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Adjudicating rights or analyzing interests: ethicists' role in the debate over conscience in clinical practice

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Abstract The analysis of a dispute can focus on either interests, rights, or power. Commentators often frame the conflict over conscience in clinical practice as a dispute between a patient's right to legally available medical treatment and a clinician's right to refuse to provide interventions the clinician finds morally objectionable. Multiple sources of unresolvable moral disagreement make resolution in these terms unlikely. One should instead focus on the parties' interests and the different ways in which the health care delivery system can accommodate them. In the specific case of pharmacists refusing to dispense emergency contraception, alternative systems such as advanced prescription, pharmacist provision, and over-the-counter sales may better reconcile the client's interest in preventing unintended pregnancy and the pharmacist's interest in not contravening his or her conscience. Within such an analysis, the ethicist's role becomes identifying and clarifying the parties' morally relevant interests.

Keywords Conscientious objection · Emergency contraception · Conflict resolution · Interests

> "This (sex) was with someone I did not even know and did not want to have intercourse with, and I am in no place now to have children," she said. "I just don't think this should be the pharmacist's decision" [1].
>
> Because I regard that complicity in making available products that are intended for the termination of human life to be immoral, I will not stock or have dispensed these therapies in my pharmacies. If the Governor forces our

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pharmacies to comply, I will not be able—in good conscience—to continue to run a pharmacy [2].

In the conflict over the role of conscience in clinical practice, ethicists use arguments to adjudicate the claims of the parties involved. One common framing characterizes the problem as patients' right to legally available medical treatments versus health care providers' right to refuse to participate in any intervention they find morally objectionable. After arraying arguments for and against each of these putative rights, ethicists state which position they find most compelling. There are, however, good reasons to believe that ethicists cannot provide a single, best answer to this dispute. In addition, the implicit characterization of the dispute as a zero-sum game may lead to undesirable consequences. Rather than focus on the parties' rights or relative power, one should instead focus on the parties' interests and various ways in which these interests can be reconciled. The principal parties in this dispute are a subset of clinicians, who believe particular medical interventions are immoral, and their potential patients or clients. The clinicians' primary interest is not being complicit in an action they consider immoral and the patients' primary interest is access to health care services. Alternative systems of providing health care accommodate these interests to different degrees. Ethical argumentation can help identify and clarify what the parties' relevant moral interests are.

In this paper, I will focus on the dispute regarding the prescribing and dispensing of emergency, hormonal contraception.[1] Consider, for example, the situation of a seventeen-year-old woman who has intercourse with her boyfriend on a Friday night. They regularly use condoms, but this time the condom breaks. The following day, she relays her anxiety about becoming pregnant to a friend who tells her about emergency contraception. She is finally able to get an appointment on Monday afternoon with her pediatrician, who she has not seen in years. The pediatrician, discusses testing for sexually transmitted diseases and writes her a prescription for Plan B®. The patient takes the prescription to a local, independent pharmacy. The owner and pharmacist on duty is an evangelical Protestant who refuses to stock emergency contraception and who, after telling the woman that emergency contraception is immoral, refuses to return or transfer her prescription.[2]

[1] Women can use several drugs or devices after un- or under-protected intercourse to prevent unintended pregnancy. Under-protected intercourse includes when a condom slips or breaks or a woman misses two or more of the first seven oral contraceptive pills. I will focus on the use of oral contraceptive pills or pharmacologically equivalent dedicated products for this purpose. Women can also use copper-containing intrauterine devices (IUDs) for emergency contraception but this is more logistically difficult because a trained provider must place them. I will also not discuss the use of mifepristone (RU-486) because, unlike oral contraceptive pills, it can interrupt an established pregnancy and, at higher doses, can cause a medical abortion. The Food and Drug Administration has also not approved its lower, emergency contraceptive dose [3].

The literature also refers to emergency contraception as postcoital contraception and the morning after pill. Experts criticize the term morning after pill as misleading individuals to believe treatment must wait until or is ineffective after the next morning and prefer the term emergency contraception, in part, because it conveys that it is not intended for ongoing use [4, p. 44].

[2] For news reports of similar cases, see [1, 5].

Interest, rights, and power disputes

Disputes, which involve one person's or organization's claim or demand on another who rejects it, contain three basic elements: interests, rights, and power. Interests are the needs, desires, concerns, and fears that people care about or want and which underlie people's positions, the tangible items they say they want [6, pp. 4–5; see also 7, pp. 40–41]. For example, in a salary negotiation, positions may include annual salary, weeks of paid vacation, health insurance, and retirement benefits. The potential employee's interests could include financial security, including the ability to purchase a home, and a balance among work, family, and recreation. There are also relevant standards or rights that can direct a fair outcome and a certain balance of power between the parties. In resolving disputes, the parties may focus primarily on one of these elements [6, pp. 3–10].

