

Conscientious Objection, Emergency Contraception, and Public Policy

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Defenders of medical professionals' rights to conscientious objection (CO) regarding emergency contraception (EC) draw an analogy to CO in the military. Such professionals object to EC since it has the possibility of harming zygotic life, yet if we accept this analogy and utilize jurisprudence to frame the associated public policy, those who refuse to dispense EC would not have their objection honored. Legal precedent holds that one must consistently object to all forms of the relevant activity. In the case at hand, then, I argue that these professionals must also oppose morally innocuous practices that may prevent pregnancy after fertilization. These results reveal that such objectors cannot offer a plausible and consistent objection to harming zygotic life. Additionally, there are good reasons to reject the analogy itself. In either case, these findings call into question the case supporting refusals of EC based on scruples.

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I. INTRODUCTION

Much of the recent controversy concerning medical professionals' rights to conscientious objection (CO) has centered on emergency contraception (EC). In this discussion of refusals focused on Plan B (levonorgestrel [LNG]), I will understand CO as a refusal to comply with a request based on personal or religiously inspired moral reasons (Childress, 1985). Defenders of conscientious refusal offer a simple yet forceful argument supporting medical professionals' rights to maintain their integrity¹: since those who oppose

killing humans in combat can be granted CO status, those who oppose the killing of human life in medicine should have a comparable privilege. To cite an example, Cantor and Baum (2004) defend a moderate position on this question in an influential paper published in the *New England Journal of Medicine*,² stating the following in an argument supporting CO: “. . . like the draftee who conscientiously objects to perpetrating acts of death and violence, a pharmacist should have the right not to be complicit in what they believe to be a morally ambiguous endeavor . . .” (2004, 2009).

Yet is the rubric of CO the proper one for this discussion? This is the case only if the analogy to CO status granted to persons facing military combat is a compelling one that supports conscientious refusals of EC. Although such pharmacists and physicians typically object to EC since it has the possibility of harming zygotic life (Stein, 2005), I will argue that there is no good case to be made in support of CO with respect to EC if one draws a comparison to CO regarding war. Of course, this is not the only way one may choose to support conscientious refusal (c.f. Card, 2007a), yet it is enlightening to analyze the way proponents of CO regarding EC set the stage for their argument with this comparison.

Instead of rejecting the analogy outright, I will initially embrace it³ in order to show that on this basis, those who refuse to dispense EC would not have their objection upheld. The US Supreme Court has decided that one who conscientiously objects to combat since it involves the possibility of killing another human being must object to all relevant forms of the activity. In the case at hand, this would imply that medical professionals must also oppose numerous morally innocuous practices, as I will argue, since it is possible that these may also cause zygotic death. Since objectors to EC cannot offer a consistent and plausible objection to harming zygotic life, their objection should not be honored as a matter of public policy because their claim does not meet a necessary condition for CO. Finally, I examine the comparison of CO to EC with CO to combat and conclude that it does not hold up to close scrutiny; as such it does not provide strong support for the position of those who are opposed to dispensing EC based on scruples. The argument in this paper puts supporters of conscientious refusals in a problematic position: if the analogy between military CO and medical CO is granted, then it fails to support professionals' COs, and if the comparison is examined critically then there are serious disanalogies that speak against its use to defend conscientious refusals of EC.

II. BASING PUBLIC POLICY REGARDING EC ON THE MODEL OF CO STATUS TO WAR

If we take the analogy to CO status to war seriously, then we should model public policy regarding conscientious refusals in medicine on the basis of legal precedent outlining the scope of acceptable objection by those

opposed to combat on the basis of scruples. After all, objectors may propose to lay claim to a moral right, but they also advocate for conscientious refusals to be *legally* protected; in many instances, such medical practitioners are asking for immunity from damage awards or professional censure (Guttmacher Institute, 2008). A landmark case on CO regarding combat decided by the US Supreme Court is *Gillette v. U.S.* (1971). The Court held that petitioners' objection must be to *all* fighting, not simply to fighting in a war with which they morally disagree. As the Court notes, the possibility of exemption from service draws from section 6(j) of the Military Selective Service Act of 1967 that provides:

Nothing contained in this title . . . shall be construed to require any person to be subject to combatant training and service in the armed forces of the United States who, by reason of religious training and belief, is conscientiously opposed to participation in war in any form (401 U.S. 437 (1971), 441).⁴

In this case, petitioner Gillette objected to the Vietnam War based on a humanist approach to religion, stating that his opposition was grounded in the fact that military operations in Vietnam were "unjust." Petitioner Negre (whose case was combined with Gillette's) was a devout Catholic who did not object to all wars, but believed it was his duty to discriminate between a "just" and "unjust" war and he concluded that the Vietnam War was the latter (401 U.S. 437 (1971), 440).

