The Controversy Surrounding Emergency Contraceptives

By: Dameshia Graham

Not since the historic 1972 Roe v Wade Supreme Court decision that legalized abortions in this country has there been such an emotionally charged issue that once again puts a woman’s right to choose on center stage. It is truly a topic that is proving to have scientific, political, sociological, and religious ramifications the world over. After extensive reading, reflection, and discussion with colleagues, friends, (male and female alike) family members, adolescent & elderly subjects, and viewing several recently televised pieces concerning this matter, it is safe to conclude that taking a firm stance on either side of the issue would be an exercise in futility. As I attempted to build a case for one side and climb the steep mountain of reason to defend it, I frequently found the surface becoming slippery, the air getting thin, and my logic repeatedly being challenged by a vast web of intricacies. As I approached the opposing side with equal fervor and what I believed was sufficiently examined rationale, I was ever confronted by issues of morality and conscience that would subsequently diffuse my passion.

Let’s get right to it. Being a well rounded, well informed, educated, 21st century female, I am absolutely pro-choice: Where an individual woman’s decision concerning her body should not have to be dictated by US Supreme Court rulings nor FDA approvals. Her decision to use Emergency Contraceptives or to abort or to continue with her pregnancy is solely hers. She should not be denied access to current scientific and medical treatment options due to legal, political, economical, or religious agendas. On the other hand, being a devout Christian, I believe it is utterly wrong to prevent implantation of a fertilized egg (killing a potential life) or to abort (killing a fetus) if the prevention fails. Predestination and Divine Order are vital parts of my faith and to alter or intentionally tamper with the Will of Divinity is moral disobedience. Thus, the ‘faith’ me says that this pill is indeed an abortion pill not much different from the RU-486 (abortion pill) and is therefore not an option. However, the ‘science’ me says this pill is NOT an abortion pill, but helps prevent the need for an abortion. So, my personal choice is to not use these two methods of contraception (EC & abortion) since both involve discharging a fertilized egg (a life), while at the same time, my choice gives me no right to denounce the choices of women who do opt to use these methods. Hence, I am a soul fragmented. One of my dilemmas: How can I be pro choice or pro life and not be (within the realms of my logic) pro death? It’s a catch 22. Nonetheless, I am a mind on a mission.

The Mission: What makes the Emergency Contraception (Plan B, morning after pill) issue so controversial?

Opponents are claiming the pill is merely an ‘updated’ abortion pill and will indeed increase and encourage unprotected sex, decrease the need for professional medical care and intervention, as well as increase the number of STD’s including HIV. Those for approval claim it is not an abortion pill, and that it will not encourage irresponsible sexual behavior, and thus would not increase the spread of disease.
Note: Although it appears that the majority of Physicians, Pharmacists, women, men, adolescents, mothers, and many politicians accept the scientific data supporting the safety of over-the-counter availability as well as the need for the morning after pill, the FDA has denied approval.

The Debate:

1) FDA approval for OTC ECs (which would shakeup the established women’s healthcare process) VS.

2) FDA denial (which would keep things exactly as they are)

The Players:

1) Food and Drug Administration

2) FDA advisory panel (special government employees/scientists, public health experts, sociologists, educators, etc)

3) American College of Obstetricians and Gynecologists (ACOG)

4) Physicians for Reproductive Choice and Health (PRCH)

5) The Pharmacists

6) Women at Large (whose health and very lives are affected)

7) Barr Labs (designated manufacturer of OTC EC in the US)

The Objective:

As an inquisitive PharmD student seeking truth and justice for all, I will observe, compile, organize, and objectively record and analyze some of the many components of the debate as well as submit my own opinions.

The need and demand for such a pill

After reflecting deeply upon the subject matter for several days, my first question to myself was, ‘How did the concept of such a pill come about?’ Some likely answers were: Perhaps it was simply a matter of Pharmaceutical and Medical researchers pursuing the need to improve upon and advance currently approved, marketed, and consumed contraceptive products. OR perhaps it was pressure from lobbyists for women’s groups to fine tune the available contraceptive methods by demanding that ECs get OTC approval, to expand a woman’s arsenal of ‘choices’. Who knows for certain why and how to explain the timing or the reason for this pill, this issue, or the massive controversy surrounding it.
ACOG statement: [1]

Emergency contraceptive pills, which are specific combinations of birth control pills in higher doses, act to prevent pregnancy. Unlike early medical abortion, if a woman is already pregnant, EC will not terminate her pregnancy. Emergency contraception can prevent pregnancy in several ways. It may prevent ovulation, fertilization, or implantation of the egg in the uterus. All are necessary stages for pregnancy to occur. Emergency contraception is highly effective in preventing unintended pregnancy. Access and speed are important if ECPs are to be effective. If taken within 72 hours of unprotected sexual intercourse, ECPs prevent 89% of pregnancies. Efficacy is greatest, however, if used within 24 hours. ACOG and PRCH estimate that making EC widely available over-the-counter has the potential to prevent at least half of unintended pregnancies in the US (or about 2 million pregnancies annually) and half of US abortions (or nearly 500,000 abortions per year).

