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Target Article

Conscientious Objection and Emergency Contraception

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This article argues that practitioners have a professional ethical obligation to dispense emergency contraception, even given conscientious objection to this treatment. This recent controversy affects all medical professionals, including physicians as well as pharmacists. This article begins by analyzing the option of referring the patient to another willing provider. Objecting professionals may conscientiously refuse because they consider emergency contraception to be equivalent to abortion or because they believe contraception itself is immoral. This article critically evaluates these reasons and concludes that they do not successfully support conscientious objection in this context. Contrary to the views of other thinkers, it is not possible to easily strike a respectful balance between the interests of objecting providers and patients in this case. As medical professionals, providers have an ethical duty to inform women of this option and provide emergency contraception when this treatment is requested.

Keywords: conscientious objection, emergency contraception, healthcare delivery, professional ethics, referrals, refusals of care

Decisions regarding health policy frequently involve a volatile mixture of medical science, politics, and ethical values. One of the most contentious recent issues concerns prescriptions for emergency contraception (EC), especially given the reticence of the United States Food and Drug Administration (FDA) to grant over-the-counter status to the EC levonorgestrel (Duramed Pharmaceuticals, Inc., Pomona, NY) and the resignation of one of the FDA's directors over this issue. On August 24, 2006, FDA announced approval of levonorgestrel as an over-the-counter medication for women age 18 and older,[1] yet a general moral question still remains: what is the scope of medical providers' right to refuse treatment based on their own ethical objections to this treatment? As it turns out, FDA's decision may simply make the relevant ethical issues more subtle —imagine cases in which a medical provider refuses to mention or discuss EC with a woman who is expressing her concern regarding an unplanned pregnancy. The FDA's recent plan still uses pharmacists as a gatekeeper because women younger than age 18 years must secure a prescription and women age 18 years and older must be able to prove their age to a pharmacist who keeps the drugs behind the counter. As observed in the *Washington Post*:

> The FDA decision does not resolve other controversial issues swirling around the pills, including the refusal of hospitals run by religious organizations to offer them, of some pharmacies to stock them and of some antiabortion pharmacists to dispense them. "The FDA doing a stupid thing doesn't change anything for those of us who need to do the right thing," said Karen Brauer, president of the group Pharmacists for Life International, which opposes the use of the emergency contraceptive (Stein 2006, A06).

There has been increased attention focused on this issue, given numerous reports (Greenberger and Vogelstein 2005; Stein 2005) that medical professionals have refused to honor women's requests for EC based on conscientious objection. This discussion broaches a relatively unexplored issue within biomedical ethics; conscientious objection raises interesting questions in other contexts such as abortion and physician-assisted suicide. A standard way to address this issue is to advocate referral of care to a willing provider. To cite just one such example, Dan Brock states in the context of active euthanasia that if performing the associated actions "conflicted with a particular physician's reasonable understanding of his or her moral or professional responsibilities, the care of a patient who requested euthanasia should be transferred to another" (Brock 1992 [2004], 215). This is a popular approach to managing conscientious refusals, yet as I will argue within this discussion of EC, it is not an unproblematic response.

I will understand conscientious objection as a refusal to comply with a request based on personal moral or

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1. This announcement was made while this article was under review; however, this event does not change the basic philosophical issues and proposed objections to EC — the consideration of which is the focus of this discussion. For details on the FDA's approval and plan for distributing EC as an over-the-counter pharmaceutical, see FDA 2006.

religiously-inspired moral reasons (Childress 1985). This general moral question applies not only to pharmacists who refuse to dispense EC but also to physicians who refuse to discuss EC on moral grounds. This article focuses mainly on the former controversy because this is an issue of current relevance; 15 states have recently considered bills concerning conscientious objection in the pharmacy (Greenberger and Vogelstein 2005, 1557). In what follows, a critical examination will be conducted regarding the ethical duties of professionals with respect to hormonal EC (e.g., estrogen and progestin/levonorgestrel). In contrast to other thinkers that advocate the duty to refer patients, this paper argues that providers have a professional ethical obligation to inform women of this option and dispense EC when this treatment is requested.