The Court upheld the denial of conscientious objector status to both petitioners by the military in accordance with 6(j). According to the Court, in order to satisfy 6(j) the CO must be directed to war in a general form. The Court's main reasoning for its conclusion in support of the Government's policy concerns fairness; as the Court states:

The Government argues that the interest in fairness would be jeopardized by expansion of 6(j) to include conscientious objection to a particular war. The contention is that the claim to relief on account of such objection is intrinsically a claim of uncertain dimensions, and that granting the claim in theory would involve a real danger of erratic or even discriminatory decision making in administrative practice (401 U.S. 437 (1971), 455).

The Court stresses that the judicial policy must lead to even-handed and uniform decision making, yet objections to a particular war may often rely upon incidental facets of a conflict or mistaken beliefs about the war (401 U.S. 437 (1971), 456).

In addition to the condition that (1) one object to participation in war in any form, it also must be the case that (2) the belief upon which the objection is based is sincere (*Witmer v. U.S.* (1955)). This means, minimally, that the reason is offered in good faith, and the belief is a central one around which the person organizes his or her life. In *Gillette*, the Court states that although sincerity is important, ". . . we must recognize that 'sincerity' is a concept that can

bear only so much adjudicative weight “ (401 U.S. 437 (1971), 457), implying that condition (1) is assigned greater relative importance.

Although the US Supreme Court is certainly not issuing binding moral imperatives in its opinions, the commitment to consistency built into the doctrine of “general” CO (in contrast to “selective” CO) supported in *Gillette* is understandable and valuable. From the point of view of ethics and policy, I see the wisdom in not having to adjudicate the truth of persons’ sincerely held beliefs on a case-by-case basis. Instead, we say “If your belief is sincere, you must apply it consistently by being opposed to all activities of that type and then you will be granted CO status.”⁵

If we assume, along with defenders of conscientious refusals of EC, that their objection is analogous to fighting in a war with which they morally disagree, then the jurisprudential line of reasoning sketched above is not a very promising avenue of support for refusals of EC. The objection to providing EC, in its most general form, is to contributing to that which has the possibility of killing zygotes—and as such constitutes harming human life in opposition to the Hippocratic Oath. (Stein, 2005) Yet on the *Gillette* line of reasoning the objection must be to any form of activity of that sort; this requires in this context that one object to all relevant activities that pose a threat to zygotic life.⁶ Discussions of EC pills have made clear that although it seems that they act primarily by delaying or inhibiting ovulation (Croxatto et al., 2004), it is possible that all may act after fertilization—a point that causes much of the heated debate (Glasier, 1997). If we utilize the *Gillette* precedent, then, supporters of CO regarding EC must be opposed to any action that functions similarly, that is, any actions that pose a threat to zygotic life.

This criterion should, then, lead EC opponents to reject, for example, breastfeeding, since this has a proven association with extremely low pregnancy rates and has a mechanism of action that may act after fertilization, as I will now discuss. Diaz et al. (1992, 498) studied postpartum women who experienced *lactational amenorrhea*—an abnormal stoppage or absence of menstrual flow—associated with decreased fertility given the low incidence of ovulation during the amenorrheic period. Diaz et al. studied the ovulation rates and cumulative probability of pregnancy for a sample of fully nursing women; approximately two-thirds of the women were amenorrheic 6-month postpartum, and their ovulation rate and risk of pregnancy during this period were 27.7% and 0.9%, respectively (Diaz et al., 1992, 502). Whereas only approximately one-quarter of the amenorrheic women ovulated and their cumulative risk of pregnancy was less than 1%, after the first postpartum menses, 97% of these women ovulated and the cumulative probability of pregnancy was 7% (Diaz et al., 1992, 501). An abnormal hormonal profile and a shorter *luteal phase*—the time during which the uterine lining develops and thickens in preparation for possible implantation of an embryo—was observed in such women, providing protection against pregnancy for women who ovulate during lactational amenorrhea within the first 6 months

of giving birth.⁷ Interestingly, breastfeeding has lasting effects on becoming pregnant: as lactational amenorrhea ends and such women begin to resume normal ovulatory cycles, a decreased risk of pregnancy was noted. As Diaz et al. (1992, 503) state:

For a short interval at the end of amenorrhea, breastfeeding prevented pregnancy in ovulatory cycles. Interference with implantation associated with luteal phase defect seems the most plausible explanation . . .'

This is a clear statement that lactational amenorrhea can in fact have a post fertilization effect. In essence, the shortened luteal phase resulting from breastfeeding serves to prevent or interfere with implantation, thereby potentially resulting in the loss of zygotic life. It is worthwhile to summarize the chain of reasoning just offered. It is not the case that all women who choose to breastfeed will experience lactational amenorrhea; in fact, it is not known in advance the women in which this will occur. However, choosing to breastfeed may lead to lactational amenorrhea, and lactational amenorrhea may lead to the killing of early human life. Therefore, choosing to breastfeed may lead to the killing of zygotic life, and as such, for the sake of consistency breastfeeding must be opposed by those who object to EC on these same grounds.

This would imply that objecting medical providers should deny supportive care to women who choose to nurse their infants and are sexually active with their mates. Although such providers must refuse a range of care, the clearest case for pharmacists would include refusing to dispense prescription drugs (e.g., Reglan) used to attain adequate milk supply in lactating women. For objecting physicians, they must not answer questions posed by women having breastfeeding difficulties and should not write prescriptions for medications such as Reglan. The fact that we have not seen a campaign against breastfeeding by those who oppose EC given its potential to kill zygotic life could certainly be the result of ignorance of this possibility; yet given that we are highly unlikely to see such a campaign, this signals an inconsistency within such objectors' position. I submit that the requirement to oppose breastfeeding is an absurd result that blocks opponents of EC from appealing to the well-developed body of law regarding objection to combat to build their case for CO regarding EC.

Another argument along these lines is presented by Bovens (2006). Bovens argues that the "rhythm method" of contraception may be responsible for at least as much embryonic death as other methods of birth control. His basic argument is that if we make a few "relatively innocent" assumptions, then we must conclude that the rhythm method should be deemed equally as unacceptable as abortion and the morning-after pill by pro-life advocates. The first assumption he makes is that there are many conceptions that never result in missed *menses* (Bovens, 2006, 355). Various studies cited by Bovens conclude that only 50% (and perhaps as few as 20%) of conceptions actually

lead to pregnancies. The second assumption is that the rhythm method can fail if unprotected sexual intercourse occurs in the last days before and the first days after the prescribed abstinence period (Bovens, 2006, 355). His third assumption is that there is a greater chance that a conception will lead to a viable embryo if it occurs in the center interval of the fertile period than if it occurs at the beginning or end of this period. Since we know there is a high embryonic death rate, this point seems to be intuitively plausible, according to Bovens, since an embryo resulting from an (e.g.) “old” sperm that is also trying to implant in a uterine wall that is less receptive is likely to be less viable than an embryo that is created at the *center* of the fertile period (i.e., the heightened fertility [HF] period). This discussion brings out the interesting hypothesis that the rhythm method may owe its efficacy (at least in part) to the lesser viability of embryos created outside of the HF period. As Bovens (2006, 355) puts the point:

Rhythm method users try to avoid pregnancy by aiming at the period in which conception is less likely to occur and in which viability is lower. So their success rate is due not only to the fact that they manage to avoid conception, but also to the fact that conceived ova have reduced survival chances.

Bovens presents a reasonable case to support the claim that the rhythm method can lead to zygotic death,⁸ and his points are general enough to apply to other methods of natural family planning (NFP). Since we have not seen a campaign against the rhythm method by opponents of EC—and are unlikely to see this since many of these same persons are supporters of the rhythm method or a related method of NFP—this shows an inconsistency in the objection lodged by those who are conscientiously opposed to EC since they believe it ends zygotic life.