Consensus: What’s the ACOG saying?

According to a published news release statement, by the American College of Obstetricians and Gynecologists in February, 2001, the ACOG supports making emergency oral contraception available to women over the counter in a designated product. The US Food and Drug Administration declared emergency contraceptive pills to be safe and effective in preventing pregnancy. Yet, substantial barriers exist to women obtaining this fallback contraceptive method that must be used within 72 hours after unprotected intercourse.

What are Medical Groups and Individual Physicians saying?

On May 4, 2004, a few days before the FDA’s formal announcement of denial or approval of the Morning After pill, several Physicians chimed in with strong statements directed at the FDA panel after learning that the FDA was leaning towards ‘denial’[2]: “Representatives from ACOG and the Physicians for Reproductive Choice and Health (PRCH) strongly objected to the Food and Drug Administration’s announcement to deny provision to grant over the counter (OTC) status to an emergency contraceptive pill (ECP) known as Plan B. In Dec. (2002), two FDA appointed advisory panels overwhelmingly recommended approval of the drug by a 23-4 vote. The agency typically follows the assessment of the scientific committees.

In response to EC opponent’s concern that approval would encourage young people to have unprotected sex, Dr. Vivian M. Dickerson, ACOG president elect and associate professor at the University of California Irvine (UCI) and director of the division general ob-gyn at the UCI medical center, states, “I feel somewhat like a broken record. THESE ISSUES WERE CONSIDERED AND LARGELY REJECTED BY THE FDA ADVISORY PANEL THAT CONCLUDED THAT OVER-THE-COUNTER STATUS WOULD NOT ENCOURAGE YOUNG PEOPLE TO HAVE UNPROTECTED SEX.” In that same report The ACOG and PRCH say Plan B meets all the FDA criteria for OTC status. More than 15,000 pages of clinical data from approximately 40 sources were
submitted with this application. Studies presented at the December FDA hearing also showed evidence that women will not misuse or abuse EC, another issue raised by opponents of the switch to OTC status. Dr. Dickerson goes on to state, “There is a public health imperative in this country to increase access to EC. More choice for women equals a reduction in unintended pregnancies and fewer abortions. That is an argument even opponents of abortion cannot debate.”

Dr. Harry S. Jonas, a member of the PRCH Board of Directors and past president of ACOG states, “I am stunned that an evidence-based agency like the FDA can ignore the overwhelming scientific data and advice of their own committee determining the safety and efficacy of having emergency contraceptives available OTC. When political expediency prevails over sound scientific information, women have once again become marginalized in their ability to make critical decisions.”

Dr. David A. Grimes, a clinical professor in the dept. of ob-gyn at the Univ. of North Carolina at Chapel Hill School of Medicine and vice president of biomedical affairs for Family Health International said, “Barriers to this safe, effective medicine hurt women’s health. The current FDA delay is indirectly causing more unintended pregnancies, with their associated morbidity, mortality, and expense. Ironically, by failing to act promptly, on the advisory committee recommendation for OTC status, the FDA is now impairing rather than promoting women’s health.”

Dr. Wendy Chavkin, a founding member and current chair of the Board of Directors of PRCH as well as professor of clinical public health and ob-gyn at the Columbia University Mailman School of Public Health and College of Physicians and Surgeons, simply states, “Thousands of women are in need of emergency contraception everyday, particularly over the weekends.”

In a recent Chicago Tribune article, Dr. David Archer, director of clinical research at the Contraceptive Research and development Program of Eastern Virginia Medical School in Norfolk, addressed the ‘pervasive myth’ that EC is an abortifacient. There’s no evidence that that’s true..researchers for the ACOG, the National Institute of Health, and the FDA all agree that EC is a contraceptive, not an abortifacient. Like all contraceptives, it helps prevent the need for abortions; it does not cause them.

BOTH ACOG AND PRCH RECOMMEND THAT PHYSICIANS PROVIDE ADVANCE PRESCRIPTIONS TO IMPROVE PATIENT ACCESS TO THIS CARE.

I could go on and on with statements, claims, and quotes from professionals that strongly feel ‘approval’ is necessary and eminent, but that would take an abundance of time and many, many pages. I believe the point has been made. Still with such overwhelming scientific data and a great deal of support from the medical profession, I am truly baffled, perplexed, and confused as to why the FDA is holding firm on its decision to deny approval.
On May 7, 2004, as predicted, the FDA issued its formal letter of denial to Barr Labs. [3]:

**FDA Issues Not Approvable Letter to Barr Labs; Outlines Pathway for Future Approval**

The Food and Drug Administration (FDA) today acknowledged that it has issued a “Not Approvable letter to the sponsor of an application to make the Plan B emergency contraception product available without a prescription. In its letter to the sponsor, FDA outlined the additional information that would be required to gain approval to market Plan B over-the-counter. FDA based its action primarily on the lack of data concerning OTC use of the product among adolescents younger than 16 years old. The sponsors’ application contained no data in subjects under 14 years of age and very limited data in adolescents 14 to 16 years old. FDAs letter to the sponsor notes that the application does not provide adequate data to support use of Plan B by young adolescent women without the intervention of a physician. The letter also points out that the sponsors March 11th amendment of its application to allow marketing of Plan B by prescription only to young women under 16 years of age was not complete. As a result, the agency was unable to do a complete review on that amendment during this review cycle. Dr. Steven Galson, Acting Director of FDA’s Center for Drug Evaluation and Research (CDER), said “Although we did not have sufficient data to approve this application now, I will be working toward the expeditious evaluation of Barr’s response to the Not Approvable letter. If Plan B is approved for nonprescription use, it would dramatically increase access to this product and will represent an important incremental step forward in contraceptive availability in the United States. Wide availability of safe and effective contraceptives is important to public health. I look forward to supporting CDER's important continued role in ensuring improved availability of these products.” Although U.S. law prohibits FDA from discussing pending applications because they contain commercial confidential information, in this instance the sponsor of Plan B, Barr Research, has allowed FDA to comment in general terms on the status of Barr’s application to make Plan B available as an OTC product, and on the agency’s action.

Additional information on FDA action is available, in question and answer format, on the agency’s website www.FDA.gov

Granted one of the primary reasons for declining OTC approval being ‘lack of data concerning use of the product among adolescents’ is a legitimate concern but, in my mind is certainly no reason to deny thousands of responsible women of age of this option. First of all, the pill is readily available at health centers and planned parenthood facilities around the country [8]. There are several ways to stipulate the transaction: 1) pharmacists would have to be involved by asking questions including ‘ID carting’; if underage, return with mom or guardian, both of whom would have to provide photo ID. 2) Underage purchases would have to be logged into a central database. 3) Each sale should consist of patient counseling via the pharmacist as well as an FDA note that it is imperative that the consumer visits a healthcare practitioner to insure safety and health immediately after use. 4) A 2nd attempt to purchase would require a physicians’ prescription. These are just my personal suggestions. Of course there can be an
exploratory period that could last for maybe a year, at which time adjustments can be made.

As Planned Parenthood’s director Karen Pearl noted earlier this year: Barr Labs submitted its application for over-the-counter status of their Plan B product over two years ago. Despite the fact that the FDA’s own Nonprescription Drugs and reproductive Health Drugs Advisory Committees voted overwhelmingly in favor of making EC available without a prescription, the FDA rejected their recommendations and denied over the counter status for Plan B. Even after Barr resubmitted its application, modifying it to address the FDA’s concerns well before the Jan. 26, 2005 deadline, on Jan. 21, the FDA announced it was postponing its decision indefinitely.

I pose a burning question, why? Could it be that the over-the-counter status of this pill might very well revolutionize the entire Supreme Court ruled upon ‘abortion institution’ that’s been in place for well over 30 years? Could it be that the Government could not tolerate the unspeakable torment of such a change? Given that it could grind to a halt a well greased ‘machine’ that’s been monopolizing and capitalizing on the desperate needs and vulnerability of worried, unintentionally impregnated women since the ‘machine’s’ inception? Could it be that the cost of ECs currently at $50-$65/pill could slice deeply into the Abortion business’ bottom line? Which, currently, has a fee that averages, a whopping $300- $600/person! Could it be that one of the primary platforms for getting the present ‘White House Crew’ reinstalled for a second term was anti-abortion? How else can we justify this absurd FDA denial? It makes it quite difficult to understand what the FDA’s real plight is? Why this bazaar standoff, when approval and accessibility of such a pill has the potential to eradicate so much pain, unnecessary loss of blood, psychosis, and emotion duress suffered by thousands of women each year? And indeed, would save each individual patient hundreds of dollars? It is utterly unconscionable and borderline unforgiveable!

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What are the Politicians saying and doing?

In a June 05 internet blog from The Planned Parenthood Federation of America interim president, Karen Pearl [5], we find an instrumental bill introduced and vital relevant statements from several members of the political arena:

Senators Hillary Clinton (D-NY), John Corzine (D-NJ), and Olympia Snowe (R-ME) showed how much they cared for survivors of rape, sexual assault, and incest yesterday when they introduced CARE - the Compassionate Assistance for Rape Emergencies Act. The bill would require hospitals to provide survivors of sexual violence with information and access to emergency contraception (EC), as well as proper medical care to prevent sexually transmitted infections. This bill would help the approximately 300,000 women who are raped or sexually assaulted each year - and the 25,000 of them who will become
pregnant as a result of the attacks. Twenty-two thousand of those pregnancies could be prevented, if EC were routinely distributed in emergency care facilities. We shouldn't need this bill. This should already be the standard of care, at every hospital and emergency care facility in this nation - just as the American Medical Association and the American College of Obstetricians and Gynecologists recommend. But this isn't just about common sense. This is about compassion. Why would anyone want to add to the trauma that a rape survivor already faces by forcing her to confront a possible pregnancy? EC is the only contraceptive option many survivors of rape or sexual assault have. How could anyone in the medical profession deny these women the only chance they have to try to avoid becoming pregnant?