The analysis presented is based on professional ethical obligations and should not be construed as necessarily supporting or denying legal or regulatory requirements. Professional ethics is a different and higher standard as compared with legality. Because not every moral obligation is (or ought to be) codified into law, the discussion of this article should be understood as centered on professional ethics.

THE MODERATE VIEW OF CONSCIENTIOUS OBJECTION

In an influential article, Julie Cantor and Ken Baum (2004) focus on the objecting pharmacist's duty to refer patients requesting EC to another willing pharmacist. They note that the American Pharmacists Association (APhA) (Washington, DC) has endorsed referrals, and they hold that pharmacists do not have an absolute right to object nor do they lack a right to conscientious objection (Cantor and Baum 2004, 2011). There is no absolute right to object because autonomy rights are limited in their scope. Clearly, pharmacists cannot ethically refuse to provide treatment based on the patient's race or ethnicity. Mark Wicclair (2000, 212) points out that if a medical professional conscientiously objected to forgoing aggressive treatment on the grounds that it would deny her an opportunity to test a new drug, then this type of reason would properly be accorded no moral weight as a ground for conscientious refusal. Pharmacists have a right to object because the APhA has explicitly adopted a pharmacist conscience clause, this states that:

> [the] APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patients' access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal (APA, 2004).

As I view it, this clause grants a (defeasible) professional right on the part of pharmacists to engage in conscientious objection. Cantor and Baum believe that a position in the "vast middle ground" is most defensible. This moderate position, although reasonable on its face, is problematic on closer inspection.

Referrals may not be possible for economically disadvantaged patients and/or those who live in rural areas, thereby leaving such patients with no true access to medical treatment. In the case of EC, time is of the essence, as such medication works best in the first 12 to 24 hours after sexual contact and must be administered within 72 hours (Greenberger and Vogelstein 2005, 1557). This position can therefore result in great harm to women. Further, by exercising the referral option, objecting pharmacists are not fulfilling their role responsibility. The precise role of pharmacists within the United States healthcare system is somewhat murky, but some plausible suggestions include the following: checking for drug interactions with the patient's prescription medications and instructing patients on using a medication. A pharmacist's role is not to second-guess an adult's decisions regarding the use of an approved pharmaceutical but is to provide convenient and safe access to medications. Additionally, the publicity of confrontations with objecting pharmacists, especially at the counters of large, chain pharmacies, compromises patient integrity and confidentiality.

While the moderate view stresses a duty to refer instead of a duty to dispense the medication as a way to strike a balance between the interests of patients and pharmacists, it is unclear what actual ethical difference exists between these two duties for the conscientiously objecting pharmacist. Cantor and Baum state, "[a] referral may also represent a break in causation between the pharmacist and distributing emergency contraception, a separation that the objecting pharmacist presumably seeks" (Cantor and Baum 2004, 2011). Is this really true, and do all objecting professionals support the referral option? Referring the patient to another willing pharmacist certainly does not remove the pharmacist from the causal chain of events that leads to the use of EC, an act that is considered morally wrong by such objecting pharmacists. Supporters of pharmacists' right to conscientious objection such as Karen Brauer, hold that such medical treatment violates the Hippocratic Oath by doing harm to human life (Stein 2005). Brauer defends pharmacists' rights to refuse to dispense medications themselves as well as to refuse to refer customers to other willing pharmacists. Brauer holds this position because she believes that referring customers makes no intrinsic moral difference:

> That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing (Stein 2005, A01).

A staunch defender of pharmacists' right to conscientious objection (such as Brauer) clearly sees no ethical difference between dispensing the medication herself and allowing another willing pharmacist to do so. This presents a serious challenge to the moderate view. Because the proponents of the moderate view have not defended an intrinsic moral distinction between "doing" and "allowing," this argument by the staunch defender of conscientious objection remains unchallenged. At the very least, referrals are not as ethically unproblematic for objecting pharmacists as moderates think. In fact, because referrals are equally morally

troublesome for these objecting pharmacists, Cantor and Baum have not provided the "respectful balance" between the interests of pharmacists and patients that they seek.

