Rep. Nita M. Lowey, U.S. House of Representatives, et al. to Dep’t of Health & Human Servs. (Sept. 25, 2008), *available at* <http://www.rhrealitycheck.org/emailphotos/pdf/HHSCommentsLetter092608.pdf> (noting the ambiguity caused by failing to define abortion and the potential negative consequences).

religious beliefs.¹⁵¹ The leaked draft demonstrates the motives behind the rule to apply federal abortion refusal law to contraception, shedding light on Secretary Leavitt's misplaced reliance on the ACOG policy. HHS jumped at the opportunity to redefine the boundaries of federal refusal clauses to encompass a broader range of persons and entities, including pharmacies and pharmacists, as well as a broader range of activities, including referrals.¹⁵² The next section examines the impact of the HHS Refusal Rule on the state laws and regulations discussed in Part III using a preemption analysis.

C. Preemption

Though HHS determined that its new rule would have a "negligible" effect on states, provided they currently follow federal law, the above review of state law casts doubt on that conclusion.¹⁵³ It is a "fundamental principle of the Constitution . . . that Congress has the power to preempt state law."¹⁵⁴ The Supreme Court has likewise held that federal regulations may have a similar effect.¹⁵⁵ There are three ways under current preemption doctrine for a federal law or regulation to preempt state law.¹⁵⁶ First, and most obviously, preemption

151. See *supra* notes 11–13 and accompanying text (discussing the redefinition of contraception as abortion by some religious pharmacists).

152. See *supra* notes 125–31 and accompanying text (analyzing HHS Rule); see also *PLANNED PARENTHOOD*, *supra* note 116 (surveying actions taken under Bush Administration to chip away at reproductive rights).

153. See HHS Refusal Rule, *supra* note 22, at 78,095–96 ("Insofar as these regulations impact State and local governments . . . they do so only to the extent that [those] governments are required to submit certifications of compliance. . . ."). HHS itself admits that nearly 600,000 entities would be required to submit written certifications, including 57 state and territorial governments. *Id.* at 78,094. HHS's argument that state and local governments would be unaffected if they are currently in compliance with federal law contradicts its assertion that this rule is needed because of the disregard for federal law. *Id.* at 78,073–74, 78,096.

154. *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000); see also U.S. CONST. art. VI, cl. 2 ("This Constitution and the Laws of the United States . . . shall be the supreme Law of the Land . . . [the] Laws of any State to the Contrary notwithstanding."); Cass R. Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 331 (2000) ("Congress is entitled to preempt state law if it chooses.").

155. *Fid. Fed. Sav. & Loan Ass'n v. De la Cuesta*, 458 U.S. 141, 153 (1982); see also Christopher R.J. Pace, *Supremacy Clause Limitations on Federal Regulatory Preemption*, 11 TEX. REV. L. & POL. 157, 163–68 (2006) (questioning the proposition that "an unelected official appointed by the President has the power, without direction from Congress, both to create and then to enforce a federal regulation that preempts state law").

156. *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 541 (2001). Though in the past some courts have declined to use the preemption doctrine for federal statutes (and presumably regulations) enacted by virtue of Congress's power under the Spending Clause, there is a "growing consensus . . . to analyze such claims under traditional preemption doctrine." *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d

occurs where the federal law contains express language indicating congressional intent to preempt state law.¹⁵⁷ Second, federal law preempts state law where it can be implied from the “depth and breadth of a congressional scheme that occupies the legislative field.”¹⁵⁸ Finally, and most relevant to the present discussion, is preemption through implication produced by a conflict between the state and federal enactments.¹⁵⁹ Termed “implied conflict preemption,” the third method of preemption occurs where “‘compliance with both federal and state regulations is a physical impossibility’ or where state law ‘stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.’”¹⁶⁰ Thus, “it is reasonable to assume that Congress would want a properly authorized agency action to be effective, and thus to trump directly conflicting state law,” where it is “physically impossible to comply with both a substantive agency rule and state law.”¹⁶¹

As the previous section illustrated, the HHS Refusal Rule protects pharmacists from having to fill, or even refer, a prescription to which they have a conscientious objection.¹⁶² Under the rule, state and local entities that receive HHS funds may not discriminate against those who exercise that right.¹⁶³ Further, pharmacies receiving HHS funds may not discriminate against their employees on that basis either.¹⁶⁴ Depending upon the laws of the particular state, this new rule may preempt state law, at least with regard to those entities and governments

324, 329–30 (5th Cir. 2005).

