

## Provider Refusal and Access to Reproductive Health Services: Approaching a New Balance

By Adam Sonfield

In November 2007, the American College of Obstetricians and Gynecologists (ACOG) put itself squarely in the middle of a simmering debate about health care providers' refusal to participate in sexual and reproductive health services. In an opinion entitled "The Limits of Conscientious Refusal in Reproductive Medicine," the college's committee on ethics asserted that a right to refuse does exist but must be balanced with other values and duties that physicians accept "by virtue of entering the profession of medicine."

The opinion laid out four criteria for gauging this balance, namely, the degree to which refusal imposes the provider's beliefs on patients' autonomy, impacts patients' health and perception of well-being, is based on proper understanding of scientific evidence, and results, intentionally or not, in discrimination and inequality. Based on these criteria, the committee asserted that regardless of their religious or moral objections, health care professionals must provide all patients with accurate and unbiased information, prior notice of professionals' objections and timely referral in cases of refusal, and medically indicated care in an emergency. Moreover, the committee stated outright that "the patient's well-being must be paramount" and recommended that professionals with objections to specific services either practice near other providers who do not object or maintain a referral process that ensures patients' access to care.

The ACOG committee opinion is notable for its comprehensiveness, drawing on principles of scientific integrity and nondiscrimination against

patients that are often overlooked in public debate. However, numerous other associations of health care professionals—including the American Medical Association, the American Nurses Association, the American Academy of Physician Assistants, the American Academy of Pediatrics and the American Pharmacists Association—have endorsed standards of practice that attempt to balance a provider's conscientious objection and a patient's access to care (related article, August 2005, page 7).

The ACOG opinion was met with predictable outrage by groups such as the Christian Medical Association (CMA) and by some antiabortion members of Congress, who want far more weight to be given to providers' moral and religious beliefs. They object, among other things, to any obligation to refer a patient to another provider and accuse ACOG of being biased by what they see as its traditional support for abortion rights.

Perhaps less predictable was a response by the U.S. Department of Health and Human Services (DHHS). In March, DHHS Secretary Michael Leavitt sent a letter to the American Board of Obstetrics and Gynecology—released to the press the same day—expressing concern that physicians who refused to refer patients for abortion would be in violation of ACOG's ethical guidelines and therefore risk losing their board certification. This, in turn, asserted Leavitt, could result in state and local governments violating federal laws prohibiting "discrimination" by DHHS-funded entities against physicians who object to providing or referring for abortion.

From a policy standpoint, the value of publicly releasing the letter was questionable, as both the college and the board readily acknowledged that the opinion was not binding on physicians and will have no impact on board certification. From a political standpoint, however, the message was clear: The Bush administration sides with those who would put the religious and moral beliefs of health care providers above those of individual Americans when it comes to their reproductive health care needs. The administration's black-or-white mentality appears to be out of touch not only with the guidelines of health care associations, but also with current trends in public opinion and policy making on the issue, all of which support finding an appropriate balance between what most people deem to be legitimate competing interests.

### A Spiral of Demands

In the 1960s and 1970s, the states and the courts began to formally establish the right of Americans to control their childbearing through contraception and abortion, culminating in the 1973 Supreme Court decision in *Roe v. Wade*. Opponents of these services foresaw a world in which doctors, nurses and hospitals would be forced to provide them, even if they found them offensive to their religious or moral beliefs.

The result was an avalanche of legislation designed to preempt this future. Almost immediately after *Roe*, Congress approved legislation stating that the government cannot, as a condition of accepting DHHS money, force health care personnel or institutions to perform or assist in the performance of an abortion or sterilization procedure, or make facilities available for these services, and that institutions accepting those funds cannot force (or ban) such participation by their personnel. All but a handful of states have similar "refusal clause" policies in force, most adopted by the end of 1974, allowing health care providers—whether or not public funds are involved—to refuse to participate in the delivery of abortion services and, in some cases, sterilization and contraceptive services as well.

For two decades, the refusal issue largely lay dormant. It reemerged in the 1990s, sparked by

new developments that led proponents of refusal rights to broaden their demands in Congress, state legislatures and the courts (related article, February 2000, page 8). Some have objected to scientific advancement in the form of new medical drugs, devices and practices, including infertility treatments (such as in vitro fertilization), end-of-life practices (such as living wills) and potential treatments based on embryonic stem cell research. Others have been dismayed at changes in societal norms, such as Americans' increasing tolerance of homosexuality and sex outside of marriage, and object to anything—from providing birth control to offering Pap tests and fertility treatments—they see as complicity in what they believe to be immoral behavior.

Social conservatives have also called for granting refusal rights to a broader collection of individuals and institutions involved, even tangentially, in the provision of health care. Prominent examples include insurance companies and employers in their roles as health care payers and pharmacists and pharmacies in filling prescriptions. Less publicized but even more far-reaching have been demands related to the most indirect involvement in reproductive health services, such as hospital employees assigned to complete insurance forms or to clean surgical instruments, or ambulance drivers assigned to transport patients between facilities. As part and parcel of these demands, refusal clause advocates have sought freedom from any type of liability (such as from patient lawsuits) or from any response by an employer or the government (which they label "discrimination").