A LESS MODERATE VIEW OF CONSCIENTIOUS REFUSALS BY MEDICAL PRACTITIONERS

In this section, I critically analyze proposed objections to the dispensing of EC to arrive at a less moderate view on the reasonableness of conscientious objection in this context. Before beginning this task, however, I wish to briefly elaborate on how I have framed the issue in order to set the stage for the weighing of reasons that is to follow. From the outset of this article I have viewed this debate as involving the autonomy rights of medical professionals. Valuable insight into this debate is gained by taking seriously the notion that medical providers (e.g., physicians, pharmacists, nurses) are members of a profession. Writings by numerous thinkers (Arras 1988; Pellegrino 1987) suggest plausible characteristics of a profession that are satisfied by the medical field. Edmund Pellegrino makes some thought-provoking observations about why physicians (and, by extension, other healthcare providers) are members of a profession. To discuss just one of his points, Pellegrino views medical knowledge as a "public trust." This knowledge was gained by invasions of privacy and experimentation on human beings, and these decisions were justified because medicine should use this knowledge to reduce human suffering and serve humankind. This suggests that there are social obligations on the part of medical professionals that are not possessed by persons who are simply members of an occupation. The distinction between the concepts of a *profession* and an *occupation* is rough around the edges, but it marks off a useful and important distinction. The issue at hand requires balancing the moral values of the medical professional and the patient. Medical professionals are persons who possess autonomy rights, and hence may refuse care in some circumstances, yet we cannot forget to take the patients' moral values into consideration as well.

To imagine just one concrete scenario, perhaps the woman seeking EC finds using contraception to be ethically unproblematic but does not morally agree with abortion at any stage. The professional's refusal may cause a delay in care which, given the circumstances of the woman, may then require her to have an abortion later. Are we then at a standoff in this conflict between the moral values of the patient and the provider? This is not the case, because refusals of care with respect to EC may jeopardize the health and the well-being of women. At the moral center of medical professionalism is the requirement that practitioners give primacy to their patients' interests. This is echoed in ethical codes, for instance, in statements of research ethics (e.g., the Declaration of Helsinki) proclaiming a professional's duties to safeguard subjects' well-being and to not treat subjects merely as a means to advancing the interests of society or medical science. Because EC must be used within 72 hours of sexual contact, time is of the essence. A refusal of care in this context may amount, in practical terms, to a right to impose their beliefs on their patients, yet professionals do not possess this right. This follows from the fact that patients possess autonomy rights and the point that providers should give primacy to patients' interests. The position of this article is that conscientious objection is different with respect to EC as compared with physician-assisted suicide, for example; the extremely narrow time frame for care is one such salient difference.

One may downplay the importance of the previous discussion by proposing that if pharmacists refer patients to other professionals who will give the patients timely access to EC, there is no significant threat to women's health or well-being. In response, I would ask the objector whether he or she accepts the position that the professional must dispense EC if a referral is not possible. I doubt this is the case. If the objector does not accept this position, then he or she fails to safeguard the patient's interests. If the objector does accept this position, then he or she agrees with the argument set out previously: that medical providers can be under a professional obligation with respect to EC that overrides their personal moral beliefs. Further, this objection is clearly premised upon a hypothetical scenario. If, for example, war is declared and there are so many able-bodied persons willing to enlist that conscription is not necessary, then it may be thought that conscientious objection becomes an issue that is of mere theoretical interest (if no injustice or bad consequences occur in such a state of affairs). But with respect to EC, unfairness and bad consequences do in fact occur,[2] and hence this objection is not realistic in the circumstances in which the debate regarding EC occurs.

Physicians who conscientiously refuse to provide EC object on the same basis offered by pharmacists — yet a critical examination of this basis may lead to a reconsideration of these reasons. This section focuses on examining this basis in general; after all, physicians' greater stature within the profession does not itself make their professed reasons more forceful. What are these reasons? Professionals may object to dispensing EC because a) s/he considers EC to be unethical since it is equivalent to abortion, or b) s/he considers contraception itself to be immoral. I will evaluate these versions of conscientious objection to dispensing EC in turn.