157. *Lorillard Tobacco*, 533 U.S. at 541. Where an administrative agency is interpreting a federal statute, it is typically given substantial deference, even in interpreting whether Congress intended to preempt state law. *See, e.g.*, *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843–45 (1984) (“We have long recognized that considerable weight should be accorded to an executive department’s construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations” (citation omitted)); *Wachovia Bank, N.A. v. Watters*, 431 F.3d 556, 560–61 (6th Cir. 2005) (holding that where Congress has not spoken directly to the issue, by application of the *Chevron* doctrine, an administrative agency may preempt state law through regulations), *aff’d*, 550 U.S. 1 (2007).

158. *Lorillard Tobacco*, 533 U.S. at 541. An example of this type of preemption is immigration. *See, e.g.*, Nina A. Mendelson, *A Presumption Against Agency Preemption*, 102 NW. U. L. REV. 695, 700 (2008) (citing *Hines v. Davidowitz*, 312 U.S. 52, 62–63 (1941)).

159. *Lorillard Tobacco*, 533 U.S. at 541.

160. *Planned Parenthood of Houston*, 403 F.3d at 336 (quoting *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 204 (1983)).

161. Mendelson, *supra* note 158, at 700.

162. *See supra* Part IV.A (analyzing provisions of HHS Rule).

163. HHS Refusal Rule, *supra* note 22, at 78,072, 78,099.

164. *See supra* notes 128–31 and accompanying text (describing HHS Rule).

hoping to continue receiving HHS funds.¹⁶⁵ Though HHS attempts to downplay the number of entities that are affected by its rule, a quick look at the depth and breadth of HHS funding debunks that assertion. In 2003, for example, the fifty states received a total of \$200 billion in HHS grants, with California alone receiving over \$25 billion.¹⁶⁶ An example of how these funds are allocated is the California Family Planning, Access, Care and Treatment Program (Family PACT), a program administrated by the California Department of Health to run health clinics for low-income individuals.¹⁶⁷ Well over half of Family PACT's operating costs, or \$300 million, comes from HHS.¹⁶⁸ Furthermore, the definition of "health service program" includes "any plan or program that provides health benefits, whether directly, *through insurance*, or otherwise, which is funded, in whole or in part, by [HHS]."¹⁶⁹ Significantly, Medicare and Medicaid make up the largest portions of the HHS budget.¹⁷⁰ As HHS admits, in its "Table—Affected Entities" included in the rule, all fifty states and seven territorial governments are affected by the rule.¹⁷¹

Looking first at the Illinois law, which protects individual pharmacists but places the burden to fill all contraceptive prescriptions on pharmacies,¹⁷² the HHS Rule renders the state requirement meaningless by precluding a remedy against pharmacies that refuse to comply with the state law. For example, if a woman were to take an emergency contraceptive prescription to a Chicago pharmacy and the pharmacist on duty refused to fill it based upon a religious objection, the pharmacy would be in violation of Illinois law for failing to require its pharmacists to transfer the prescription to another pharmacist or pharmacy.¹⁷³ However, under the HHS Rule, such a requirement

165. *Id.*

166. OFFICE OF GRANTS MGMT. & POL'Y, U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS GRANT AWARDS 7–8 (2003), available at http://tags.hhs.gov/AnnualReport/FY2003/TAGGS_2003_Annual_Report.doc.

167. See OFFICE OF FAMILY PLANNING, CAL. DEP'T OF HEALTH SERVS., FACT SHEET ON FAMILY PACT 1 (2006), <http://www.cacsap.org/FPACTOverview.pdf>.

168. See *California Could Lose Federal Funding for Family Planning Program Unless It Begins Verifying Immigration Status of Participants*, MED. NEWS TODAY, Oct. 7, 2008, <http://www.medicalnewstoday.com/articles/124459.php>. ("The state receives \$315 million of the program's \$432 million annual operating costs from the federal government.")

