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# WHOSE SELF-DETERMINATION? BARRIERS TO ACCESS TO EMERGENCY HORMONAL CONTRACEPTION IN ITALY

Emanuela Ceva, University of Pavia – Sofia Moratti, European University Institute

## 1. INTRODUCTION

It is a standard requirement of democratic theory that all members of society be treated with equal respect as capable of self-determination (Christiano 2004; Dworkin 1977; Gutmann and Thompson 2004; Patten 2011; Waldron 1999). The fulfillment of this requirement is problematic vis-à-vis conscientious dissenters. Conscientious dissenters refuse to comply with legally enforced duties when compliance risks jeopardizing their moral integrity, because the required behavior would compromise their loyalty to (some of) their moral commitments. Coercing conscientious dissenters into behavior they deem morally wrong, *qua* contrary to their conscience, amounts to disrespect because it threatens their capacity for self-determination (Brock 2008; Ceva 2011; Sulmasy 2008; Wicclair 2011).[1]

In recent years, the problem of conscientious dissent has been discussed with special reference to requests for exemptions from professional duties (Pope 2010; Wicclair 2000). Specifically, the debate has revolved around the following dilemma: should the safeguard of the professionals' capacity for self-determination be prioritized over the protection of persons whose capacity for self-determination depends, also, on the professionals' fulfilling the contested duty?

[1] Throughout the article we make reference to conscience as the faculty possessed by persons to discern what is morally right or wrong, and to moral integrity as action according to conscience.

[2] Articles 323, 328, 340 and 593 second paragraph of the Italian Criminal Code

[3] The President had released his statement in response to numerous requests from doctors. The President stressed that doctors who do not wish to prescribe EHC should see to it that the patient receives the drug within a reasonable time (for example, by referring her to a colleague).

[4] Available at http://bit.ly/LicA4H (last accessed 30 May 2012).

[5] In one ED the prescription was written after the patient insisted on it. In the other, it was written 30

We address the dilemma with reference to a specific case of professional conscientious dissent: doctors' and pharmacists' refusal to prescribe and distribute Emergency Hormonal Contraception (EHC). And we focus on the situation in our country, Italy, where EHC is a prescription medication available only in pharmacies. The case of access to EHC in Italy is particularly significant. Doctors have a statutory right to refuse conscientiously to perform abortions, in which case they have a legal obligation to inform the local health-care authorities in writing and in advance. The doctor's right to conscientious objection (CO) does not extend to the prescription of EHC. However, there is evidence that in Italy (and elsewhere) doctors refuse to prescribe the drug, without informing the health-care authorities, on grounds of conscience. In addition, it has recently been discovered that some pharmacists refuse to dispense EHC (Cooper, et al. 2008; Wynn, et al. 2007). This state of affairs translates into a double barrier to access to EHC in Italy. Two professional groups, doctors and pharmacists, are currently in a position to undermine the right to reproductive self-determination of women, and to do so without any public scrutiny of their behavior.

How can this situation be addressed in a way consistent with the respect due to doctors' and pharmacists' professional self-determination as well as women's reproductive self-determination? A possible, widely discussed, solution consists in granting statutory recognition to doctors' and pharmacists' CO, along the same lines in which abortion is regulated in Italy and elsewhere. The promoters of this solution would emphasize that its virtue consists in protecting professional self-determination (by allowing doctors and pharmacists to choose what services they provide), while monitoring the situation so as to ensure that women's reproductive self-determination is not undermined (for instance, by taking actions to ensure geographical coverage).

In this paper we suggest that the discussion of the proposal for the statutory recognition of doctors' and pharmacists' CO to EHC is flawed in an important sense: it takes for granted that doctors' and pharmacists' claims are appropriately addressed under the rubric of CO, so that the relevant question is whether they should be allowed a statutory right to exemption or coerced into providing the service to which they object. The

novelty of our approach consists in questioning what standard discussions take for granted and claiming that in fact the case at hand cannot be appropriately addressed through the category of CO. The general idea is rather simple and, we believe, fairly uncontroversial: in a democracy, committed to the principle of equality of treatment of all citizens, the instrument of legal exemptions is in need of a strong justification as it risks introducing forms of differential treatment which may bestow privileges on certain citizens that are foreclosed to others. In particular, it seems that the circumstances for a right to CO obtain in those situations in which the dissenter experiences a conflict between two moral duties, one arising from her conscience, the other enforced by the law and correlative to someone else's moral right. In such cases a possible way forward is to exempt the dissenter from compliance with the latter duty, while preserving it in place for all the other individuals to whom the duty applies. This feature is typical of such paradigm cases of conscientious dissent as that to the military draft or to abortion, but is absent in the case of EHC. Doctors' and pharmacists' professional duty to provide EHC is a consequence of contingent *legal* arrangements, but it is not a *moral* duty analytically derived from women's moral right to reproductive self-determination. So, we suggest that the way forward is in the legal revision of the regulation of EHC, to prevent the apparent dilemma between women's and medical professionals' self-determination from arising in the first place. EHC should be available without medical prescription and outside pharmacies, in a number of outlets (including supermarkets).

Although our argument is built on the Italian case, it has implications for the debate on the provision of EHC and on conscientious dissent by health-care professionals in general. The first implication is methodological and general: we submit that conscientious exemptions should be used sparingly and should be justified in ways consistent with the egalitarian *ethos* of a democracy. The second implication is normative and concerns the debate surrounding EHC. We offer a moral justification for distributing the drug without medical prescription and in a number of different outlets outside pharmacies. The justification is consistent with individuals' and institutions' moral duties correlative to women's moral right to reproductive self-determination. At

the same time, this regulation would prevent the issue of doctors' and pharmacists' self-determination from arising in the first place.