If either of these examples concerning breastfeeding or the rhythm method is plausible, then the objector to EC would not have his or her objection honored based on the jurisprudential framework derived from consideration of the military context. Since he or she is not opposed to participation in all activities that threaten zygotic life, this fact prevents supporters of CO regarding EC from possessing a plausible and consistent position. Even if such practitioners would be willing to extend their objection to include these two cases, these examples then simply show the absurdity of premising an objection upon the small probability that a postfertilization effect may result from an activity.⁹ In the former case, the refusal undermines a choice made by a mother about her own body that has beneficial effects for her infant. In the latter case, the medical provider must (e.g.) refuse to help a woman determine her ovulatory cycle since this may lead to the use of an objectionable form of birth control (given the practitioner’s beliefs). Yet women have numerous reasons for wanting to know their ovulatory cycle, not all of which are related to contraception, and therefore an unconditional refusal of this request is unreasonable and violates the standard of care. Since significant

legal precedent demands that petitioners make the basis of their objection general in form, these absurd results uncover a crucial weakness in an argument that utilizes a comparison to conscientious objector status to military combat.

The main objection I anticipate to the argument in this section is the following: the claim that EC kills an embryo is not similar to the implications of the breastfeeding or the rhythm method cases, since even if the latter practices create a higher expected zygotic death rate, this does not imply that the medical practitioner is directly involved in a killing. In other words, the enabling medical professional does not intentionally harm zygotic life by giving supportive care to women who breastfeed or use the rhythm method, although it can be said that dispensing EC involves intentional harm. Therefore, there is no inconsistency in approving of these other practices but opposing EC.

In reply, it is outside the scope of this paper to tackle the question of the intrinsic moral relevance of intentions and the viability of the doctrine of double effect, but this does not prevent offering a plausible response to this criticism. The first point to make is that given the argumentative strategy of this section, it makes perfect sense to not focus upon intentions since these do not play a substantial role in the framework for assessment of CO. A reference to intentions was not included in the legal model derived above; the objection must simply be general in form and premised upon a sincerely held belief. The Court does not grant an exemption based on whether or not a petitioner believes he/she is engaging in intentional killing when participating in combat. Imagine someone who agrees with involvement in a just war and would not view their sort of participation in combat activities as intentional killing; the fact that individuals on the other side died was a mere side effect and the relevant intention of the agent was simply to protect his country. Now imagine two individuals who subscribe to this line of reasoning, except that the latter believes that the war in question is not a just war. As a result, this latter person holds his participation to be immoral and may think that he would be engaging in intentional killing in a war of aggression, not simply acting with the intention of protecting his country. In both cases, the intentions of these petitioners are irrelevant from the point of view of the law that governs the granting of such exemptions and shapes related public policy—neither person would be given CO status since both engage in *selective* CO. This result holds despite their differing beliefs regarding whether their participation constitutes intentional killing. My task in this paper is simply to apply the jurisprudential model for military CO to see what it would imply regarding CO in the medical context. I have not questioned the sincerity of objectors to EC, but instead have argued that they cannot offer both a general and plausible objection to EC based on the reasoning that this medication poses a risk to early human life.¹⁰

Further, it is reasonable to think that the medical professional is involved in killing when dispensing EC—*if it is the case that EC has postfertilization effects*—yet to make this determination strictly in terms of intentions is dubious at best; the degree of closeness to the effect seems to be the most salient factor. Just as there is some distance between giving supportive care to women who breastfeed and the effect this might have on a possible conceptus hosted by such a woman, there is some distance between dispensing EC to a woman who will herself decide whether or not to take the pills with the purported result that a zygotic life is ended. She may not in fact become fertilized in any case and hence taking EC will cause no harm to zygotic life. The professional who helps a woman determine her ovulatory cycle or dispenses Reglan is in a position sufficiently similar to a practitioner who dispenses EC pills to a woman—both provide a means that, assuming the relevant beliefs are true, then may cut short a zygotic life. This suggests that the EC case, the breastfeeding case, and the rhythm method case belong in the same class: either the provider is not sufficiently involved and none of these practices possess a chance of harming zygotic life, or (as this author thinks) all of these ought to be sufficiently worrisome to a medical provider with the moral belief system characteristic of conscientious objectors to EC.¹¹