The first line of argument (a) is empirically questionable. There is no evidence that levonorgestrel and similar hormonal EC regimens have an effect on an established pregnancy (Glasier 1997, 1060). Conception represents the start of the process of becoming pregnant; as David Bainbridge says regarding conception, *conception* is "a term to include all the different mechanisms that must act for a pregnancy to be established, of which fertilisation is only one" (Bainbridge 2001, 278). His point is that pregnancy is not equivalent to fertilization. Another source states the following regarding EC: "By medical definition, the pills block rather than terminate pregnancy." (Editors of *Scientific American*, 2005) The scientific data suggest that hormonal EC operates mainly

2. In a compelling narrative, Dana L. discusses her difficulty acquiring levonorgestrel in Virginia and the subsequent choice regarding abortion she was forced to make as a result (L., Dana 2006).

by inhibiting or disrupting ovulation (Glasier 1997, 1063). What this means is that EC inhibits follicular development and the maturation and/or the release of the ovum itself (Glasier 1997, 1058), thereby preventing pregnancy. As Anna Glasier puts the point, "it cannot be stressed too strongly that if hormonal emergency contraception works largely by interfering with ovulation, then it cannot be regarded as an abortifacient" (1997, 1063).

Why, then, would anyone regard hormonal EC as equivalent to abortion? One hypothesis is based on simple scientific ignorance of the mode of action of EC. A more interesting hypothesis is offered by Glasier: "Although it seems likely that the estrogen-progestin regimen works mainly by interfering with ovulation, it is nevertheless regarded by many as an abortifacient because it is taken after, rather than before, intercourse" (1997, 1063). This highlights a line of reasoning that is obviously mistaken because it involves a causal or temporal confusion. It is worth taking a moment to sort this out in order to see the mistake. If a woman has unprotected sexual intercourse, she may become pregnant. Sperm can remain in the female genital tract and are capable of fertilization for up to 5 days; the ovum appears to be capable of fertilization for only about 24 hours (Glasier 1997, 1058). If a woman's request for this medication is satisfied, EC may interfere with ovulation and hence fertilization does not occur. The point is that EC has lasting effects and could thereby prevent a pregnancy that might have otherwise occurred even after the 72-hour "window period" — the time during which EC must be taken in order to be effective. EC is a form of contraception, not an abortifacient.

An astute objecting pharmacist might object to the definition of pregnancy used in the previous discussion, suggesting instead that pregnancy is equivalent to fertilization (or, at least, that fertilization marks the point at which an individual with moral standing exists). On this understanding, if fertilization had occurred, then EC would terminate the pregnancy and is equivalent to abortion. Because the mode of action of currently available EC is not precisely known, it is possible that EC may interfere with the transport of the embryo to the uterus or inhibit its implantation into the endometrium (Dresser 2005, 9). A review of the literature suggests that there is no solid reason to believe that hormonal EC works in either the former or latter manner (Glasier 1997, 1059); recent scientific evidence (Croxatto et al. 2004) suggests that hormonal EC does not have post-fertilization effects.

Consider further that the astute pharmacist bases his or her objection to EC on the fact that a pregnancy has occurred, but this is an unknown within the 72-hour window period. Some basic facts about human pregnancy make this clear. Pregnancy can be detected in women by the measurement of human chorionic gonadotropin, a hormone produced by the placenta in early pregnancy. Bainbridge makes clear that the embryo has an aggressive approach to the maternal recognition of pregnancy (relative to other species); he reports that "the embryo can form a considerable bulk of placental tissue as early as five to seven days after fertilisation" (Bainbridge 2001, 93). However, even given this fact and the existence of sensitive and reliable pregnancy tests it is not possible to confirm a positive pregnancy within the 72-hour window period.