The paper unfolds as follows. Sections 2 to 6 provide the essential context, details and critical tools to characterize and discuss the issue of doctors' and pharmacists' protests against EHC in Italy. Specifically, in Sections 2 and 3, we present respectively current regulation and practice. In Section 4, we critically present the Italian Bioethics Committee's (IBC) statements on the ethical and legal acceptability of CO to EHC by doctors. In Section 5, we review local regulations, self-regulation by the medical profession and court rulings regarding the right to access to EHC. In Section 6, we proceed to discuss the IBC's position statement on the ethical and legal acceptability of CO to EHC by pharmacists. Sections 7 and 8 complement and expand on the empirical and legal analysis, with a philosophical discussion of the issue. In Section 7, we review the current debate concerning the moral justifiability of a right to CO to EHC and argue that most debates seem to have reached an impasse. In Section 8, we offer our own argument and suggest that the dilemma concerning whose self-determination must be protected can be overcome by distributing EHC without medical prescription and in different outlets outside pharmacies. In Section 9, we bring our general argument to bear on the Italian context and address possible concerns regarding our proposal. In Section 10, we conclude.

## 2. EMERGENCY HORMONAL CONTRACEPTION IN ITALY

In Italy, patients who need a prescription for EHC can turn to a variety of sources: their GP's surgery, an Emergency Department (ED), the local 24-hour medical service doctor, or a family planning center. Almost all health-care institutions in Italy are public bodies and part of the Italian National Health Service, the *Servizio Sanitario Nazionale* (SSN). Most of the few private health-care institutions are SSN-bound and receive public funding for part of the medical services they provide. The majority of pharmacies in Italy are privately owned, but the distribution of medicines is a public service under Italian law, and one of the legal requirements for opening a pharmacy is a special

license from the regional government. The license is very difficult to obtain because this market sector is tightly regulated. Pharmacies have a monopoly over the distribution of medicines, including over-the-counter drugs.

The distribution of EHC in Italy was authorized in 2000 with a decree under the then Minister of Health Umberto Veronesi (Ministerial Decree, 26 September 2000, no. 510). Shortly thereafter, a national pro-life organization challenged the decree in court, claiming that what the Minister had done amounted to unlawfully extending the sphere of applicability of the 1978 abortion law (Parliamentary Law, 22 May 1978, no. 194). In 2001, the court rejected the claim (Lazio Regional Administrative Tribunal, 12 October 2001, ruling no. 8465), stressing that EHC produces its effects before the embryo attaches itself to the wall of the uterus ("implantation"). The court argued that EHC is not a form of abortion, and therefore the abortion regulations do not apply to it. More recent research has shown that EHC does not prevent pregnancy by hindering implantation, but rather by inhibiting ovulation: EHC seems therefore to act at an earlier stage than was previously thought (Baird 2009; Gemzell-Danielsson 2010; Gemzell-Danielsson and Cameron 2011; Noé, at al. 2010), as is acknowledged in a recent position paper by two Italian Medical Societies for Contraception (2011).

Many of the rights that the 1978 abortion statute ascribes to women who choose to have an abortion do not extend to EHC. Unlike abortion, EHC is not free of charge. An EHC prescription from an ED costs 25€ and, based on triage regulations, the case is considered "not in need of urgent medical attention," which may have serious consequences if the ED is crowded and no other doctor is available. The drug itself costs 12€. In addition, there is no special protection given to women's privacy. The prescription for EHC must report the patient's name, date of birth, and social security number. Finally, the provision that grants health-care professionals the right to CO in the abortion statute does not include the right to refuse EHC: the writing of prescriptions by SSN and SSN-bound doctors and the provision of drugs by pharmacists are public services patients are entitled to receive. Various criminal law provisions

apply in case of refusal to provide public services: abuse of authority, dereliction of duty, disruption of public service and failure to render assistance.[2]

## 3. CONSCIENTIOUS OBJECTION TO EMERGENCY HORMONAL CONTRACEPTION: AN UNDERGROUND PHENOMENON

Given the legal situation described above, doctors and pharmacists never disclose their choice for CO to the head of their institution or to the director of the SSN unit. A call to disclose by the President of the College of Physicians in late 2006 was ignored (National Federation of the Colleges of Physicians 2006).[3] The Ministry of Health does not monitor CO to EHC, and it has so far remained an underground phenomenon. The available data on medical practice and pharmacists' behavior come from research by medical societies, associations for the rights of patients and women's rights organizations.

In 2010, a report by the Italian Society of Gynecology and Obstetrics showed that about 1,000 requests for EHC were made over one year in Milan, a city with 1,324,000 inhabitants (*Corriere della Sera* 2008). Half the requests came from women under 18, but not all of these were honored. In 2009, the same society reported that the sale of EHC had declined by 4.7%, while the sale of birth control pills had slightly increased. The Society speculated that the two facts may be linked; however, there is no evidence to support this. Italy currently ranks sixth in Europe for EHC sale, and 55% of buyers are women younger than 20 (Italian Society of Gynecology and Obstetrics 2010).

At weekends and at night, GPs are not available and family planning centers are closed. Women who need EHC will most likely turn to an ED for the prescription. In June and July 2008, two researchers based in Rome, a man and a woman, spent part of their

[2] Articles 323, 328, 340 and 593 second paragraph of the Italian Criminal Code

[3] The President had released his statement in response to numerous requests from doctors. The President stressed that doctors who do not wish to prescribe EHC should see to it that the patient receives the drug within a reasonable time (for example, by referring her to a colleague).

weekends visiting all 20 EDs in the Rome urban area. The pair requested an EHC prescription and secretly filmed the reactions they got from health-care personnel, later producing a documentary film.[4] In ten EDs, the request was turned down: nearly all of these were attached to Catholic hospitals, which was the reason most of the health-care professionals gave for refusing to prescribe EHC. In seven hospitals, some of which were Catholic, the researchers obtained the prescription immediately.[5] The health-care personnel in some EDs appeared not to be aware of (informal) policies in other hospitals with regard to prescribing EHC. In the remaining three hospitals, health-care personnel told the patient that in principle the prescription could be obtained, but strongly discouraged her by postponing the decision and making her wait for up to one day.