Finally, it is worth emphasizing that the most vocal defenders of medical professionals' rights to conscientiously refuse to dispense EC do not frame the debate in terms of intentions or relative degrees of involvement, but instead in terms of consequences. Karen Brauer, the president of Pharmacists for Life International, opposes dispensing EC since it harms human life (Stein, 2005). She also rejects the notion that there is an intrinsic moral difference between doing an action oneself versus producing the same result through a more indirect role. This becomes clear in her disdain for the idea that objecting professionals should simply refer patients to other willing practitioners; as she puts it, "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). Clearly, such a referral would put more distance between one's own act and the purported negative outcome, yet Brauer rejects the moral significance of this move. Neil Noesen, a Wisconsin pharmacist who was fired because he refused to fill or transfer a prescription for a hormonal contraceptive, takes a similarly broad view on the level of participation necessary for that contribution to be immoral. When he was called by another pharmacist regarding the scrip he refused to fill, he refused on moral grounds to transfer the prescription since he believed that would constitute "participating in contraception" (Rohde, 2008). Although many thoughtful individuals might wish to factor in the moral relevance of intentions in such controversies, the fact that providers may be able to distance themselves and hence not be said to have intended the final outcome seems beside the point for such objectors. These arguments by conscientious objectors are focused

on *harm*—the putative harm caused to the zygote and the harm caused to professionals who do not wish to contribute to a result they believe is immoral.

III. ANALYZING THE COMPARISON BETWEEN CO TO MILITARY SERVICE AND CONSCIENTIOUS REFUSALS TO DISPENSE EC

If the analogy between CO with respect to EC and CO regarding combat is not apt, then this comparison does not provide a compelling argument for honoring conscientious refusals of care in the medical context. Upon reflection, it does seem that there are significant disanalogies between CO regarding EC and regarding war. First, pharmacists voluntarily choose to enter into (and continue in their) field of work, although this may not be the case for those who conscientiously object to military service. The force of the objection by the person selected for military combat significantly derives from the fact that the person cannot simply quit and may be subject to court-martial and probable prosecution and imprisonment if determined to have deserted the military. By contrast, those who conscientiously object to EC claim that they should not be made to fulfill their professional responsibilities even though these were willingly assumed, and should not be disadvantaged in any way in terms of their career (e.g.) by suffering a formal reprimand. This is an unreasonable measure, yet some states have put such legal protections in place. For instance, South Dakota's conscience clause states that "no such refusal to dispense medication pursuant to this section may be the basis for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist" (S.D. Codified Laws Sect 36-11-70 (2006)). Arkansas' conscience clause includes both private institutions and physicians as well as ". . . any agent or employee of the institution or physician," as well as ". . . any employee of a public institution acting under directions of a physician"; if any of these act based upon a CO, "no such institution, employee, agent, or physician shall be held liable for the refusal" (Ark. Code Ann Sect 20-16-304 (1973)). These laws do not sufficiently acknowledge the voluntary nature of membership in the medical profession in their policies on CO.

One may object that military personnel in the 21st century *do* voluntarily enter into the service since there is no draft, and therefore there is no disanalogy. The point is well taken, but it is not clear that this point undermines the proposed disanalogy. Consider the situation of many reservists who signed up in the late 1990's as a means to help afford college tuition. Anyone who signed up for military reserves should have understood that he or she could have been ordered into combat. Clearly, the initial choice to sign up for the reserves was a voluntary choice, and by extension one can understand that acceptance of the possibility of being called up for combat duty

was also sufficiently free. Considering this case reveals that CO has its clearest force in a *nonvoluntary context* such as that found in a conscripted military—yet since all who enter the health care professions do so voluntarily, the comparison that conscience-based objectors to EC attempt to draw to CO by a potential conscript fails.¹²