This is another way in which conscientious refusal within the context of EC differs from other cases in which medical professionals invoke such objections. In a case of conscientious objection regarding abortion, a physician knows whether or not a fetus exists. The same is true, *mutatis mutandis*, in cases of conscientious objection regarding assisted suicide. Yet there is a small and unknowable probability that dispensing EC during the window period would cause something morally wrong to occur (by the objecting professional's own beliefs). Since the objecting professional lacks relevant evidence for the very foundation of his or her conscientious objection, there is not sufficient reason to grant substantial weight to a refusal on this ground.

A very astute professional might accept the foregoing discussion, but respond by arguing that, while this probability is an unknown, there is a non-zero probability that pregnancy has occurred. If the professional dispenses EC, then there is a possibility that he or she has contributed to the commission of a morally wrong action (by his or her own beliefs). Or, in a slightly revised version, an objecting professional might state that by doing so in numerous instances, there would be a non-zero probability that he or she has contributed to the commission of a morally wrong action (by his or her own beliefs).

I will call this *the zero probability argument*: persons should not perform an action unless it is true that there is a zero probability that their action (or their contribution to an action) will issue in immoral results. The zero probability argument leads to absurd results because the mere possibility of contributing to immoral results exists with virtually anything a human being does — given the existence of spurious causal chains, this may be true of acts such as taking a walk or brushing one's teeth. More specifically, the mere possibility of contributing to wrongdoing applies to many acts performed by a medical professional (e.g., dispensing cold and sinus medicines that might be abused in various ways) and would suggest that such professionals should stop assisting patients in general. This is unacceptable; it is simply unreasonable to withhold medication because of the *mere possibility* that this may contribute to an immoral result.

In this portion of the discussion, we have discovered a general problem with conscientious objections to EC based on a comparison to abortion. If fertilization has occurred, because there is no evidence that EC has post-fertilization effects, dispensing EC will not change the outcome. On the other hand, if fertilization has not occurred and EC acts to inhibit ovulation, thereby preventing a pregnancy that would have otherwise later occurred, nothing immoral happens even granting the objecting professional's beliefs as discussed. In either case, the basis for the professional's conscientious refusal with regard to dispensing EC is called into question. EC causes something ethically-problematic to occur only if contraception itself is considered morally unacceptable.

Perhaps members of Pharmacists for Life (Powell, OH) represent this remaining type of objecting professional; recall, they stated above that EC constitutes "doing harm to human life." If this notion is taken literally, then this implies that medical treatments such as chemotherapy are morally wrong in themselves. Chemotherapy destroys human cells and hence seemingly counts as doing harm to human life in some way. Yet it is absurd to think that chemotherapy is morally wrong in itself. It is more plausible to suppose that the objecting professional believes that the human life in question is somehow limited specifically to individual sperm and ova. This professional might argue that reproductive cells are special because they possess the potential to become persons. Sperm and ova that are not given at least an opportunity to become persons are harmed.

The fact that this claim lacks a sound basis is made clear by referring to a version of the non-identity problem. Contraception, if effective, prevents conception; yet does not being conceived constitute a moral wrong to one who otherwise would have come into existence? Laura Purdy discusses the non-identity problem and addresses this question in the negative:

> [T]here seems to be no reason to believe that possible individuals are either deprived or injured if they do not exist . . . [if we had not been created] we would not exist and there would be nobody to be deprived of anything (Purdy 1978 [2004], 258).

This argument states that if an individual never comes into existence, then there is no one that is harmed because no one exists who is a subject of harm. This general argument is not beyond dispute; Dan Brock (1995) questions the dismissal of harms to "possible persons" by referring to the non-identity problem. Yet Brock's discussion centers on the case of genetically-transmitted handicaps, and his point is that the possible harm to a potential offspring should not be dismissed if one could have a different child without comparable burdens (Brock 1995, 313). Hence, the foregoing argument is not directly affected; even a critic of the non-identity argument such as Brock does not accept that being deprived of existence itself constitutes a moral harm. After all, if not being brought into existence were an injury and we were committed to a principle of minimizing harm, this would imply (in certain circumstances) the absurd result that failing to reproduce at a maximal rate is a moral wrong. In sum, before one is conceived, there is no individual of which to speak. If one was never brought into existence, it is not the case that harm occurs by virtue of the deprivation of "actualizing" the potential to become a person — there is no one who could be said to have been deprived of anything.