Ask Bill Owens, the governor of Colorado. Earlier this year, he vetoed a bill that would have required all hospitals in the state to inform sexual assault survivors of the availability of emergency contraception. His veto came in spite of the fact that nearly all - 85 percent - of Colorado voters support making EC available in the ER to all survivors of rape and incest. It's not just Colorado that falls short. According to a 2004 report commissioned by the ACLU, fewer than one in 10 (6%) of emergency care facilities in Louisiana provided EC on site to survivors of sexual assault. In New Mexico, Pennsylvania, and Wisconsin, women fare only slightly better - they can find EC at 28% of emergency care facilities. In fact, only five states have laws requiring ER personnel to inform sexual assault survivors about the availability of EC.

At the press conference announcing the CARE act, Sen. Corzine said: "It is simply unacceptable that a rape victim's care depends on which hospital she is taken to... This legislation will help sexual assault survivors across the country receive the medical care they need and deserve."

Again my question is, ‘considering all the scientific factual data generated by an Advisory Panel that THEY appointed, all the general support (particularly from the medical and pharmaceutical arenas), all the political input, and the majority of women at large, why is the FDA still denying approval?’ Could it be that the FDA is acting as a go-between in a clandestine love affair that matches extremists who would outlaw all birth control with undercover pro-life congressmen and senators? Why are there just a handful of House and Senate representatives that are taking a ‘visible’ stance on this crucial women’s health issue? Where are the Representatives from every state on this issue? Are they not cognizant of the fact that over 50% of the country’s voters are now female? Are the lobbyists and proponents of the Abortion machine lining their wallets so effectively that they’ve become infected by selective amnesia and forgot about the health plight of their own daughters, nieces, sisters, and friends? Why the mysticism and absenteeism? To take the issue one step further, why the mysterious lack of knowledge and interest from arenas that pride themselves on information and compassion: hospitals emergency rooms, pharmacies, and politics?
In a recent CBS 60 minute story in Nov, 2005, it was quoted by a reputable research group that 65-70% of all hospital ERs and Pharmacies around the country do not stock nor are they versed in the dispensing of ECs. One of the reports showed that, earlier this year, 2005, a woman that was raped and went to St. Vincent’s Catholic Hospital for help. She was told that catholic hospitals ‘do not dispense birth control’. She then went to the police, where an officer directed her to a facility that would accommodate her urgent need. St. Vincent’s Hospital is now under investigation by the state of N.Y. for patient neglect. In that same piece, a Pharmacist in Arizona this year (2005) refused to dispense EC to a patient because ‘she didn’t know her??!!’ Her exact comment was, ‘I have the right to refuse filling a prescription whenever I choose anyone can walk in off the street and request a script to be filled and that’s just not what I’m licensed to do!’

The Plot Thickens

Not only has the FDA put up a major road block with its declining to approve EC OTC, we now have Pharmacists professing and exercising their right to refuse. There have been publicized stories of pharmacists refusing to dispense the ‘morning after pill’ because of their faith or conscience. In a recent National Catholic Reporter Newsweekly article by George Bryjak dated 10-7-2005 [7], we find several quite revealing comments concerning the ‘costs of conscience’:

A question was raised: ‘Are we moving toward a patchwork healthcare system wherein some physicians and pharmacists will provide ALL legal drugs and services while others render only medicine and care that is in line with there religious convictions?’

Throughout this very poignant and well thought out and expressed article, we find disturbing insights as to how pharmacists are becoming more and more ‘consciencious objectors’ to dispensing EC. In all fairness, in reality there are ‘refusal clauses’ throughout many professions and jobs in our society, namely: police, fire, and emergency treatment teams if they feel their safety is at risk; physicians, nurses, refinery workers, high rise window washers, insurance companies, clinics, realtors, the military, even inner-city pizza deliverers and some cab companies. Refusals to service are based on various reasons; some monetary, some out of fear (for safety), some racial, and as of late, most prevalent, moral conflict. Pharmacists ranks among the greatest number of refusals for this cause, according to the Alan Guttmacher Intitute, which tracks reproductive health issues. There are several states, and the number is increasing steadily, that currently permit pharmacists to refuse dispensing contraceptives or abortifacients on the basis of religion or conscience. The reasons and way in which the refusal takes place may vary as well: some pharmacists refuse to dispense, but will recommend a colleague either in the same store or at another site; some just flat out will refuse filling an EC script and refuse to send the patient to another pharmacist; and still others, who are even more callous, will refuse to dispense and won’t return the prescription.
The points raised by Mr. Bryjak, particularly a key point by University of Pennsylvania, law professor, Anita Allen, within the piece concerning the consequences of declining dispensing are crucial points to acknowledge in our profession. Ms Allen, author of “The New Ethics”, states ‘if you open the door to this, I don’t see any place to draw a line’ and the point is noted again by University of Wisconsin, law and bioethics professor, R. Alta Charo who says, “I’m waiting for the bus driver who refuses to make that routine stop because it happens to be near the abortion clinic.” The point being as Mr. Bryjak alludes, ‘it will only be a matter of time before bills expanding rights of refusal well beyond the medical profession are introduced in state capitols across the country.’