Second, those who refuse to dispense EC are under no obligation to explain their conduct and to offer justifying reasons in support of their claim, unlike petitioners for conscientious objector status within the military. It is not unreasonable to ask for reasons. Further, it is not unreasonable to assess one's reasons if the cost of honoring one's refusal is significant. As various newspaper accounts have made clear, the costs to women of conscientious refusal of EC by medical professionals are very weighty. For example, a rape victim in Texas was refused EC and a Virginia woman who was refused EC became pregnant and as a result had to face a traumatic abortion decision (Dana, 2006; American College of Obstetricians and Gynecologists, 2007). In contrast to those who conscientiously object to EC, petitioners for military CO must present their reasons to a Review Board for assessment. The difference in the two contexts is stark when one considers that in medicine, one can exercise CO *without anyone else ever knowing about it*. This is most clear in a case in which a physician refuses to discuss "objectionable" alternatives with patients—such as the option of EC for women who have been victims of a sexual assault. This might seem to be a remote possibility, yet in a survey published in 2007, 14% of providers did not think they had to disclose information to patients about controversial medical practices (Curlin et al., 2007, 593).

Third, such a right to CO seems boundless and may lead to discrimination; if we allow such claims, then we might be faced with an impossible scenario where we can merely attempt to accommodate all of the "COs" that might be lodged. This would include (e.g.) those by police who do not want to investigate or prosecute instances of gay bashing or real estate agents who do not want to sell a house to an interracial couple (LaFollette and LaFollette, 2007, 251). Dresser (2005, 9) imagines cases in which a practitioner conscientiously refuses to retrieve organs from patients declared dead by whole-brain criteria or to assist with prenatal diagnosis. Yet where does the right to CO within medicine end? Perhaps, it is within the rights of medical providers to conscientiously refuse to utilize reproductive technology for adults because the intended couple is gay or for a pharmacist to refuse to fill prescription requests for Viagra from unmarried men. Such cases seem outrageous, at least to this author, since labeling them "CO" appears merely to be window dressing for unjustified meddling with patient autonomy. These might appear to be fantastical examples, but they are actual cases of conscientious refusal reported in US newspapers (Stein, 2006; Dolan, 2008). The case in which a lesbian couple was refused infertility treatment was heard by the California Supreme Court; the Court decided that the physicians' refusal

was unacceptable since it constituted discrimination on the basis of sexual orientation (North Coast Women's Care, 2008).

Finally, those who refuse to dispense EC do not perform "alternative service" to compensate for those duties they fail to perform. Yet successful petitioners for CO must still serve either in the military in a noncombatant capacity (e.g., as a member of a medical unit) or outside of the military in some charitable capacity (e.g., working in education or health care) as part of alternative service. By contrast, those who claim a right to CO regarding EC do neither offer nor expect to undertake any activities to compensate for their refusals. This shows that such professionals want conscience without consequences—no costs are borne by the objector, but instead, harm accrues to the women who are refused the medication. None of the relevant state laws that protect provider conscience mandate any alternative service. This bespeaks a lack of understanding regarding the gravity of asserting a CO.

Despite these disanalogies, one might argue that there remains a compelling similarity that outweighs all of these differences—the fact that dispensing EC and participating in war both involve a significant chance of killing a human person. To properly engage this discussion, we must grapple with the fundamental issue of whether EC's mechanism of action does in fact prevent a fertilized egg—presumed to be a human person—from implanting. A brief review of the scientific literature will provide the needed background for drawing an ethical conclusion, since it will reveal the evolving consensus in the literature that EC works primarily by inhibiting or delaying ovulation and hence truly acts as a form of contraception. The possibility that EC has postfertilization effects is low, yet "It is unlikely that this question can ever be unequivocally answered, and we therefore cannot conclude that ECP's [emergency contraception pills] never prevent pregnancy after fertilization" (Trussell and Jordan, 2006, 87). The mere possibility of posing a threat to zygotic life cannot be ruled out in general; in many cases when a medical professional prescribes or dispenses a drug to a woman she may be hosting a fertilized egg, perhaps unbeknownst even to her, and taking this drug may harm or endanger zygotic life. Such providers, if truly concerned about performing an action that threatens zygotic life, should not dispense many medications, at least to possibly fertile women. This itself may constitute sufficient reason to leave the profession for such objecting providers.