## 4. THE ITALIAN BIOETHICS COMMITTEE'S STATEMENT ON CONSCIENTIOUS OBJECTION TO EMERGENCY HORMONAL CONTRACEPTION BY DOCTORS

In 2004, in response to a question posed by the Order of Physicians of Venice, the IBC held that doctors' CO to prescribing EHC is morally acceptable. The IBC observed that scientific research "has not excluded" that EHC may hinder implantation, displaying its effect after fertilization: in fact, this is the mechanism of action described in the leaflet that comes with the drug. "Therefore," the IBC concluded, EHC is abortion to those who believe that pregnancy commences with fertilization. According to the WHO, pregnancy actually begins with implantation: but the IBC apparently found the WHO definition of gestation too restrictive. The IBC further argued (unanimously) that CO to prescribing EHC is legally acceptable, based on a provision in the Code of Medical Ethics, which entitles the doctor to "refuse to perform professional duties that are in contrast with his conscience […] unless this causes grave and direct harm to the

[4] Available at http://bit.ly/LicA4H (last accessed 30 May 2012).

[5] In one ED the prescription was written after the patient insisted on it. In the other, it was written 30 minutes after the patient had requested it, because the gynecologist was in the delivery room at the time of the request.

patient's health."[6] The IBC's argument assumes that not prescribing EHC – a drug that is not effective unless taken within a short time – never causes grave and direct harm to the patient's health.[7] We revisit and engage critically with this controversial position in Section 7 below.

## 5. LOCAL REGULATIONS, SELF-REGULATION BY THE MEDICAL PROFESSION AND COURT RULINGS

In order to prepare the way for our argument in Section 8, we need to provide further details on the Italian legal context. Although no systematic study is available to date, case law and legal developments at the local or regional level in the past few years all seem to point in the direction of considering doctors' CO to EHC legally unacceptable.

In 2008, the Regional Council of Tuscany passed a resolution addressed to all SSN doctors working in the region (*Repubblica* 2008). In the resolution it is clearly stated that refusal to prescribe EHC is a breach of the criminal law. Soon after the resolution was passed, two cases involving a doctor's refusal to prescribe EHC were reported by the patients concerned to an SSN unit in Tuscany. The first doctor was tried by a regional medical-disciplinary tribunal[8] and received a fine.[9] Following this case, the Minister of Health of the center-left cabinet then in power set up a dedicated hotline, encouraging patients to report doctors' refusal to prescribe EHC (Aduc 2008).

Again in Tuscany in 2010, on a Sunday, the doctor on shift refused to prescribe EHC and referred the patient to a nearby medical center, where EHC was prescribed right

[6] Article 22 of the Code of Medical Ethics. The code, enacted in 2006, is a form of self-regulation by the medical profession, drafted by the national College of Physicians. Each provincial College of Physicians elects a board, which hears cases of alleged violation of the code and may or may not punish the responsible doctor (Moratti 2008).

[7] Seventeen members of the IBC pointed out that the exercise of CO by doctors employed by the SSN should never result in undermining women's rights, but did not give more specific suggestions.

[8] The tribunal is the 'College of Arbitration for General Medicine'.

[9] The fine amounted to 10% of the doctor's monthly salary, for one month only (Pisa Aut-aut Association 2008).

away (*Repubblica* 2010). In a similar case, the Regional Administrative Tribunal of the Apulia region (15 March 2010, ruling no. 735) ruled that CO to prescribing EHC is a breach of both the criminal and medical-disciplinary law. The director of the SSN in the Marche region sent a statement to the SSN regional authorities arguing that refusal to prescribe EHC is illegal and contrary to professional ethics (Lupi 2009). The President of the local College of Physicians in the city of Udine released a statement to the same effect: the patient is entitled to receive a prescription for EHC, and doctors who do not wish to prescribe it should refer her to an available colleague. If no such colleague can be found, or if further delay is inadvisable, then the doctor must write the prescription. Ideally, the President concluded, EHC should be an over-the-counter drug (*Friulinews* 2007). In 2009, the SSN unit of Savona drafted, with the local Court's assistance, some policy guidelines, including mention of a doctor's duty to prescribe EHC. The guidelines attracted criticism from pro-life organizations (*Il Giornale di Genova* 2009).

## 6. THE ITALIAN BIOETHICS COMMITTEE'S STATEMENT ON CONSCIENTIOUS OBJECTION TO EMERGENCY HORMONAL CONTRACEPTION BY PHARMACISTS

To complete the framework within which our discussion is situated, a final step is still to be made concerning the IBC's opinion statement on another professional category: pharmacists. After the Pope, in 2007, urged pharmacists never to dispense EHC, the spokesman of a professional association of pharmacists released a statement to the effect that, as the law stands, pharmacists have an obligation to hand over the medication to the patient without delay, if the latter holds a valid medical prescription (Federfarma 2007). Should the pharmacist not have supplies of the prescribed medication, the same law demands that he acquires it as soon as possible (Article 30, Royal Decree, 30 September 1938, no. 1706). Failure to comply is a breach of the criminal law, the spokesman added. On 25 February 2011, the IBC released a statement on pharmacists' CO to EHC, requested by an MP and a representative of a Catholic political party. Like doctors, pharmacists have their own Code of Professional Ethics, drafted by the College of Pharmacists, whose board has disciplinary power over all Italian pharmacists. A provision in the Code (Article 3, first paragraph, sub c) grants

pharmacists the right to make decisions based on their professional conscience, "considering patients' rights and respect for human life." Most members of the IBC (n=15) argued that this provision legitimizes pharmacists' CO to EHC, advancing the same argument used in the 2004 opinion statement: EHC may display its effects after fertilization. The fifteen members of the Bioethics Committee developed this argument much in the same way as in the 2004 opinion statement on doctors' CO to EHC.