169. HHS Refusal Rule, *supra* note 22, at 78,072, 78,097 (emphasis added).

170. U.S. DEP'T OF HEALTH & HUMAN SERVS., BUDGET IN BRIEF: FISCAL YEAR 2009, at 3 (2008), available at <http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf>.

171. HHS Refusal Rule, *supra* note 22, at 78,094.

172. ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2009).

173. *Id.*

may constitute discrimination.¹⁷⁴ Further, by complying with the state law, a pharmacy may run afoul of federal law if it disciplines an employee for failing to refer or transfer a prescription according to the pharmacy's policy.¹⁷⁵ As this demonstrates, the rule cedes all power to pharmacists who define abortion according to a religious rather than a medical understanding of when a pregnancy begins, thereby upsetting the careful balance created by states such as Illinois. It is physically impossible to comply with both the federal rule and the Illinois rule, at least to the extent described above.¹⁷⁶

The California rule poses more challenges. As discussed in Part III.D, California law requires pharmacists to "fill or refer," unless they have given their employer prior written notice of their objection so that their employer can make "reasonable accommodations."¹⁷⁷ If a pharmacist fails to comply with California law, she is subject to disciplinary review.¹⁷⁸ Thus, if a pharmacist has a conscientious objection to contraceptives and gives her employer notice, but that employer is unable to make a reasonable accommodation—for example, the employer can only afford to employ one pharmacist—under current California law, there are circumstances in which the objecting pharmacist could be fired.¹⁷⁹ However, by doing so, a pharmacy that receives HHS funds, such as Medicare or Medicaid, would find itself in violation of the federal rule. Further, the California State Pharmacy Board would no longer be permitted to discipline pharmacists who harbor conscientious objections but fail to notify their employer ahead of time.¹⁸⁰ Where it is physically impossible to comply with both laws, the federal rule preempts the state rule;¹⁸¹ in this case, as with Illinois, the HHS Rule takes the teeth out of the state law, rendering it meaningless.

174. See *supra* notes 128–31 and accompanying text; see also HHS Refusal Rule, *supra* note 22, at 78,077 (declining to adopt a definition of "discrimination," but "reject[ing] the suggestion that the reassignment of an employee who states a religious or moral objection to a certain activity (such as abortion) may not constitute discrimination in all cases").

175. See *supra* notes 128–31 and accompanying text.

176. See *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 336 (5th Cir. 2005) ("Implied conflict preemption occurs when 'compliance with both federal and state regulations is a physical impossibility' or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" (quoting *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 204 (1983))).

177. CAL. BUS. & PROF. CODE § 733(b) (West Supp. 2009); see *supra* text accompanying notes 108–11 (discussing the details of the California law).

178. CAL. BUS. & PROF. CODE § 733(a), 4314 (West Supp. 2009).

179. See *supra* note 111 and accompanying text (discussing reasonable accommodation).

180. CAL. BUS. & PROF. CODE § 733(a), 4314 (West Supp. 2009).

181. *Planned Parenthood of Houston*, 403 F.3d at 336.

With regard to states with must-fill laws, such as Maine, though these are questionable in light of recent case law,¹⁸² these laws are clearly preempted by the HHS Refusal Rule—it is physically impossible to both require pharmacists to fill all prescriptions regardless of their religious objections and to prohibit any discrimination based on religious objections to filling prescriptions.¹⁸³ In sum, far from having no effect on state laws, as the HHS Rule asserts, those state laws will be preempted to the extent that they conflict.

V. FEDERALISM

The Framers of the Constitution divided power among the federal and state governments, recognizing state and local governments' role in promoting democracy and acting as a check on the power of the federal government.¹⁸⁴ Though the federal government has grown enormously since the time of the Constitution, federalism is still relevant today. Though federal law has governed refusal clauses since the 1970s, health law, and pharmacist conduct in particular, is an area traditionally governed by the states.¹⁸⁵ Since the 1970s, the culture of the United States has remained divided as to the values associated with both provider and patient autonomy. The diversity in refusal and must-fill laws among the states brings this to light. Clearly, there are many ways to balance the rights of the

182. See *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245, 1266 (W.D. Wash. 2007) (enjoining enforcement of a Washington law imposing sanctions on pharmacies that permit pharmacists to refuse to fill valid prescriptions).