One may object that I have not properly interpreted the moral objection to contraception. One may instead think that contraception is wrong because intercourse is ethically acceptable only if the goal is procreation. In response, I call attention to the ambiguity of the term *goal* and critically analyze this proposed reason. If this reason is to be understood as "intercourse is ethically acceptable only if the natural 'goal' is procreation," then in this argument no contraception is morally permissible. This position is unreasonable because it is inconsistent with the compelling fundamental idea that adults possess a moral reproductive right founded in autonomy. This notion was first articulated as a legal right in *Griswold v. Connecticut* (1965). If the term *goal* is to be understood as "intercourse is ethically acceptable only if a person's 'goal' is procreation," then we must determine the subjective intentions or circumstances in which potentially procreative activity occurred. If a woman requests EC because of contraceptive failure, then obviously her goal was not procreation and EC should be dispensed. Yet this does not support the objecting professional's position. What if, instead, a woman who is a rape victim requests EC? Was the goal in the activity procreation? It is reasonable to say that she had no positive goal with respect to the intercourse because she was an unwilling participant. Notice that objecting providers do not distinguish cases of sexual assault from other cases in which women request EC, so this subjective understanding of the reason is not applicable to the situation at hand. This proposed reason based on the wrongness of contraception does not successfully support conscientious objection on the part of professionals with respect to EC.

FURTHER THOUGHTS

This discussion has proceeded using the rubric of "conscientious objection" in medicine, although it is not clear that this term is entirely fitting. In a 1985 article, James Childress discusses the refusal to meet a professional demand in precisely these terms; he states that "I will use "conscientious objection" to refer to public, nonviolent, and submissive violations of law based on personal-moral, often religious, convictions and intended primarily to witness those principles or values" (1985, 68). Civil disobedience, by contrast, is a refusal to obey a demand instead on moral-political grounds as a way to make an open public statement of advocacy for change (Childress 1985, 67–68). Notice, however, that an act of conscientious objection need not necessarily involve a violation of law, contrary to Childress's conception. There are instances in which state law grants medical professionals a right to conscientious objection (Greenberger and Vogelstein 2005, 1557). More importantly for our purposes, a person who engages in conscientious objection typically undertakes the risk of suffering any negative consequences stemming from that decision, yet with the presence of the APhA conscience clause, the risk of negative consequences disproportionately falls on women in need of EC. One may wonder whether the medical professionals in question are engaging in conscientious objection or civil disobedience. Using Childress's conception, I would say both. Their acts are guided by moral beliefs, and they are public — these professionals do not attempt to be evasive by, for example, falsely informing patients that EC is not in stock or is contraindicated in their case. Perhaps the framework of conscientious objection is not the best or sole one in which to conduct this discussion.

If we take the rubric of conscientious objection seriously and apply it to the context of healthcare, then

perhaps we should establish conscientious objector status for medical professionals. This is an idea worth considering because at the very least it would put women on notice with regard to their practitioners' views on EC. Yet, as a general matter, to which sort of medical treatments can a professional properly conscientiously object? If objecting to participation in abortion is on one end of the continuum, can the practitioner acceptably refuse providing infertility treatments for an unmarried individual or removing organs from patients declared dead according to whole-brain death criteria? (Dresser 2005, 9). The establishment of conscientious objector status with respect to certain activities would be a step forward by requiring that medical professionals state succinctly their reasons for refusing to serve and be open to these reasons being evaluated as part of institutional practice, similar to the manner in which determinations of conscientious objector status work within the military. In a powerful narrative recently published in the *Washington Post*, Dana L. finds it particularly frustrating that medical professionals "... aren't even required to tell the patient why they won't provide the drug ..." (2006, B01). In the present circumstances, because professionals need not even state their reasons for the decision to not provide care, their right to conscientiously object is unlimited in practice.[3]