My argument is, simply because a bill is introduced doesn’t mean there’s justifiable reason to pass it. In many instances, judges on the bench should debate and decide which laws are applicable based on past cases, current facts, majority public opinion, personal logic, and human evolution; and I’m certain it will be a provocative and heated debate. In the case at hand, we have evolved to accept that silent chemical killing (a pill) is a much more humane and acceptable approach than the surgical bludgeoning that is abortion. In my view, professors Allen and Charo, the judges (the courts) must draw the line even though there will be eternal pros and cons surrounding the decision. Therein lies, another personal dilemma: On the one hand I don’t believe the courts should be involved with a woman’s right to choose, however, on the other hand it is absolutely essential for the courts to determine which rights are applicable for given circumstances. Just as buses have to stop in front of that abortion clinic whether the drivers want to or not, it stands to reason that without jeopardizing the safety of the patient and risking my license and violating the Pharmacist code of ethics, I must as a pharmacists dispense whether I want to or not!

If there is a law in place that we do have a right to refuse based on conscience, with a clause that states that we should direct the patient to a pharmacy that WILL dispense, where’s the reasoning in that?!? I’m still guilty by association! So, it comes down to us (the pharmacists) allowing women to choose what they feel is best for them. There is a difference between conscience and control. We have no right to dictate the choice of another human being or pronounce our doctrine to that human being by way of our actions. That behavior in and of itself wreaks of the stench of anarchy, whereby some pharmacies will run things one way, while others another, and still others will have implemented yet another set of their own abstract rules. With such chaos, in time, our profession will soon be viewed as a joke! That alone, is a very high price to pay for the sake of expressing our conscience in the workplace. We are individual professionals, but I believe we should be willing to sacrifice our individualism for the sake of upholding the dignity and respectability of the whole.

I stated in my Pharmacists Code of Ethics paper that I would not use religious beliefs under any circumstances as a determining factor in whether or not I would dispense. How do I justify not filling an EC prescription based on my beliefs? The fact is that this pill doesn’t even work if a woman’s pregnant! So, where’s the ‘refusal to dispense’ logic? How dare any of us superimpose our beliefs onto a patient that comes to us for clinical
help! If they want spiritual assistance, I’m sure they’re able to discern the difference between a pharmacist and a man of the cloth. I’m in complete agreement with Karen Pearl’s (interim Dir. Of Planned Parenthood) comments in her Jun. 22, 2005 blog [8] in which she states, “Whether pharmacists should or shouldn’t have to fill all valid prescriptions isn’t a fair debate. A fair debate implies that the two opposing sides are standing on factual ground. In this case, the anti-choice pharmacists who refuse to fill women’s contraceptive prescription prescriptions are rejecting established medical and scientific truths in favor of their own personal views of biology and pregnancy….There is no debate! This is a matter of fact versus ideology-ideology framing itself, illegitimately, as conscience. If a pharmacist’s understanding of pregnancy wouldn’t earn him or her a passing grade in a high school biology class, it shouldn’t trump a woman’s health, conscience, or relationship with her Doctor.”

**What are pharmacists saying?**

In a WebMD Medscape article by Christine Wiebe posted 8-11-2005 [9], a poll was conducted in July 2005 which asked, ‘Should pharmacists refuse to fill prescriptions that conflict with their personal beliefs?’ The question was posed to ‘all professions’. Some of the responses are quite enlightening. Almost 80% of those polled said NO!

I posted the bulk of the article as well as most of the responses as many of the comments actually prompted me to question what I thought and felt were some of my own well-grounded beliefs. All of pharmacist responses are italicized below this posted article:

From Medscape Pharmacists

**From the Editor**

**Pharmacists Speak on the "Right to Refuse"**

Posted 08/11/2005

**Christine Wiebe**

The widely publicized stories of a few pharmacists who refused to dispense the "morning after pill" have ignited a firestorm of controversy in the profession and in the public. A recent poll conducted on Medscape unearthed smoldering opinions on both sides of the issue. It also revealed that those few pharmacists making headlines actually reflect the feelings of many more, while others have strongly opposing views as well.

We found readers' comments so interesting and compelling that we decided to share some of them with you. We had to do some editing and some condensing, but we have tried to preserve readers' voices.
Some writers could not resist attacking others' views, as is common with such controversial subjects. Those comments were discarded, as were those that focused mostly on religious interpretations.

Many comments duplicated others, so only a sample is presented here. One of the most common viewpoints expressed the need for pharmacists to separate their personal beliefs from their professional obligations. Most writers who supported pharmacists' "right to refuse" also drew the line at preventing a patient from filling the prescription elsewhere. Several pharmacists argued that the issue was no different for any other health professional who refuses to provide certain types of care because of personal convictions, such as the physician who refuses to perform abortions.