It is this point regarding the avoidance of the mere possibility of harm to zygotic life that is at the heart of the problem for medical professionals who refuse to dispense EC. As alluded to above, for nearly obvious reasons it will be difficult to unequivocally assign a probability of zero to the existence of a postfertilization effect, yet this should not provide any solace to the defender of conscientious refusals of EC. Although it can be rational to avoid the very small possibility of a great harm, given the significant known harm caused by refusals of EC, the existence of this mere possibility does not plausibly demonstrate that professionals' conscientious claims for refusing EC

should be honored. These harms include (e.g.) negative health effects for women stemming from unintended pregnancies and the autonomy violations that occur even if women who are refused EC do not become pregnant. Perhaps paradoxically for those opposed to EC, this debate regarding CO has raised awareness of EC among women. Yet as this awareness is raised and more women request EC, the amount of harm resulting from granting medical professionals a de facto blanket privilege of conscientious refusal increases.

Also, we should factor into this discussion the point that there are positive reasons to think that a postfertilization effect does not exist. In other words, although we may never be able to conclusively disprove the existence of a postfertilization effect, some of the evidence we possess for the claim that the primary mechanism of action consists of interference with ovulation directly speaks against a postfertilization effect. As L. Lewis Wall and Douglas Brown observe:

There is abundant clinical evidence that the main mechanism of action of emergency contraception involves disruption of the physiology of ovulation, probably by interfering with the luteinizing hormone surge. The fact that pregnancy rates are much lower the earlier after intercourse the medications are taken¹³ strongly suggests that emergency contraception operates through pre-fertilization mechanisms rather than through postfertilization effects (2006, 1150; emphasis added).

This is a remarkable point worth further discussion. The luteinizing hormone surge occurs directly before the egg bursts forth from the ovarian follicle, and this is essential for ovulation to occur. If EC acts by preventing ovulation, then it is properly called a form of contraception. The point of Wall and Brown is that if pregnancy rates are lower the sooner after intercourse the drug is taken, then this suggests that EC does not act primarily via postfertilization mechanisms such as (e.g.) creating an unfavorable uterine environment for a fertilized egg by causing changes in the endometrium and thereby preventing implantation. The remark of Wall and Brown raises the intriguing question of precisely how the timing of EC affects its efficacy, assuming that it is taken within the 72 h “window period” after intercourse necessary for its mechanism of action to work.

A critical study clarifying the role that the timing of taking Plan B plays in its effectiveness was carried out by Novikova et al. (2007). This study found that rates of effectiveness of Plan B taken *before* ovulation and the rates of pregnancy in women who took Plan B *after* ovulation were markedly different. In the study involving 99 women who took LNG EC, three pregnancies occurred among the 17 women who had unprotected intercourse from 1 day before ovulation to the day of ovulation and who took LNG on the second day after ovulation. Three or four pregnancies would have been expected in this population if LNG had not been taken. By contrast, no pregnancies occurred in the 34 women who had unprotected intercourse from 2 to 5 days

before ovulation and who took LNG before or around the time of ovulation. Four or five pregnancies would have been expected in this population if LNG had not been taken (Novikova et al., 2007, 112). This study provides solid positive evidence that LNG EC's primary mechanism of action is not interference with postfertilization events; if this was the case, then the efficacy rates would not be as disparate as observed. In sum, the fact that we cannot conclusively rule out the existence of a postfertilization effect does not undermine the compelling reasons that support the claim that EC truly acts as a form of contraception and is not properly regarded as an abortifacient.

These considerations may appear to have taken us far afield from our original consideration in this section of whether the analogy to CO within the military was an apt comparison to conscientious refusals of EC. But this is not the case. We have seen that there is good reason to be skeptical of the claim that an individual human life would end as a result of a medical professional dispensing EC. In addition, given these scientific findings, one cannot in principle know during the 72-h window period whether such an individual (i.e., conceptus) does in fact exist, since this event will not be detectable by measuring levels of human chorionic gonadotropin until at least a week after fertilization (Wall and Brown, 2006, 1150). The fact that a putative medical objector cannot even know whether the individual he or she objects to harming exists, at the time of asserting the CO, may reveal the most significant disanalogy between the medical and military contexts. Certainly, a military CO may object to firing mortars or dropping bombs even though he/she may never in fact kill another person. Yet a person conscientiously objecting to combat certainly knows at the time of petitioning that the subjects he/she objects to possibly harming are individuals in existence. Although I have granted for the sake of argument that the conceptus is a person with full moral standing, it is difficult to take CO seriously in a case where one cannot know whether harm is even possible to the purported subject of the CO at the time of lodging the objection. For all of these reasons, the analogy between CO with regard to EC and participation in combat fails.