In the majority statement it is argued that the role of the pharmacist with regard to EHC is of no less importance than that of the doctor. If doctors can lawfully refuse to prescribe EHC as the law stands, so can pharmacists. The argument is entirely focused on the boundaries of the domains of authority of professional groups, and no mention is made of patients' rights or women's self-determination. Ten members cautiously criticized the majority statement. While finding CO acceptable "with respect to [pharmacists'] professional ethics" – thus not questioning the authority of the professional group – they argued against the enactment of a statute giving pharmacists the right to CO, because such a law would undermine doctors' professional authority and women's self-determination. The ten members reasoned that it could even open the floodgates: many professional groups are involved in the synthesis, preparation, and distribution of EHC, if they all were to claim successfully the right to CO, EHC would probably no longer be available in Italy. The ten members stressed that the dispensing of drugs in pharmacies is a public service on which patients have the right to count.

The IBC's general conclusion was that a woman's entitlement to receive EHC has primacy over the pharmacist's prerogative to refuse to dispense the drug. Such a conclusion was meant to strike a balance between the majority and the minority statements, but in fact seems not to reflect closely either of them.

It is important to notice for our argument in Section 8 that the regulation of pharmaceutical services and the role of the pharmaceutical profession, when all medications are produced by large corporations, have been subject to controversy for

the past few decades. Relatively recent attempts by a center-left cabinet to relax the monopoly that pharmacists enjoy over the sale of medications met fierce opposition from the pharmaceutical profession, and essentially failed. The IBC chose not to take a stand either in favor of, or against, regulating CO in pharmaceutical practice through an act of parliament.

## 7. CAN A RIGHT TO CONSCIENTIOUS OBJECTION TO EMERGENCY HORMONAL CONTRACEPTION BE JUSTIFIED?

Can the dilemma between doctors' and pharmacists' professional self-determination and women's reproductive self-determination, outlined in the previous sections, be resolved? Is the statutory recognition of doctors' and pharmacists' CO a morally well-grounded and promising way to go? In what follows we offer a concise critical survey of the debate revolving around these questions. Specifically, we discuss the merits and limits of three strands of the debate focusing respectively on (1) the voluntariness of entering the medical profession; (2) the harm CO causes to women; and (3) the protection of health-care professionals' moral integrity. We suggest that the three strands of the debate have reached an impasse, and that we should go beyond them by deepening the level of the philosophical discussion of the issue by questioning the very roots of the dissenters' claims. This is our aim in Section 8.

### 7.1 VOLUNTARINESS

Some have dismissed professional CO on the grounds that the duty against which the objection is raised was freely contracted by the professionals when entering their profession, unlike general duties such as those to serve in the military (La Follette and La Follette 2007; Savulescu 2006). One may well say, the argument goes, that gynecologists who were already in the profession when abortion was made legal can hardly be thought to have voluntarily contracted the duty to perform it; however, this line of argument does not seem available to doctors who entered the profession in recent decades. What is more, at any rate, doctors (and pharmacists) who enter the profession *now* certainly know that their tasks include the provision of certain services, including

EHC. So, if they do not want to provide some of these services, they may either choose a different career, or leave the medical profession at any time without incurring any sanction (although this is not to deny that the choice may imply some costs, especially in personal terms). On these grounds, no room for the statutory recognition of a right to CO is left open to professionals.

Despite some degree of plausibility, this argument faces problems. Some commentators have noticed that the mere fact that a person chose to become a doctor while holding – say – religious convictions, is not in itself a strong enough reason to deny her an exemption from a *specific* task associated, *among others*, with her profession. This would imply an arbitrary reduction of the set of opportunities open to those holding certain religious or ethical views, forcing them to choose between their (professional) self-realization and their moral integrity, in a context in which such a choice would in fact not be necessary (Ceva 2011; Quong 2006; Morton and Kirkwood 2009; Wicclair 2008).

This strand of the debate seems to reproduce an old divide: whether we should prioritize freedom of choice, and accept the responsibility associated with its voluntary exercise, or equality of opportunity, which, on occasion, requires positive action to correct the effects and consequences of voluntary free choices. This does not seem a promising strategy to resolve the dilemma between the self-determination of women versus that of doctors and pharmacists, as it simply moves the focus of the discussion onto a different dilemma at risk of impasse.

### 7.2 HARM

A more nuanced set of considerations is in order to address a broad strand of the debate concerning the possible impact that CO to EHC may have on women, on their capacity for self-determination, and, in particular, the harm inflicted upon them. The general line of thought is that, as suggested above through the description of the current situation in

Italy, widespread CO may undermine women's access to EHC especially in rural areas, at the weekends, at night or during the holiday season, considering the short amount of time within which EHC must be taken for it to be effective.[10] Unlike the opinion stated by the IBC in 2004, such a delay may be harmful to women's health and undermine their capacity for reproductive self-determination. This would amount to an unwarranted act of disrespect.

Against this argument, Elizabeth Fenton and Loren Lomasky (2005) argue that when women seeking EHC fail to obtain it, they certainly experience disappointment and frustration but no harm is – strictly speaking – inflicted upon them. By Fenton and Lomasky's account, pharmacists who refuse to dispense EHC fail to provide a benefit to women seeking it, but they do not inflict any liability (2005: 583). *Contra* Fenton and Lomasky one may argue that, although it seems plausible that physical and emotional harm may depend on circumstances (e.g. when an unwanted pregnancy occurs, see Wicclair 2000), there is a sense in which women are certainly exposed to moral harm in that the exercise of their right to reproductive self-determination is jeopardized (see Del Bò 2012). There may be several senses in which harm may or may not be inflicted upon women, but that consisting in an arbitrary restriction of their capacity for self-determination seems particularly morally troublesome in democratic states, which, as stated above, derive an important part of their justification from their ability to protect the capacity for self-determination of all citizens on an equal basis.