Rights disputes

Parties in a dispute may seek to determine who is right, based on some independent standard. Law, contract, or socially accepted standards of behavior may provide standards. If the parties themselves are unable to reach an agreement, they may turn to a third party. Adjudication, in which the parties present evidence and arguments to a neutral third party with decision making authority, is the prototypical rights procedure. Courts and administrative agencies provide public adjudication while arbitrators provide private adjudication [6, p. 7].

One can analyze the aforementioned dispute between the pharmacist and the woman in terms of the parties' rights: the client's right to procreative liberty and the pharmacist's right not to contravene his or her conscience. John Robertson characterizes procreative liberty as "the freedom to reproduce or not to reproduce in the genetic sense, which may also include rearing or not, as intended by the parties" [8, pp. 22–23]. Robertson asserts that this liberty should enjoy presumptive primacy because it is central to personal identity, dignity, and the meaning of one's life [8, p. 24].

Robertson's characterization of procreative liberty as a negative right, however, makes its application in this case complex. He argues that others have a duty not to interfere with one's procreative choices but they are not obligated to provide resources or services [8, p. 23]. He states: "Procreative freedom does not entitle one to the services of providers who profoundly disagree with the means that one is willing to use to achieve procreative goals" [8, p. 172]. While the pharmacist's refusal to return or transfer the woman's prescription interferes with her freedom, it is not clear within Robertson's framework that the client has a right to have her prescription filled. For example, pharmacies may not stock emergency contraception for reasons unrelated to conscientious objection [9]. If patients have a right to emergency contraception in spite of pharmacists' conscientious objection, are pharmacies also obligated to stock it in spite of low consumer demand or inventory constraints?

Conversely, the pharmacist may assert a putative right not to contravene his or her conscience. For example, in its Model Legislation, Americans United for Life

asserts: "A healthcare provider has the right not to participate, and no healthcare provider shall be required to participate, in a healthcare service that violates his or her conscience" [10, p. 6]. This putative right is also inadequately circumscribed. May a health care provider thereby refuse to participate in any service without justifying or validating his or her objection?

Ethicists may position themselves as neutral third parties adjudicating between these conflicting rights claims. Julian Savulescu, for example, frames the issue as a conflict between physicians and patients and considers arguments for and against conscientious objection. On the one hand, conscientious objection is inequitable and inefficient, inconsistent with the high standard required to justify compromising patient care, contrary to doctors' commitments, and discriminatory against secular moral values. On the other hand, precluding conscientious objection is harmful to doctors and constrains their liberty. While Savulescu briefly states that doctors' values should be accommodated if this can be done without compromising the quality and efficiency of medical care, he nevertheless concludes, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" [11, p. 294].

Unresolvable moral disagreements

There are, however, good ethical reasons to believe that neutral adjudication is not possible in this dispute. Gert et al. argue that a moral theory need not provide a unique right answer to every moral problem [12, pp. 3–5, 21–22] and identify five sources of unresolvable moral disagreement [12, pp. 16, 59–60]. A number of these sources are present in the dispute regarding dispensing emergency contraception.

Disagreement about the facts

Parties disagree about whether and how often emergency contraception acts by preventing implantation of a fertilized egg into the uterine wall. This potential mechanism is morally relevant to those who believe embryos have full moral status from conception [13]. Opponents question the generalizability of experimental data from animal models and tissue culture system and proponents face logistical difficulties in overcoming the limitations of the statistical analysis of actual use studies [14]. Neither group is likely to definitively resolve the factual issues in the near future.

Differences in the rankings of the harms (evils) and benefits (goods)

Patients and pharmacists experience different harms and benefits and there is no objective ranking which provides a clear resolution of this conflict.

Differences about human nature and the nature of human societies

Parties disagree about the likely effect of widespread access to emergency contraception on sexual behavior and the use of more reliable forms of

contraception and methods to prevent sexually transmitted diseases [15]. To the extent that there is evidence about these effects [16], this may become a disagreement about the facts.

Differences about the interpretation of a moral rule

While there may be differences about the interpretation of moral rules, the dispute about emergency contraception primarily rests on differences about the scope of morality.