In the mid-to-late-1990s, refusal advocates had some modest success in embodying this vision in policy. Legislation in Illinois, for example, provided refusal clause advocates with almost everything on their wish list. It protected health care personnel, institutions and payers from any form of liability or discrimination for refusing to perform almost any health care-related task against their conscience. About the only exceptions made were related to the provision of information and emergency care, both obligated under professional standards promulgated by ACOG and other groups.

In addition, South Dakota enacted a law allowing pharmacists to refuse to fill prescriptions they believe would be used for assisted suicide, euthanasia or to “destroy an unborn child”—which under the state’s definition would encompass most contraceptives. Pennsylvania, Texas and Washington joined Illinois in extending refusal rights to at least some types of insurers. Congress allowed Medicaid managed care plans to refuse to cover counseling and referral services to which they have a religious or moral objection, although plans cannot “gag” providers from discussing a full range of treatment options. And Congress also expanded its abortion-related protections to the realm of medical education and training and to referral for abortion.

During the current decade, however, refusal clause advocates have put forward dozens of bills but have had only three real victories. In 2004, Mississippi enacted a law topping Illinois’ as the country’s most expansive, providing seemingly all-encompassing lists of people and entities granted refusal rights, specific tasks they can refuse to perform and consequences from which they are immune (related article, August 2004, page 1). Unlike Illinois’ law, it provides no exceptions for information or emergency care, instead only prohibiting discrimination against patients on the basis of such characteristics as race, ethnicity, religion, sex or sexual orientation.

Social conservatives’ second major victory, also in 2004, was Congress’ adoption of a provision (renewed each year subsequently in the annual appropriations process) that essentially forbids a federal agency or program, or a state or local government, from forcing any health care professional or institution to provide, refer for or pay for an abortion. Reproductive health advocates have feared a negative impact on abortion services in emergency circumstances and under Medicaid managed care plans, and on abortion referrals provided on request by family planning providers when counseling pregnant patients about their full range of options. As yet, there has been no reported impact, and federal courts have dismissed two lawsuits as premature, because the federal government has taken no steps to enforce the law.

In April, the Oklahoma legislature, overriding a veto by Gov. Brad Henry (D), enacted a new law that, as part of a broader package of antiabortion provisions, expands the state’s three-decade-old refusal clause, which allows individuals and private hospitals to refuse to participate in abortion. As of November, when the new law goes into effect, refusal rights will extend to all health care facilities; to assisted suicide and euthanasia; to research and procedures that involve harm to embryos and fetuses; and to making referrals for or counseling in favor of a given service.

### **A Search for Balance**

Something new, instead, seems to be happening this decade. The trend has turned toward a more balanced approach to the refusal issue, and legislation and regulations have been adopted that generally embody the principle that in the final analysis, even when religious or moral objections are recognized and accommodated, an individual’s access to care must not be impeded.

For example, 27 states have policies—seven of which were adopted since 2004—requiring insurers that cover prescription drugs in general to provide coverage of the full range of contraceptive drugs and devices approved by the federal Food and Drug Administration (FDA). Congress, too, has required such coverage for federal employees. In crafting these laws, policymakers have weighed women’s access to contraception against the objections of some employers and insurers. In response, most of the policies include tailored refusal exceptions only for bona fide religious institutions—applying, for example, to churches but not to church-affiliated hospitals or schools, which employ and serve individuals outside of the institutions’ religion.

Similarly, 16 states, including eight since 2004, have required hospital emergency departments to provide information about emergency contraception to sexual assault victims, dispense the drug upon request or both. Three of the laws explicitly allow individual hospital employees to refuse, but the hospital itself is responsible for ensuring that patients receive the required services. The laws themselves are an attempt at balancing the objections of religious hospitals

against access to necessary care, with lawmakers determining that in these extreme cases—when the patient has little choice about where to go for help and the need for services is so time sensitive—access to care must take precedence.

The newest legislative and regulatory trend in this area—in general affirming that pharmacies have a duty to dispense lawfully prescribed contraceptives and other drugs, regardless of the beliefs of their individual employees—has been in reaction to a spate of nationally publicized incidents of pharmacist refusal (see box). This trend began in 2005, when Illinois Gov. Rod Blagojevich (D) promulgated a regulation requiring pharmacies in the state that stock any contraceptives to dispense all FDA-approved contraceptives. Essentially, the 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.