Another reply may be offered, from a feminist perspective, following Carolyn McLeod (2010). McLeod questions the assumption that we should be primarily concerned with those kinds of harm that are also wrongs ("i.e., those where a person is deprived of what to which she is entitled" McLeod 2010: 16). Following Joel Feinberg (1984), McLeod considers as harm what sets a person's interest back (McLeod 2010: 17), and goes on to argue that the disappointment women suffer by not being dispensed EHC counts as harm in this sense (McLeod 2010: 18). According to McLeod, pharmacists' refusal may

[10] 72 hours, and the earlier the intake, the lower the chances of pregnancy.

corroborate sexist prejudices at the basis of social pressure against women's access to EHC (especially as regards inferences concerning their sexual promiscuity and social respectability), thus furthering their oppression (McLeod 2010: 18). Failure to contrast pharmacists' refusal, in addition, could corroborate women's persuasion that they are not respected by society *qua* autonomous agents capable of making their own decisions regarding their reproduction (McLeod 2010: 19). Such a lack of respect would count as harm to women, in McLeod's view, as this would fuel social stigma associated with their seeking EHC, thus discouraging them to do so and, therefore, negatively interfering with their interests.

We could counter that these worries are in fact a mere consequence of a lack of practical organization, and therefore could be overcome by compelling the SSN to secure the presence of non-objecting staff in EDs and municipal pharmacies. However, this proposal, timidly hinted at in the IBC's 2011 opinion statement, would be very difficult to implement: would it count as discrimination to hire doctors and pharmacists in the public sector on the basis of their conscientious convictions? This question brings into the picture the need to consider the matter not only from the point of view of the harm possibly caused to women (especially the harm resulting from an arbitrary restriction of their capacity for self-determination) but also from the harm possibly caused to the health-care professionals. After all, the counter-argument may go, coercing someone to either act against conscience on matters of life and death, or to suffer some penalty (whether social, professional or legal), can easily look like harming them. But if that is the case, then are we not faced with a new dilemma, wherein everyone stands to be harmed, at least in the relevant sense of having their self-determination undermined?[11] Although these considerations have been mainly discussed with regard to pharmacists, in the Italian context they would equally apply to doctors who are entrusted to prescribe EHC in the first place.

So it seems that the debate on this point has reached another impasse: both parties involved seem to be at risk of being harmed in many ways and, most importantly, in the

[11] We are grateful to an anonymous reviewer for pressing this point.

relevant sense of having their capacity for self-determination undermined. The dilemma is still very much in place.

## 7.3 INTEGRITY

A third argument builds on the assumption that a focus on the notion of the dissenters' moral integrity is crucial to the discussion of CO (Brock and Deans 2011; Wicclair 2000). In particular, the argument in favor of recognizing a right to CO to EHC underlines the importance of preserving a professional's moral integrity. It has been put forward mainly in reply to the "opening the floodgates" argument against recognizing pharmacists' right to CO, which goes as follows: once a conscientious exemption is granted to pharmacists, on what grounds could it be denied to drivers delivering EHC to the pharmacy, or to factory workers packing EHC in cardboard boxes? Granting an exemption right to pharmacists risks opening a Pandora's box of claims that, if combined, would expose women seeking EHC to a series of uncontrollable contingencies seriously undermining their capacity for self-determination (IBC 2011, article 2.2 sub d; Del Bò 2012).

In reply to this concern Pellegrino and Thomasma (1993) present medicine essentially as a *moral* profession, and moral integrity as an essential virtue for physicians. Accordingly, it might be claimed that if conscience-based objections are not accommodated, individuals with moral integrity will be discouraged from entering the medical profession. Similar claims might (arguably) be advanced in relation to pharmacists, but – the argument would go – are not equally plausible in relation to truck drivers and factory workers whose professions seem to lack such a distinctive moral connotation.

This is quite a controversial argument, based on a very distinctive understanding of the medical profession and on a disputable analogy between doctors and pharmacists. It should be noted, at the very least, that moral integrity seems to be a virtue of the moral

person in general, quite apart from the profession she entered. After all, why should employers not be worried to hire anyone (truck drivers and factory workers included) lacking moral integrity? The reference to the moral connotation of the medical profession does not seem to drive significantly enough of a wedge between said profession and others. As a result, the opening-the-floodgate argument mentioned above seems to persist, and constitutes a serious threat to women's self-determination should a right to exemption be granted to pharmacists objecting to EHC.

Another controversial aspect of the argument consists in presuming that, when it comes to the provision of EHC, doctors' and pharmacists' moral integrity is as much at stake as, for instance, that of anti-abortion doctors. Indeed, the members of the IBC in the 2011 statement on pharmacists' CO to EHC could not agree on this issue. It can be argued that a claim to CO is worth recognition if the claimant, by obeying the law, is at risk of committing a *direct* violation of a moral imperative (as was the case of drafted soldiers and, arguably, anti-abortion doctors forced to act in direct violation of the principle "you shall not kill" – see Ceva 2011 and Galeotti 2010). Are doctors and pharmacists refusing to prescribe and dispense EHC in this position? This is doubtful.