An alternative proposal would attempt to dissolve the conflict by noting that women could take regular birth control pills and achieve the same effect because the EC regimens focused on in this article essentially contain a greater amount of the same (or similar) hormones. The appeal to such "off-label use" of regular birth control is a diversionary tactic that avoids the central ethical issue, that of whether and when a professional has a right to conscientiously refuse medical treatment. This "off-label" use solution is not necessarily available in all cases (e.g., physician-assisted suicide where legal) and does not work in the context of EC if the pharmacist objects to filling prescriptions for birth control pills themselves.[4] Advocating such use of drugs to achieve the same effect as an FDA-approved medication indicated for precisely such circumstances is disingenuous at best; refusals to dispense EC based on an appeal to "off-label" use fails to make patient safety and well-being the first priority.

One might object to my discussion by granting my criticisms of the reasons offered against dispensing EC yet arguing that the right to conscientious refusal is not limited to ethical beliefs thought to be justified or reasonable. I find this general line of criticism to be implausible. The beliefs on which conscientious objection is based must be reasonable and should be subject to evaluation in terms of their justifiability. This is assumed in the previous discussion relating to conscientious objection in the military: an individual's reasons are to be clearly stated and evaluated in a public forum. If an individual sought conscientious objector status within the military because she or he had the moral belief that wearing green in battle was morally evil, this should not serve as a sufficient reason in itself for granting conscientious objector status. Further, the proposed line of argument stemming from this criticism has troubling implications. If a professional's reasons for seeking conscientious objector status need not be limited to those that are reasonable or justified, then on this understanding a provider can acceptably refuse EC based on, for example, sexist beliefs that women are inferior and should be pregnant as often as men wish them to be. As emphasized previously, *critical evaluation* of the reasons for proposed conscientious objector status is essential.

CONCLUSION

Initially, there seem to be three relevant alternatives regarding this issue: an absolute right to object, no right to object, or a limited right to object. This article has argued that there is no absolute right to object because it would be immoral for a provider to deny medical treatment to a patient based solely on, for example, his or her race. There is a *prima facie* right regarding conscientious objection, founded in the notion that providers are persons with their own ethical values who exercise moral judgment, yet this right may be defeated in certain cases. Working strictly within the context of conscientious refusals to dispense EC, the argument in this article suggests that fewer options exist than appear on the face of things. A limited right to object, if it is manifested in a professional obligation to refer the patient to a willing provider, can be viewed as philosophically indistinguishable from the case of dispensing EC by the staunch objecting professional himself or herself. This is the case if no stock is put into an intrinsic moral distinction between "doing" and "allowing"; the defender of the moderate view on conscientious objection with respect to EC has not adequately recognized this point nor attempted to rebut it. For the staunch defender of the right to conscientious objection discussed in this article, either such providers have an absolute right to object or no right to conscientious objection regarding EC. As argued previously, providers are medical professionals who lack an absolute right to object. Further, I have argued that the reasons offered for refusals regarding EC do not withstand critical scrutiny. Hence, it is reasonable to think that even given their moral reservations,

3. One seemingly simple response to this quandary — before the FDA's ruling allowing EC for over-the-counter use and presently for women younger than age 18 years — is to advocate advance prescriptions for EC. This is a promising idea that could remove the urgency associated with the "window period" for taking EC. Yet this response is not as simple as it seems on its face because many of the same problems discussed earlier arise with this policy. If this is implemented in the form of an undated prescription, a woman may still encounter the difficulty of finding a willing pharmacist to fill the prescription when it is needed. Further, empirical study of primary care providers suggests that physicians' misconceptions about EC lead to reluctance to provide advance prescriptions (Karasz and Gold 2004). This underscores the point that analysis of the reasons supporting conscientious refusals — the focus of this essay — ought to remain center stage in this discussion.

4. An anonymous commentator suggested this final point about the flaw in "off-label" use.

providers have a professional ethical obligation to dispense EC. ■

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