Laws in California and New Jersey and a regulation in Washington state—all adopted since 2005—are not limited to contraception, instead imposing on pharmacies a duty regarding all valid prescriptions. These policies obligate a pharmacy to ensure their customers’ timely access to prescription drugs, be it by dispensing drugs they have in stock, ordering those not in stock, or transferring or referring the prescription to another local pharmacy. The California law specifically grants an individual pharmacist the right to refuse to dispense a drug on moral or religious grounds, but only if he provides prior written notification to his employer, the employer can provide him a “reasonable accommodation” without creating “undue hardship” for the employer and the employer has protocols in place to ensure patients’ timely access to prescribed drugs and devices. The Washington regulation also spells out what it considers unprofessional conduct on the part of a pharmacist or employee, including destroying or refusing to return an unfilled prescription, violating a patient’s privacy, and discriminating against, intimidating or harassing a patient. Part of that regulation has been temporarily enjoined by a federal district court, which has ordered that pharmacies and pharmacists be allowed to

## REFUSAL AT THE PHARMACY

State Laws and Regulations	
Allowing Individual Pharmacist Refusal	Establishing Pharmacy Duty To Provide
<i>Explicit policy:</i>	<i>Pharmacies must fill valid prescriptions:</i>
Arkansas*	California
Georgia	New Jersey
Mississippi†	Washington‡
South Dakota	
<i>If patients’ access is protected:</i>	<i>Pharmacies must dispense all contraceptives if any are stocked:</i>
California	Illinois
<i>Broadly worded refusal clause may apply:</i>	
Colorado*	
Florida	
Illinois	
Maine*	
Tennessee*	
State Pharmacy Board Statements	
<i>Endorsing refusal if patients’ access is protected:</i>	<i>Asserting that pharmacists may not refuse:</i>
Alabama	Maine
Delaware	Massachusetts
New York	Nevada
North Carolina	
Oregon	
Pennsylvania	
Texas	

\*May apply to pharmacies as well. †Pharmacies explicitly included as well. ‡Under a court order, referral to another pharmacy is permissible in the case of emergency contraception. Sources: Guttmacher Institute and National Women’s Law Center, 2008.

refuse to provide emergency contraception and instead refer the patient to another nearby source of the drug.

According to a 2008 report by the National Women’s Law Center (NWLC), another 10 states have taken a public stance on the subject through their boards of pharmacy, in the form of practice guidelines, policy statements, newsletters or answers to letters of inquiry. Three of them assert that individual pharmacists may only decline to fill a prescription on professional grounds (such as contraindications), not moral or religious ones. Seven others allow for pharmacist refusal but provide some protection to ensure that patients receive the drugs they have been prescribed. NWLC and other proponents of reproductive rights have encouraged women who have been mistreated at their drug store to make a formal complaint to their state’s pharmacy board, and advocates on both sides of the issue have turned to state boards of pharmacy to

clarify what falls within the bounds of acceptable conduct within that profession.

Reproductive rights groups have also worked to influence the refusal-related policies of pharmacies without government intervention. Planned Parenthood Federation of America, for example, has been surveying national pharmacy chains, scoring their policies on stocking contraceptives and on employees' refusal and conduct, and pressuring companies that receive negative scores to change their policies. Of the 11 national chains they have scored as of April 2008, only two—Target and the southeastern chain Winn Dixie—received a “thumbs down.” The most notable success of the campaign has been the policy changes instituted by Wal-Mart: After considerable press attention, Wal-Mart began stocking emergency contraception in 2006 and changed its policy in 2007 to ensure that customers are served without harassment or delay.

### An Emerging Consensus

This proliferation of government and private policies moderating the demands of the most extreme advocates of refusal indicates a shift in how the issue of health care refusal is viewed. Historically, the issue had been framed most consistently and assertively by proponents of refusal, who have promoted it as an issue of individual, generally religious, rights and discrimination. Groups such as the American Center for Law and Justice have made a cottage industry of bringing lawsuits against employers and state agencies, arguing for an interpretation of federal and state protections against religious discrimination in the workplace that would guarantee a right to refusal.

That frame is something of a distortion: As a matter of law, there is no “right” in the United States to be employed in a given profession, any more than there is a right, by and large, to health care. Even so, what appears to be resonating among Americans is a solution rooted in essentially acknowledging those asserted rights and striking a balance between them.

Support for such a solution can be seen in the policies adopted by states this decade. It can also be seen in polls of the American public: A national poll conducted by CBS News and The New York Times in 2004, for example, found that merely 16% of Americans, and only 24% of self-described conservatives, thought pharmacists should be able to refuse to sell contraceptives on religious grounds. Similarly, in a national survey of physicians, published in 2007 in the *New England Journal of Medicine*, 86% of physicians said they have an obligation to provide information about all of a patient's options, notwithstanding their own personal beliefs, and 71% said they have an obligation to refer a patient to another provider even when they personally object to a patient's request. And collectively, health care professionals have endorsed this solution in the context of professional guidelines and standards. The American Medical Association and the American Public Health Association, in addition to ACOG, have weighed in on the subject in the past several years, recommending steps to ensure that patients can have prescriptions filled with a minimum of difficulty or interference.

At the heart of the emerging consensus is a hardheaded practicality. Americans are generally supportive of efforts to accommodate the bona fide religious and moral beliefs of health care professionals, as would be expected of a nation built by waves of immigrants often seeking to escape persecution. Yet, every schoolchild is taught that there are limits to even our most fundamental rights, particularly when two rights come into conflict. In the last analysis, when conflict does ensue, when no accommodation can be made that allows a health care professional to heed his beliefs without obstructing a patient's access to care, it is the patient's needs that must prevail. Getting this practicality written appropriately into public policy is by no means a simple proposition. To ensure that it happens, advocates of patients' health and rights will need to sound that message clearly, consistently and forcefully.

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