Consider the case of pharmacists first. It does not seem enough to ground the claim of pharmacists on concerns of complicity for which pharmacists' action may, possibly, put someone else – the woman – in the position to commit an act that would be morally wrong in accordance with standards that belong to the pharmacist, but not to the woman who acts in the first person. For the pharmacists to be in the position of making an integrity-based claim to CO, it should be established whether the very act of dispensing EHC would amount to committing a moral wrong, comparable to the case of a doctor performing an abortion. But this is highly debatable (Wicclair 2011).

Pace the IBC's 2004 opinion statement, the position of doctors is only apparently different. It is undeniable that the medical prescription precedes the pharmacist's sale of the drug in the causal chain leading a woman making use of EHC. However, this is only

arguably morally relevant because the ultimate responsibility for committing (what is viewed by some as) a morally controversial act (using EHC) rests with the woman. By prescribing EHC, the doctor does not violate a direct moral imperative. Rather, he or she puts a woman in the position of possibly committing an act which is viewed as morally wrong according to standards which do not belong to the person making use of EHC (Galeotti 2010 and Del Bò 2012).

What is more – besides the longer responsibility chain – the status of EHC as an abortion drug is largely controversial (as shown above). Scientific research in the past 10 years has shown that EHC works by blocking ovulation. In addition, that preventing implantation means causing an abortion is at the very least dubious, as emphasized by the WHO, according to which pregnancy begins with implantation. Skepticism on the contraceptive nature of EHC seems to persist, scientific evidence notwithstanding, because the idea that contraception may take place after intercourse is quite counterintuitive.

So it seems that also this strand of the debate has not lead to very fruitful results. Unlike in other cases of CO, the status of doctors' and pharmacists' moral integrity with respect to prescribing and dispensing EHC is highly contentious, and even if it were proved that their integrity is at stake we would be left with no clear criterion to decide whether protecting their integrity deserves priority over women's self-determination. We are left with the same dilemma and it is no consolation to have reached the same impasse from a different path.

## 8. IS THE CATEGORY OF CO APPROPRIATELY USED IN RESPONSE TO CLAIMS AGAINST THE PROVISION OF EMERGENCY HORMONAL CONTRACEPTION?

In the previous section we have shown that the different strands of the current debate, focusing on the question whether doctors and pharmacists should be granted a statutory

right to CO, or whether they should be coerced into providing EHC, lead to an impasse; no persuasive solution is offered to the dilemma of whose capacity for self-determination should be protected, that of women or that of health-care professionals. Is there a way forward? We propose moving to a deeper level of philosophical analysis, and challenge what all the arguments up to date seem to be taking for granted: are doctors' and pharmacists' protests against providing EHC appropriately addressed under the rubric of CO?

We think this is an important question to ask because all instances of differential treatment require a stringent justification in a democracy, since they risk introducing privileges for certain classes of citizens which are foreclosed to others. This is problematic insofar as it risks undermining the basis of equal treatment on which democracy rests. In this sense, the recognition of a right to CO could be seen as a last resort, or at any rate as an instrument to be used sparingly, when no egalitarian, universalist alternative way forward is available to resolve a moral conflict.

In particular, it seems that the circumstances for a right to CO obtain when the dissenter experiences a conflict between two moral duties binding on her: a moral duty of conscience and a moral duty enforced by the law correlative to someone else's moral right. In such scenarios, a possible solution is to exempt the dissenter from compliance with the latter duty, while preserving it in place for all the other individuals to whom the duty applies (e.g., the other members of the same profession). This solution allows carving out some limited room for differential treatment (necessary to protect the dissenter's self-determination), while preserving the general validity of a law (enforced to protect other values, goods, or interests, including someone else's self-determination).

This feature is typical of such paradigm cases of conscientious dissent as that to the military draft or to abortion. Take the case of the objection to the military draft. In that case, all male adult citizens were held under a legally enforced moral duty to serve in the military, and the grounds for the objection was the conscientious conviction that in

so doing one was forced to contravene the moral duty not to use weapons. An analogous line of reasoning applies to the case of abortion: all gynecologists, anesthesiologists and possibly paramedics are the bearers of a legally enforced moral duty correlative to a woman's right to end her pregnancy and this duty is in conflict with the moral duty of some doctors not to kill (what they regard as) a human life. In these scenarios both male citizens' and doctors' legally enforced moral duties are correlative to moral rights (respectively, a general right to security and a specific right to reproductive self-determination for women) wherein the duty-bearers are in a crucial position for the right-holders to have their right secured. Given this relation between duty-holders and right-bearers, but the absence of specific duties on specific persons, rights to CO could be granted to some (by virtue of their holding conflicting moral duties of conscience), while the legally enforced moral duty remains in place for all the others so as to grant the fulfillment of the correlative right.

Can we speak of a moral duty of doctors and/or pharmacists to provide EHC along similar lines? The question is relevant as we build on the presumption that women have a moral claim right to reproductive self-determination: they are not merely at liberty to decide whether they wish to become mothers, but they hold (certain) others under a duty not to interfere with such a right and, in fact, to put them in a position to exercise that right (Kelleher 2010). This also seems the rationale of the criminal law provisions punishing doctors who refuse to prescribe EHC, as discussed in Section 2 above. What is more, if doctors or pharmacists had no duty to provide EHC, but their doing so were supererogatory, they could simply decide not to do so without, strictly speaking, objecting to anything.

In this regard, the first, fundamental question concerns the duties applying to institutions for the safeguard of women's capacity for reproductive self-determination. A further question concerns the duties members of society have towards one another in matters concerning the exercise of women's rights to reproductive self-determination. Given the relative, but limited, power relations in society, its members may at most be held under negative duties not to interfere with women's exercise of their rights: for

instance, no one – be it a mother or a husband – should be allowed to force any woman to procreate or not to procreate (Childress 1985). The same negative duty applies to institutions: for example, no law can justifiably establish the number of children a woman may have. But institutions may also be held under a positive duty to put women in the position of actually exercising control over procreation. The argument goes as follows.