Differences about the scope of morality

Parties in this conflict disagree about whether embryos deserve full, partial, or no moral protection. Some individuals and moral communities believe that the embryo has full moral status from the time of fertilization [13] while others believe that the developing embryo and fetus obtain partial moral protection only later in gestation [8].[3]

The dispute over conscientious objection in clinical practice contains multiple sources of unresolvable moral disagreement. One can legitimately question ethicists' ability to provide a single correct resolution to this dispute. Gert et al. argue that recognition of legitimate disagreement can provide the precondition for individuals to "cooperate in trying to discover a compromise that comes closest to satisfying both of their positions" [12, p. 105].

Power disputes

If one cannot determine who is right, one can shift one's focus to the question of who is more powerful. Ury et al. define power as "the ability to coerce someone to do something he would not otherwise do" [6, p. 7]. In the dispute about emergency contraception, pharmacists initially had more power than individual clients due to the legal constraints on obtaining prescription medication. Both sides in this dispute have subsequently sought to augment their power through judicial, legislative, and regulatory processes. Ury et al. note that it is difficult to assess which party is more powerful without resorting to a potentially destructive power contest [6, p. 8].

Interests disputes

Rather than engage in a power contest, disputants can seek to reconcile their underlying interests [6, pp. 4–5]. Again, interests are the needs, desires, concerns,

[3] Commentators should carefully distinguish differences about the scope of morality from disagreements about the facts. Some advocates of access to emergency contraception, for example, argue that it is not abortifacient because it does not prevent the interruption of an established pregnancy. They cite definitions of pregnancy and abortion offered by medical organizations and the U.S. government [17, p. 847]. This is a terminological disagreement based on differing evaluations of the moral status of the embryo rather than a dispute regarding the facts. Groups that consider some or all uses of emergency contraception to be immoral do not contend that it causes the expulsion of a fertilized egg after implantation. Rather, they believe that the fertilized egg has full moral status and use the term abortifacient to include drugs and devices that prevent implantation.

and fears that underlie parties' positions. Positions, by contrast, are concrete outcomes. Interests can potentially be reconciled because they may be satisfied by several possible positions or because more shared and differing but compatible interests may underlie opposed positions than do conflicting interests [7, pp. 42–43].

In addition to the aforementioned ethical reasons why a rights based approach to the dispute over emergency contraception is likely to be ineffective, there are other reasons to favor interest based over rights or power based approaches. Criteria for comparing approaches include transaction costs, satisfaction with outcomes, effect on the relationship, and recurrence of disputes. Ury et al. enumerate a number of potential transaction costs: "the time, money, and emotional energy expended in disputing; the resources consumed and destroyed; and the opportunities lost" [6, p. 11]. Parties' satisfaction with outcomes also involves a number of considerations including fulfillment of underlying interests and the perceived justice of both the outcome and process. These costs are interrelated and typically increase or decrease together. Ury et al. argue that interest-based approaches are typically less costly because they can uncover hidden problems and identify issues of greater concern to each of the parties [6, pp. 13–14].

The parties and their interests

There are a variety of parties in the debate regarding conscience in clinical practice, each with their own interests.

Clinicians

Some clinicians articulate an interest in not contravening their consciences. The contemporary literature on conscience emphasizes its relationship to integrity. These analyses provide a justification for respecting conscience which acknowledges that it can err [18, 19]. In the dispute over dispensing emergency contraception, the scope of the claim to conscientious objection requires clarification because clinicians are not claiming the right not to use emergency contraception themselves, but are, instead, claiming the right not to participate in another's action that they consider immoral.

The Roman Catholic moral tradition provides the most extensive analysis of the concept of cooperation. Daniel Sulmasy reviews this analysis in his contribution to this issue [20], and I will highlight three key points. One, aside from the categorical distinction between formal and material cooperation, the determination of whether cooperation is morally licit is a matter of degree. Whether cooperation is licit, therefore, can itself become a matter of conscience. Two, the external environment, including legal and licensing requirements, can influence this evaluation [see also 21, pp. 307–308, 326–328]. Policy makers can modify these factors and thereby influence the parties' behavior. Three, not contravening one's conscience through illicit cooperation is a significant interest that may obligate one to forego other important interests, such as one's job or even career [see also 21, pp. 311–313, 317, 360, 373].

Patients or clients

In this case, the patient's primary interest is preventing unintended pregnancy, which is closely tied to access given the limited time frame during which emergency contraception is effective [3]. Patients also have interests in respectful treatment, privacy, and cost. Some women report feeling judged by clinicians or being verbally abused by pharmacists. Patients have an interest in privacy and confidentiality, neither wanting private information overheard by other patients nor wanting to disclose information only for a clinician's moral evaluation. Finally, patients also have an interest in obtaining emergency contraception without unnecessary additional cost.