Some of you objected to the way our poll was phrased and tallied. The poll, conducted July 12-19, 2005, asked, "Should pharmacists refuse to fill prescriptions that conflict with their personal beliefs?" One reader responded: "Your leading question and the use of the word 'refuse' sends the wrong signal and does not support an individual pharmacist's rights. As long as there are options to still get the prescription filled, there is no reason why a pharmacist should not be allowed to 'refuse' filling it. The wording of your question makes these pharmacists sound like criminals."

The most common criticism was the way responses were counted, breaking down answers only by "all professions," "doctors," and "nurses." We agree. The tech folks at Medscape are working hard to separate pharmacists' answers for future polls. We will let you know when that happens.

Meanwhile, we have these results to report:

Physician responders were strongly opposed to the idea of pharmacists "refusing to fill": 85% against vs 14% in favor. Nurses were even more critical of the practice: 87% against vs 12% in favor.

Even without doing too much math, it is obvious that "other" readers were more inclined to answer "yes." Judging from the responses sent to us, the belief that pharmacists have a "right to refuse" is a belief held by more than a tiny minority. Hopefully, this exchange of opinions can serve as a dialectic for the profession to address this issue.

If you wish to join an online discussion on this topic, you can do so at http://www.medscape.com/px/discussions/29d46bac.

As a practicing pharmacist and as a Christian, I am professionally mortified, outraged, and ashamed that others have seen fit to deprive women of their reproductive freedom in the name of their faith. This flies in the face of our professional obligation to provide safe, excellent, conscientious care. Further, it is a horrific distortion and a bastardization of Christianity, which teaches tolerance, acceptance, and love, and is
based on the concept of free will. God allows each of us to make choices, up to and including tremendously critical choices that impact eternity. Are we as humans more knowing than God, more powerful than God? How can it be appropriate for us to deny others their choices while believing in a Creator who does not deny us ours?

Pharmacists should have the right to refuse to fill prescriptions that would conflict with their individual beliefs. However, the pharmacy should notify the public that certain prescriptions may have to be taken elsewhere. The announcement should provide the nearest location where the prescription could be filled.

Oral contraceptives have been around since the year I was born (1957). Anyone who began pharmacy school after 1960 or so should be aware of these drugs' availability, mechanism of action, and intended use. If dispensing contraceptives is such an anathema to "Christian" pharmacists, why did they even stay in pharmacy school? Why not switch majors?

The "morning-after pill" and other medical means for terminating early pregnancies were available when I went to pharmacy school; they just weren't FDA-approved. I can't count the number of times a physician has ordered a "short course" of high-dose oral medroxyprogesterone, intended to bring on "withdrawal bleeding" when the drug was discontinued. Anyone with a license to practice pharmacy should know that "bringing on withdrawal bleeding" is code for starting a period that would terminate any (very early) pregnancy by "jump starting" a late menstrual period. It may not have been foolproof or approved by the FDA, but it certainly was done.

Why can't pharmacists who object to oral contraceptives and post-coital contraception find a sector of the profession where this won't be an issue? My first job, as a newly minted pharmacist, was at a Roman Catholic hospital. We did not stock oral contraceptives, nor were abortions performed at the facility. Another option would be to find employment with a mail-order pharmacy where someone else would be available to fill prescriptions you find objectionable ... Or, find a job in long-term care, serving nursing home patients ... or better yet, reviewing their charts.

Refusing to fill prescriptions based on personal beliefs is unethical. If I refuse to fill a prescription, do I also have the right to refuse other treatments -- should I refuse to treat an alcoholic? Or a smoker?

Pharmacists have a duty to their patients to fill all medically appropriate prescriptions without interjecting personal moral or ethical considerations. Patients and prescribers have already weighed the pros and cons of any given therapy, and the pharmacist
should dispense what is prescribed, as long as it is safe.

A pharmacist should ALWAYS have the right to refuse to fill a prescription that conflicts with his or her personal beliefs. Doctors have that right; why shouldn’t we?

Keeping a prescription or giving a patient a moral lecture is far different from declining to fill a prescription or provide information on medication use. I think pharmacy as a profession is taking a lot of unwanted and undeserved heat for a relatively small number of pharmacist actions. I fail to see any difference in nurses or physicians declining to participate in a medical procedure or practice if they have a moral objection.

I feel that we all have the right to refuse to do something conflicting with our morals and ethics. I, for one, would not have anything to do with abortions. However, I am careful not to work anywhere that would put me in that type of situation.

What bothers me is pharmacists who put themselves in such situations and then fail to understand how they are affecting others. When a pharmacist refuses to fill a birth control prescription, he is exercising his right. When he blocks a patient from filling the prescription elsewhere, he is standing in the way of her rights. I believe this is wrong. We all have rights, but we should not step on others’ rights in order to exercise our own.

The patient-pharmacist relationship is a fiduciary relationship. A pharmacist has specialized skills and knowledge, holds the trust and confidence of others, is accountable and obligated both ethically and legally, and is held to a high standard of conduct. Pharmacies should not be branded, caveat emptor – let the buyer beware!