IV. CONCLUSIONS

We have learned that if we take the analogy between CO with respect to EC and combat seriously, then the requirement of consistency applied to public policies regarding such claims of conscience implies that supporters of CO regarding EC would not have their objection honored or must be morally opposed to practices that are innocuous. If we take a more critical stance, we see that there are good reasons to reject the analogy itself. In sum, the conscience-based claim regarding EC fails to satisfy the jurisprudentially

established conceptual requirements of CO and, even if it did, fails to make the analogy to CO regarding military service. Either way, these findings call into question the case discussed in this paper supporting conscientious refusals of EC.

NOTES

1. Mark Wicclair offers an enlightening analysis of CO that understands conscience-based objections as attempts to maintain an individual's moral integrity. For more, see Wicclair (2000, 2006).

2. Argument of Cantor and Baum that pharmacists can acceptably object but are required to *refer* patients to a willing provider is examined in Card (2007a).

3. Along with this, I will grant for the sake of argument in this paper that all zygotic life possesses full moral status.

4. The requirement that CO be grounded in "religious" belief was removed by the US Supreme Court; see *U.S. v. Seeger* and *Welsh v. U.S.*

5. The Court does not offer anything approaching philosophical reasons for the condition requiring general CO; they focus simply on pragmatic reasons such as promoting consistent decision making. That is not to deny, of course, that there are significant philosophical considerations related to "selective" CO versus "general" CO that get to the very heart of what is meant by "CO." For instance, the *Gillette* Court's stance is centered upon the *form* of the reason as opposed to the *content* of the reason. That raises the very deep question of whether conscientious objectors must appeal to reason at all; perhaps a sincerely held (but presumably irrational or seemingly mistaken) belief can serve as the basis for a successful CO if general in form (c.f. Wicclair, 2007). I follow the Court's lead and do not present philosophical reasons bearing on selective or general CO, since my project is not a conceptual analysis of CO but instead is to uncover the legal conditions for CO and to apply these to the medical context. To put the point differently, I argue that the *Gillette* model does not support the claims of conscientious objectors to EC; this point in itself does neither support nor deny the reasoning offered in the *Gillette* case for granting CO status. I am indebted to an anonymous commentator for encouraging me to clarify the role that philosophical reasons play in the debate between selective versus general CO as it bears on the argument presented in this essay.

6. For the purposes of this paper, I will describe the human life in question as a "conceptus" or as "zygotic life." It is typical to use the term "embryo" in such bioethical discussions as a general term, but since this implies that we are referring to later (postimplantation) human life and this is precisely at issue, I will use terms that are meant simply to refer to fertilized ova.

7. By contrast, at 12-month postpartum in this study, 94% of the women ovulated and the probability of pregnancy was calculated to be 17.2% (Diaz et al. 1992, 502).

8. This claim is considerably weaker than Bovens' thesis that the rhythm method leads to as much (if not more) zygotic death as the morning-after pill. Yet the weaker claim is all that is needed for the purposes of my argument.

9. I will further discuss this point in Section III.

10. I thank an anonymous commentator for encouraging me to clarify the analysis regarding the relevance of intentions as this bears on the argument developed in this section.

11. The medical professional is certainly in a different position than that of a military CO who wishes to avoid pulling a trigger as a combatant; there is very little distance between the military CO's act and the possible negative outcome. Hence, this point about intentions and relative closeness to the effect lends greater support to CO regarding military service than to such an exemption in the medical context.

12. This does not necessarily imply that CO status is never appropriate for one who objects to (e.g.) participation in present combat operations in Iraq, however. To see this, we need only consider that relative degrees of voluntariness may exist. At the very least, the voluntariness of the medical professional's act of entering into a field with medications that may inadvertently endanger postconception human life is clearer than the voluntariness of the person's choice that joins the reserves and later ends up having to be a combatant in Iraq. For the sake of the argument offered above, this disparity is all that is needed to sufficiently ground the disanalogy discussed. I thank an anonymous commentator for discussion of this disanalogy.

13. Wall and Brown here cite Piaggio et al. (1999).

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