Others

There are a variety of additional stakeholders in this dispute, including moralists and public health officials, who have articulated further interests. These interests include regulating sexuality or promoting good sexual conduct; protecting women from sexual abuse; reducing unintended pregnancies and their associated costs; reducing the incidence of abortion; and/or decreasing sexually transmitted diseases [22].

System design

In the dispute regarding emergency contraception, the health care system places the patients' and objecting pharmacists' interests in conflict. Under certain circumstances a particular pharmacist must dispense the medication in order for the patient to receive treatment in a timely manner. It is unlikely that there are other shared or differing but compatible interests that would incline the parties to forgo their respective interests in preventing unintended pregnancy or not contravening their consciences. Other positions, however, may permit the principal parties to fulfill their interests. (I will set aside the interests of the other parties because these parties can address their interests in multiple ways unrelated to the distribution of emergency contraception.) Alternative systems to clinicians prescribing and pharmacist dispensing at the time of use include advanced prescription, pharmacist provision, and over-the-counter sales.[4] Reviewing these alternatives will demonstrate that conflict resolution need not be a zero-sum game in which gains to one party must come at the expense of the other.

Clinician prescribes and pharmacist dispenses

The default system prior to the Food and Drug Administration's (FDA's) approval of limited over-the-counter sales involved clinicians prescribing and pharmacists dispensing emergency contraception at the time of use. A. Albert Yuzpe first published studies demonstrating the safety and efficacy of using combined estrogen-progestin oral contraceptive pills as emergency contraception in 1974. Because oral

[4] Other alternatives include educational initiatives and public awareness campaigns, information and referral hotlines [23], and telephone prescription services [24].

contraceptive pills were FDA approved for another indication, clinicians could legally prescribe them "off-label" for emergency contraception. The law, however, prohibited manufacturers from marketing them for this use. In 1997, the FDA issued a notice declaring the use of certain oral contraceptives for emergency contraception safe and effective. It also solicited new drug applications noting that it would accept citations of the existing literature as evidence of safety and effectiveness. It subsequently approved the dedicated products Preven™ (Gynetics, Inc.) in 1998 and Plan B® (Women's Capital Corporation) in 1999. (Gynetics subsequently withdrew Preven™ after research showed Plan B® was more effective and had fewer side-effects.) While clinicians may prescribe emergency contraception, state law may prohibit clinicians from directly dispensing it to their patients or impose constraints such as packaging and labeling requirements. Obtaining emergency contraception, therefore, typically involves having a pharmacist dispense the prescription.

There are multiple potential barriers to access in this system, including identifying a clinician, obtaining an appointment, and filling a prescription. Many individuals do not have a primary care provider. Even if one does, the primary care provider may be difficult to reach at nights and on weekends when intercourse is more likely to occur. Some clinicians refuse to provide a prescription over the telephone without an office visit. Besides the time involved, an office visit is also an additional expense. While acute care centers and emergency departments may be more accessible, co-payments for their use are typically higher [see, in general, 25]. Finally, independent of conscientious objection, pharmacies may not stock emergency contraception due to lack of consumer demand or constraints on inventory space [9].

Advance prescription

As an alternative, some providers advocate providing a prescription in advance of actual need that patients could then fill for future use. They propose discussing the topic of emergency contraception at an appointment for another purpose, such as health care maintenance, rather than at a separate visit for this specific purpose [26]. While increasing access, research has not shown this system to decrease unintended pregnancies. A recent systematic review concludes that none of the eight individual randomized controlled trials, including two adequately powered studies, or the pooled analyses showed significant differences in pregnancy rates [16].

Pharmacist provision

Another potential way to address clinician inaccessibility as well as cost is to permit pharmacists to prescribe and dispense emergency contraception. In the United States, medications are either prescription or over-the-counter. In most other countries, there are intermediate categories of drugs, including pharmacist and pharmacy classes—medications that can only be sold after an interaction with a pharmacist and that must be sold in pharmacies, as opposed to grocery stores or gas stations [27, p. 810]. Individual states, however, have authority over who can

prescribe medications and some states permit pharmacists to prescribe under an arrangement known as "dependant-prescribing authority." Under such regimes an independent prescriber, such as a physician, delegates his or her authority to a pharmacist [28, p. 288]. Nine states permit dispensing emergency contraception under such agreements [29].