As explained in Section 1, democratic institutions are justified if they treat those living under them with equal respect. The principle of equal respect for persons requires that all members of society be treated equally in their capacity as self-determining agents. This requires, in turn, that they be treated as the authors of their own life-plans, which include decisions concerning procreation. Therefore it can be argued that institutions have a negative duty not to interfere with the exercise of women's respect-based right to reproductive self-determination, as well as a positive duty to protect it on an egalitarian basis.

If this argument holds, where do we stand regarding the initial question of whether doctors and pharmacists are under a duty to provide EHC? Like all members of society, doctors and pharmacists are under a negative duty not to interfere with women's rights to reproductive self-determination, as demanded by the principle of equal respect in horizontal relations (see also Fenton and Lomasky 2005). But, unlike other members of society, doctors and pharmacists may also be held under a positive duty to provide EHC when they act in their capacity as representatives of institutions. If the SSN entrusts them to provide EHC (that is, to discharge the SSN's institutional positive duty), they may be held under a positive duty.

What kind of duty would this be? Can it be considered a perfect duty (a fully specified duty, a specific person has to perform a specific act), or is it an imperfect one (a loosely specified duty, any person has to give full consideration of what can be done when someone else's right is threatened)? We think it could hardly be considered a perfect duty. According to the account we have just sketched, the SSN as a whole, and not any specific individual pharmacist or doctor, could be held under a perfect duty to dispense

EHC. The only perfect duty binding on individual doctors and pharmacists is the negative duty not to interfere, which may substantiate a positive obligation to provide relevant and correct information to the patient or to refer her to another non-objecting professional (Brock 2008; Card 2007; Cantor and Baum 2004; Deans 2011; Strong 2007; Wicclair 2011). What matters is that the woman has access to EHC, not that she receives it from any one specific doctor or pharmacist. So long as there is at least one doctor and one pharmacist available to provide EHC within easy reach, the SSN has fulfilled its duty and women have their right granted, as stated in the closing lines of the 2011 IBC's opinion statement.

So there seems to be no irreconcilable conflict between the doctors' and pharmacists' duties of conscience and a perfect positive duty of theirs to provide EHC. The latter duty simply does not hold. But this is not the only implication of the analysis above. It seems that doctors and pharmacists are under a positive *im*perfect duty to provide EHC only if they happen to be entrusted by the SSN to do so. But this is only one possible arrangement, which has nothing to do with the nature of women's right to reproductive self-determination (unlike the case of abortion where gynecologists stand in a crucial position to grant a woman's right). In particular, it is a contingency of the Italian law that makes EHC subject to prescription (unlike most European countries) and available only in pharmacies. This arrangement seems to place doctors and pharmacists in an unnecessarily crucial position with respect to women's exercise of the right to reproductive self-determination. In other words, this regulation puts doctors and pharmacists under a positive imperfect duty, which is, however, not analytically derivable from the relevant right.

What conclusions can we draw from this discussion? Our line of reasoning has been quite simple: the circumstances for a right to CO in a democracy obtain in cases of moral conflict, when a person is torn between the allegiance to two conflicting moral duties: a moral duty of conscience and a moral duty enforced by the law correlative to someone else's moral right. If, as argued, doctors and pharmacists have no moral duty correlative to women's right to reproductive self-determination to provide EHC, two important consequences follow: 1. doctors and pharmacists are not trapped in a conflict

between moral duties, but experience a contingent conflict between a moral duty of conscience and a legally derived one; and 2. the solution to this contingent situation is not to preserve a morally unfounded legal duty and to grant someone an exemption from it, but to dispense pharmacists and doctors from this duty altogether. Why should we keep a law in place, but grant significant exemptions from it, when the duty the law enforces is not correlative in any meaningful sense to the right the law is meant to protect? This seems unjustifiably complicated and burdensome.

The argument may be fleshed out further by analogy with an insight Brian Barry (2001) has provided with respect to the debate concerning cultural exemptions (these include, for example, the religion-based requests for exemptions from dress-codes put forward by hijab-wearing Muslim women or turban-wearing Sikh men). In particular, Barry argued that in order to assess exemption claims on the part of minorities three conditions must jointly hold: (a) there must be a good reason for the law against which the claim to exemption is addressed; (b) there must be a good reason for the claim to exemption; and (c) the good reason for the exemption must apply to certain classes of citizens but not to others (Barry 2001: 32-62). If condition (a) is not met, the law should be abrogated, regardless of (b) and (c); if condition (b) fails, granted condition (a), the law should apply universally with no exemption from it; if condition (c) is not met, granted (a) and (b), the law should be thoroughly revised and not just amended through an exemption. Our argument is to the effect of showing that in the case of the conscientious exemption requested by doctors and pharmacists from the legal duty to provide EHC, condition (a) fails insofar as there is no moral reason to make women's access to EHC dependent on doctors' and pharmacists' legal duty to provide it. Therefore, rather than finding ways to argue whether doctors and pharmacists should be exempted from complying with the duty or should be coerced into discharging it, we would do better to devote normative efforts to think of thorough revisions of the current legal arrangements, which may dispense the health-care professionals with the duty altogether.

This is an important argument to make, both from an analytical conceptual point of view and because of its practical normative implications in terms of policymaking.

First, it allows clarifying the way in which the debate about doctors' and pharmacists' protests against providing EHC has been traditionally (albeit inaccurately) framed through the lenses of a possible right to CO. This is important because the current formulations of the problem, discussed in Section 7, do not allow proposing persuasive solutions capable of solving the dilemma between women's self-determination and that of dissenting doctors' and pharmacists'. Second, our argument allows overcoming the alternative between either granting doctors' and pharmacists' a statutory right to CO (to protect their self-determination) or coerce them into providing EHC (to protect women's self-determination). Our argument dissolves the dilemma. Distributing EHC without a medical prescription and in different outlets outside pharmacies would protect women's self-determination and prevent the question of doctors' and pharmacists' self-determination from arising in the first place (because their morally unsubstantiated, legal duty to provide EHC is removed).