183. See ME. REV. STAT. ANN. tit. 32, § 13795(2) (Supp. 2008) (providing that a pharmacist may refuse to fill a valid prescription “if unsatisfied as to the legitimacy or appropriateness of any prescription presented, the validity of any photographic identification or the identity of any patient presenting a prescription or any person acting on behalf of the patient”); 02-392-19 ME. CODE R. § 11 (Weil 2009) (“A pharmacist may refuse to fill a prescription or dispense a drug only as permitted by [ME. REV. STAT. ANN. tit. 32, § 13795(2)].”); *supra* note 114 and accompanying text (discussing a district court’s finding that a Washington statute requiring pharmacists to either fill a prescription or “refuse and refer” targeted religious individuals in violation of the Constitution’s Free Exercise Clause).

184. See THE FEDERALIST NO. 52 (James Madison).

185. See *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 575 (1985) (Powell, J., dissenting) (noting areas such as police, health, and sanitation are typically governed by state and local law); Lindsay R. Kandra, Comment, *Questioning the Foundation of Attorney General Ashcroft’s Attempt to Invalidate Oregon’s Death with Dignity Act*, 81 OR. L. REV. 505, 522–25 (2002) (examining history of state regulation of health professionals and noting recent increased federal involvement in the area of public health). *But see* Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 282–88 (2004) (arguing though health care has traditionally been left to the states, today it has become a proper subject of Commerce Clause legislation because health care has become a national industry).

provider with the rights of the patient, which are best served by allowing the states to come up with their own innovative solutions to balance these rights in a way acceptable to their populations. States have responded quickly to the concerns of their citizens and the natural evolution of these policies was headed toward a consensus.¹⁸⁶ However, to the extent that HHS has struck a different balance than the states, their laws will be preempted.¹⁸⁷ Not only does the HHS Rule improperly ignore patient rights of access, it is simply the wrong venue for determining the proper balance of patient and provider rights.¹⁸⁸ This section will demonstrate that state and local policymaking is far superior to the use of federal administrative rules on this subject and thus should be left to the states to decide.

Among the reasons to advocate federalism is the ability of states to “respond to particular preferences held by their residents.”¹⁸⁹ Likewise, citizens are more likely to respond to local lawmaking, as opposed to lawmaking at the federal level (especially federal administrative rulemaking); therefore, allowing states to make their own policies is good in and of itself.¹⁹⁰ For example, local policymakers have firsthand knowledge of local problems, and people have more ready access to public officials.¹⁹¹ Furthermore, the cost of political participation at the state and local level is lower than the cost of participation at the federal level. For example, the costs of calling a local representative or attending local meetings is less than doing so in Washington.¹⁹²

Further, the use of administrative rulemaking, as opposed to legislation on either a state or federal level, involves a process that is less transparent and less democratic.¹⁹³ To enact the rule, HHS merely gave notice and accepted and responded to comments.¹⁹⁴ HHS held no hearings and apparently disregarded

186. See *supra* Part III.D (discussing state responses to patient complaints).

187. See *supra* Part IV.C (analyzing preemption).

188. See *supra* Part III.A–B (discussing proper balance of patient and provider rights).

189. Mendelson, *supra* note 158, at 709 (citing Larry D. Kramer, *Putting the Politics Back into the Political Safeguards of Federalism*, 100 COLUM. L. REV. 215, 222 (2000)).

190. *Id.* (citing Fed. Energy Reg. Comm’n v. Mississippi, 456 U.S. 742, 789 (1982) (O’Connor, J., concurring in part and dissenting in part)); *Garcia*, 469 U.S. at 575 n.18 (Powell, J., dissenting) (citing THE FEDERALIST NO. 17 (Alexander Hamilton)).

191. *Garcia*, 469 U.S. at 575 n.18 (Powell, J., dissenting).

192. See Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 391 (1997) (discussing ways in which state and local government are “breeding grounds for democracy”).

193. *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 908 (2000) (Stevens, J., dissenting) (noting administrative agencies are not designed to protect the interests of the states).