Dependant-prescribing of emergency contraception has a number of potential benefits and limitations. Pharmacies are widely available and have extended hours of operation compared with clinicians' offices. Pharmacists may be accessible to patients without a primary care provider and women may be more comfortable approaching a pharmacist for emergency contraception. Pharmacists can provide counseling, such as referral for ongoing contraceptive care or diagnosis and treatment of sexually transmitted diseases. While pharmacists may charge an additional fee for counseling, it is typically less than the fee charged by a clinician. Third party payers, however, may not reimburse for counseling. Other potential limitations include a lack of privacy for counseling at the pharmacy counter, which is particularly important given the use of emergency contraception following rape. Pharmacists have also expressed a concern regarding the increased liability risk [25, 28].

Over-the-counter sales

Over-the-counter sales are a third alternative. The FDA can approve medications for over-the-counter sales if they are not habit-forming and patients can use them safely and effectively without the supervision of a licensed health care practitioner. The FDA uses several different mechanisms, the most common of which is approval of a new-drug application, to change prescription drugs to over-the-counter status. It may require studies of label comprehension and "actual use." Examples of drugs switched to over-the-counter include diphenhydramine (Benadryl®), ranitidine (Zantac®), nicotine (gum and patches) and ketoconazole (an antifungal medication used to treat vaginal yeast infections) [27].

Emergency contraception is a strong candidate for over-the-counter status. It has no potential for addiction. The indication for use (un- or under-protected intercourse) is identifiable by a nonprofessional. The dose is the same for all women, so patients do not need clinicians to tailor the dose to patient characteristic or therapeutic response. Its most common side-effects are nausea and lower abdominal pain and it is safer than some available over-the-counter medications. Emergency contraception's only contraindication is pregnancy—not because of teratogenicity, but due to ineffectiveness [30].

While initially rejecting over-the-counter sales of Plan B®, the FDA eventually approved its sale without a prescription to individuals 18 years of age and older in 2006 [31]. Overruling its advisory panels, the FDA originally asserted that an insufficient number of women ages fourteen to sixteen participated in the actual use study to permit valid inferences of safety and effectiveness in this age group. Critics accused the FDA of basing its decision not on the stated reasons but on broader political and moral interests [15]. Because minors continue to require a prescription to purchase emergency contraception, sales to adults are "behind-the-counter" rather than truly "over-the-counter."

System design and the parties' interests

Each of these potential modes of dispensing emergency contraception accommodates the principal parties' interests differently. For example, each of the successive modes potentially decreases the cost of dispensing. Advance prescription avoids the charge for a separate clinician visit, pharmacists typically charge a lower counseling fee than other clinicians, and, finally, over-the-counter sales eliminates professional fees altogether. It should be noted, however, that insurance typically does not reimburse for over-the-counter medication so that the direct cost to the consumer may be higher [25, p. 608; 27, p. 815].

Each of these successive alternative systems also potentially increases access and, thereby, increases the scope for accommodating conscientious objection. Advanced prescription, while still requiring a clinician visit, makes emergency contraception available when patients need it. Pharmacist provision may make it more readily available, given that pharmacies are open on nights and weekends, while still providing counseling. Finally, true over-the-counter sales would make emergency contraception available in multiple outlets including grocery stores and gas stations. To the extent that conscientious objection is problematic because it interferes with timely access, these alternative systems make accommodation feasible. In addition, clerks' attenuated participation in over-the-counter sales precludes justifiable claims that such participation amounts to immoral cooperation. Alternatively, clerks' ability to find alternative employment is significantly less constrained than pharmacists'. The dispute need not be a zero-sum game in which gains to one party come at the expense of the other.

The framing of the dispute in terms of interests also changes the role of the ethicist. When one focuses on the parties' rights, the ethicist is a judge. Given the multiple sources of unresolvable moral disagreement represented in this dispute, commentators' adjudication of the competing claims rests on assumptions the parties do not necessarily share. When one focuses instead on the parties' interests, the ethicist has a different role: that of an analyst. In the debate regarding emergency contraception, ethicists can analyze the types of moral disagreement and the evidence that might resolve them and examine the concept of illicit cooperation.

Conclusions

Framing the dispute over dispensing emergency contraception in terms of pharmacists' and clients' rights creates a zero-sum game. There are good ethical reasons to believe that this dispute cannot be resolved objectively at this level because of persistent disagreements about the facts and the scope of morality. Rather than pursue a potentially costly power struggle, analyzing the parties' interests and alternative systems of pharmaceutical distribution may contribute to greater social cohesion. Multiple systems of distribution are possible that may better accommodate both the pharmacists' and the clients' interests. In addition, these alternatives address barriers to obtaining emergency contraception apart from conscientious objection including access to clinics, the cost of medical visits, and

pharmacies' decisions not to stock emergency contraception. With such a reframing, the ethicist's role changes from that of judge to analyst.

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