Physicians have Hippocrates, who counsels them to "First, do no harm," and pharmacists have Maimonides, who said, "May I never see in the patient anything but a fellow creature in pain." For that reason, I choose not to let my personal beliefs enter into the relationship I have with patients.

Pharmacists should refuse to fill prescriptions that conflict with their beliefs, but those intentions should be made clear to their employers and patients in advance. Patients and employers can then make their own choices as to whether they can work with this person. Employers may miss out on good employees, and patients may need to decide if they want to stop using the corner drugstore in favor of a competitor. I see no problem with this; it happens all the time in other industries.
Let's say a barber was asked to shave a swastika into the back of a customer's head. Would anyone have a problem with the barber saying no? The barber makes the choice to lose a customer, and the customer makes a choice to find a new barber. Such is life.

No pharmacist or other medical professional should be required to perform duties that conflict with their personal moral or religious beliefs. However, no healthcare professional -- including pharmacists -- should ever block a patient from receiving a treatment or medication that is legally viable. Blocking, denying, or otherwise influencing treatment choices based on anything other than sound medical practice is completely unacceptable, and should result in a review of that person's professional license.

Pharmacists should have the right to deny filling a prescription on moral grounds ... otherwise, where is the freedom of religion in this country? This country was founded as "one nation under God." Living "under God" may not be easy, but alternate lifestyles are deadly. I would rather see abstinence training than dispense a pill that not only kills an unborn child, but can have devastating, long-lasting and even deadly effects on the woman taking the pill. We as a culture must stand up for what is right and regain our values.

Why do people have a problem with this? Except in sparsely populated areas where there is no alternative choice of pharmacy and no Internet access, prescriptions can be filled without much problem. As far as the "morning after" pill is concerned, why should it be a pharmacist's problem that someone has not taken responsibility for their actions? A bumper sticker that is a favorite of mine reads: "Your failure to plan ahead should not be deemed an emergency on my part."

Thankfully, my current job does not force me to confront such thorny issues. However, when I was a junior staffer in a chemist shop, I made my views clear to my employer from the outset. I remember him calling my attitude childish: Did I not realize the customer would just go somewhere else? Of course I did. He decided to put up with me anyway; had he not, I simply would have found another job. And, if it came to the crunch, I would rather give up the practice of pharmacy than compromise my beliefs.

This is America, pharmacists. This country was founded on the freedom of personal beliefs! If you don't believe you should fill a prescription, by the power vested in you by God Almighty and the Constitution of the United States, don't fill it!
Die before you fill it. Find other employment before you fill it.

Any pharmacist who refuses to fill a prescription on personal grounds should have the license taken away permanently.

I think pharmacies should be required to fill all prescriptions or to have at least one person on duty who will do so. One danger in allowing pharmacists to refuse is that it could encourage right-to-life terrorists to harm or intimidate pharmacists who do fill prescriptions they don't like.

I am very unhappy with the way we pharmacists are being portrayed in the media. Unlike nurses, we do not feel obligated to automatically follow physicians' orders. It is our job to catch mistakes, correct potential errors, and provide patient and practitioner information. If there is any script I don't feel comfortable with (ie, 511 Percocet for a 1-month supply), I will not fill it. I am not obligated by law to fill anything that comes through the door. I am a patient advocate.

Pharmacists: Do you ever fill scripts for pain medication even though you question the MD's wisdom in prescribing? Have you ever filled a prescription for an antibiotic that you felt was like "using a cannon" when only a slingshot was needed, because you knew the MD would not change it if asked? Have you ever filled an Rx for a medication that you thought was ineffective for the situation? Why is this different from those situations?

We are acting as agents of the MD. We do our best to consult with the MD and to advocate for the patient, but in the end, the decision is between the patient and the physician. If the patient wants to assume the risk and consequences, then the pharmacist should dispense the medication.

Should pharmacists be allowed to refuse to fill prescriptions? Yes! Not all Ob/Gyns perform abortions; ministers do not marry every couple presenting; bar tenders do not have to serve every customer; the media does not accept every advertisement. The primary duty of pharmacists is to prevent a treatment from doing unintended harm. Thus, a drug-seeking person should not be given 100 morphine doses per day.

As a pharmacy owner, I have started putting a note into the oral contraceptive packets I dispense, explaining that I conscientiously object to the sale of artificial contraception. The note asks patients seeking contraceptives to respect my views and
take the prescription elsewhere in the future. Because a significant number of women use oral contraceptives for medical reasons, I don't believe it is fair to quiz them about it. I leave it up to them whether they want to return. In 3 1/2 years, I have only received 3 complaints and plenty of encouragement. However, I also have received negative publicity about this practice.

I do not stock condoms, IUDs, progesterone-only contraceptives, or the "morning after pill," which unfortunately is available over the counter here in Australia. Condoms encourage promiscuity and have a high failure rate both for pregnancy and sexually related disease transmission. IUDs, progesterone-only pills, and the "morning after pill" rely on preventing embryo implantation rather than preventing conception and can be defined as abortifacients. If I sold them I would feel like an accessory to an abortion, and cannot countenance selling them under any circumstances.