194. See 5 U.S.C. § 553 (2006) (outlining notice and comment requirements for

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the direction that state laws and recently proposed federal legislation were going.¹⁹⁵

Beyond the procedure for enacting federal administrative rules, state laws also provide their populations with opportunities to challenge their validity and to participate in shaping the bounds of the protections afforded to providers and patients.¹⁹⁶ For a challenge to be successful against a federal agency regulation, would-be plaintiffs face tough odds. Administrative Agencies are typically afforded wide deference with regard to their interpretations of congressional intent.¹⁹⁷ As shown above, though on their face the HHS Rule comports with the federal refusal laws authorizing them, subtle changes in definitions, and the omission of a definition of abortion have allowed HHS to change the dynamics of the debate over access to contraception, perhaps in a way that Congress would not have done itself.¹⁹⁸ However, these subtle changes would likely be given substantial deference, making challenges difficult.¹⁹⁹

Advocates of federalism also point to the value of state policymaking experiments as instructive to other states, as well as to the federal government.²⁰⁰ Here, for example, states can learn from the example of the Washington statute denying pharmacists the right to refuse at all, which was struck down,²⁰¹ by providing a more carefully balanced law like that of California or Illinois. Though Congress had responded to these changes—proposing similar federal legislation in recent years—HHS entirely ignored them.²⁰²

rulemaking).

195. See *supra* notes 17–21 and accompanying text (discussing the “emerging consensus” of state and federal legislation).

196. See *Vandersand v. Wal-Mart Stores, Inc.*, 525 F. Supp. 2d 1052, 1056 (C.D. Ill. 2007) (holding that an Illinois pharmacy law mandating the dispensing of contraceptive prescriptions does not eliminate the employer’s duty to make reasonable accommodation of an individual pharmacist’s religious beliefs); *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245, 1266 (W.D. Wash. 2007) (enjoining enforcement of a Washington law imposing sanctions on pharmacies that permit pharmacists to refuse to fill valid prescriptions).

197. See *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843–45 (1984).

198. See *supra* notes 19–21 and accompanying text (discussing recently proposed bills protecting patient access to contraceptives).

199. *Chevron*, 467 U.S. at 843–45.

200. *Gonzales v. Raich*, 545 U.S. 1, 42–43 (2005) (O’Connor, J., dissenting) (noting that states sometimes play the role of “laboratories” for experiments with new social and economic policies).

201. *Stormans, Inc.*, 524 F. Supp. 2d at 1248.

202. See *supra* notes 19–21 and accompanying text (discussing recent bills to protect patient access to contraceptives).

The federal government should have left the states to develop their own strategies in the “emerging consensus” around protecting individual pharmacists, so long as patient access can be protected. The HHS Refusal Rule should be repealed in its entirety.²⁰³ State refusal laws are more easily attacked than federal regulations (both when they go too far in protecting patient access over the consciences of providers and when they do the opposite), and individuals denied a referral in the face of a religious objection should be encouraged to take to the courts or write their representatives to make sure their laws achieve the proper balance of provider and patient rights.

VI. CONCLUSION

As the debate over reproductive rights has shifted to encompass not just abortion but also contraception, pharmacists have been drawn into a nationwide debate over their right to refuse to dispense prescription contraceptives. This Comment has demonstrated that the states are better suited to balance patient and provider rights in the context of pharmacist refusals. Unlike the context of abortion, in which federal law protects an absolute right of providers to refuse to provide abortion services, the rights of the provider must be balanced with the rights of the patient to access legal and constitutionally protected medications. The HHS Refusal Rule came down solely on the side of the provider and expanded the coverage of federal refusal law to include pharmacies and pharmacists. The rule disrupted the “emerging consensus” demonstrated by states such as California and Illinois and embraced by the American Pharmacist Association, which allow pharmacist refusals only where the patient access can be preserved through referral or transfer. This rule must be repealed.

Jane W. Walker

203. In March 2009, the Obama Administration proposed rescinding the HHS Rule and formally requested comments in order to evaluate whether to rescind the rule in its entirety or in part. *See* Rescission of the Regulation Entitled “Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law,” 74 Fed. Reg. 10,207, 10,209–10 (proposed Mar. 10, 2009). Though the comment period ended in April, no further action has yet been taken.