I am sure most reasonable people do not believe in forcing other people to act against their consciences.

This brings up the matter of accessibility. If a pharmacist is adamant about his or her refusal to dispense based on conscience, should there be an obligation to post on-site to the public his choice to refuse to dispense certain prescriptions? Should there be a list? AND should the patient have a right to receive a referral to where he/she might get the prescription filled? I found a vast reservoir of information concerning EC’s on the ‘Not-2-late’ website. Where listed below, are some crucial questions that were answered [10]. Although not approved for OTC by the FDA, EC’s can still be obtained from various facilities with a bit of a search.

Where Can I Find Emergency Contraception?

In many countries, but not the United States, emergency contraceptive pills ("morning after pills") are available from a pharmacy without a prescription. For the United States, we (www.not-2-late.com) maintain a directory of providers who have informed our office that they are willing to provide information about and prescribe emergency contraceptives. We also maintain a directory of emergency contraceptive pills available in each country.

How much do emergency contraceptive pills cost?

The cost of emergency contraceptive pills will depend on where you get them. In the United States, Planned Parenthood and other family planning clinics often use a sliding scale to determine how much to charge. Without a sliding scale, the average cost for the pills in the US is $20-$25, and the average cost of a visit is $30-35. However, there is considerable variation and you should always ask what the costs will be before you go to a health care provider.
One way to reduce costs would be to request ECPs in advance, when visiting a provider for another reason. This would eliminate the cost of the visit, and would also allow you to start the regimen immediately if the need arises. In addition, some clinics, including some Planned Parenthood clinics, will phone in a prescription for ECPs, eliminating office visit costs.

**What are the side effects of ECPs?**

Almost all women can safely use ECPs. The only absolute contraindication to use of ECPs is confirmed pregnancy, simply because ECPs will not work if a woman is pregnant. There are no long term or serious side effects from using ECPs. About 50% of women who take combined ECPs experience nausea and 20% vomit. If vomiting occurs within 1 hour after taking a dose, some clinicians recommend repeating that dose. The non-prescription anti-nausea medicine meclizine reduces the risk of nausea by 27% and vomiting by 64% when two 25 mg tablets are taken 1 hour before combined ECPs, but the risk of drowsiness is doubled (to about 30%). The risk of nausea and vomiting with progestin-only ECPs is far lower than the risk with combined ECPs: 23% experience nausea and 6% vomit.

Other side effects of ECPs include fatigue, headache, dizziness, and breast tenderness.

**What Are My Friends Saying?**

Initially, my intent was to hand out spreadsheet designed surveys with 3 or 4 questions to all my friends. But, instead I conducted a less formal conversational type of survey. Where, I opted to be spontaneous with the questions and casually ask them via emails, over the phone, in person, even over the Thanksgiving Day feast; women at my church, my job, and occasionally even strangers. All whom were polled are not pharmacy students, but were just the lay public. I found that this informal approach indeed yielded genuine expression of feelings and thought and was by far a better way to prompt them to ‘keep it real’. After each discussion, I would proceed to recording the gist of each response.

**The questions:**

1) Are you familiar with the morning after pill?

2) Would you use it or recommend it?

3) Should the FDA approve OTC sales?

4) Do you know where to get it or how to get it?

5) Do you think Pharmacists should have the right to refuse dispensing it?
Answers (out of 40 informal participants)

1) 90% familiar

2) 50% would recommend; 50% would not

3) 50% agreed FDA should approve OTC; 25% against; 25% not sure

4) 60% knew for sure where to get it; 40% weren’t certain

5) 90% felt pharmacists shouldn’t have right to refuse

One of the primary questions raised during many of the conversations was: ‘Is this pill-EC, morning after—an abortion pill?’ Some say yes, some say no, some are not sure. On the side of the yea’s, the school of thought is, since this pill is a simply a doubling up of the ingredients in oral contraceptives to ‘kill’ a fertilized egg, albeit unplanted, it is indeed aborting a newly created human being. On the side of the nay’s, the reasoning is, because the fertilized egg is not implanted, it is not and should not be considered a human being, but simply a biological compound not much different from a cyst or tiny clot; the pill is preventing this clot from developing into a human being which would have to be aborted if unwanted. Thus, it is not aborting, but preventing the act of aborting; and lastly, the not sures are the group that raise two main points: 1) how can we be sure that after unprotected sex that an egg was indeed fertilized to be dispelled? And 2) if the egg was fertilized, at what point do we consider that microscopic cell the beginning of a new life?

All three positions can be backed up with an abundance of scientific data; Data that will be up for discussion, debate, and even heated arguments for many, many years to come. Facts, data, and unanswerable questions that have paralyzed the FDA, angered the religiously convicted, created dissention among pharmacists, postured legal and academic minds to defend or denounce refusal clauses, and added yet another weapon to the vast arsenals of both pro-life and pro-choice groups. With such sharp and fervent opposition, it is safe to conclude that the matters of oral contraceptives, emergency contraceptives, abortion pills, and abortions themselves will be matters of controversy forevermore throughout the existence of mankind.

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