In sum, the thought underlying our argument is that there is no philosophical reason to limit ourselves to ask whether we should or should not grant statutory recognition of a right to CO to doctors and pharmacists under the current legislation and licensing scheme, making doctors and pharmacists respectively responsible for prescribing and dispensing EHC. We have suggested, rather, a reason to question this legislation, and scheme which seem to be the very source of the problems with which we are grappling: they expose women to arbitrariness and uncertainty concerning the exercise of their capacity for reproductive self-determination, and put doctors and pharmacists in an unnecessary troublesome position by creating a conflict between their moral duty to act conscientiously and their legal duty to provide EHC. By showing, as we have done, that the latter duty has no moral ground, we suggest that doctors and pharmacists should be relieved of it. In the following section we expand on this suggestion to give a sense of how it could be made to work in the Italian context.

## 9. REMOVING THE BARRIERS TO ACCESS TO EMERGENCY HORMONAL CONTRACEPTION IN ITALY

In Section 8, we suggested that the dilemma between women's versus doctors' and pharmacists' self-determination could be *prevented* by removing the current restrictions

on the distribution of EHC. The drug should be distributed without medical prescription and pharmacies should not enjoy a monopoly over its distribution. Doctors and pharmacists lament a conflict between dispensing EHC versus following their conscience, but that conflict is the consequence of a contingent state of affairs, open to change and transformation. As argued above, there seems to be nothing essential either to the nature of EHC or to the function of doctors and pharmacists that demands that it should be their responsibility to provide the drug (see, respectively, the arguments in Sections 2 and 8).

Our proposed solution requires some qualification regarding the scope and extent of the new EHC distribution policy we support. First, while making EHC available without prescription is a *necessary* condition of our proposal, it is not *sufficient,* so long as pharmacists hold a monopoly over its distribution[12]. We submit that EHC should be available without prescription *and* from a number of different outlets, which would include – but would not be limited to – supermarkets and on-line stores. This follows from our argument concerning the absence of a *moral* duty for doctors and pharmacists to provide EHC and, relatedly, their merely contingent collocation in a crucial position to do so. Dispensing doctors and pharmacists from the *legal* duty to provide EHC allows us to overcome the dilemma, or rather to dissolve it, by taking the professional self-determination of doctors and pharmacists out of the picture.

Second, the abolition of the current licensing scheme granting pharmacists a monopoly in the distribution of EHC has important implications on the other horn of the purported dilemma: a woman's right to reproductive self-determination, which pharmacists are currently in a position to undermine. Recent research shows that, *even in countries where EHC is distributed without medical prescription*, pharmacists are reluctant to

[12] EHC is an over-the-counter drug in most European countries: Austria, Belgium, Bulgaria, Denmark, Estonia, Finland, Greece, Iceland, Ireland, Israel, Latvia, Lithuania, Luxemburg, the Netherlands, Norway, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland and the UK. In some countries, the distribution of EHC is not limited to pharmacies: in France the drug is available in schools, while in the Netherlands, Norway and Sweden it is sold in drugstores. HEC is a prescription medication in the Czech Republic, Germany, Hungary, Italy, Poland, Romania and Russia: however, in the latter two countries EHC is in practice distributed as if it were an over-the-counter drug.

dispense the drug, especially to certain patient groups, thus undermining their capacity for self-determination.

For example, French law (Decree 2002-39 of 9 January 2002) gives minors the right to obtain EHC free of charge, anonymously and without a prescription, from pharmacies, family planning centers, public and private hospitals and school infirmaries. The 2002 law prohibits health-care professionals from refusing to dispense EHC and provides that the discussion with the minor about EHC must take place away from indiscreet ears (for example, not at the counter if other customers or patients are present.) In addition, the health-care professional must inform the teenager on the side-effects of EHC, on other birth control methods and on STDs. In mid-2006, a team of gynecologists based in Nice (southern France) interviewed a sample of minors who had requested EHC from a pharmacy (Delotte et al. 2008.) As many as 87% reported that their request was not handled confidentially and discreetly (the discussion took place at the counter with other people present), and 38% reported having had their request for EHC turned down. According to the minors interviewed, most (80%) of the pharmacists who refused to dispense EHC said the medication (which is in fact free of charge to minors) was too expensive. The remaining refusals were justified with moral reasons. None of the patients interviewed received any information on STDs.

In the US, EHC is available without prescription at health centers and in drugstores. An exception is made for patients aged 16 and younger, who can only obtain EHC by producing a prescription. The costs of EHC vary between $10 and $70, and a health center visit to get the prescription can cost up to $250, unless the patient is a Medicaid recipient. Recent research shows that some pharmacists in the US are reluctant to provide EHC. Two female research assistants at Boston University called every commercial pharmacy (nearly 950 in total) in five major cities (Austin, Texas; Cleveland; Nashville, Tennessee; Philadelphia; and Portland, Oregon) (Wilkinson et al 2012a, Wilkinson et al 2012b.) The researchers contacted each pharmacy twice, once posing as 17-year-old patients who had had unprotected intercourse, and once posing as

doctors. In 19% of calls, the fictional teenage patient was told she could not obtain EHC under any circumstance. This misinformation occurred more often (23.7% vs 14.6%) among pharmacies in low-income neighborhoods. When researchers posing as doctors called the same pharmacies on behalf of a (fictional) 17-year-old patient, only 3% pharmacies said EHC was unavailable. Pharmacies, moreover, incorrectly reported the age guidelines for over-the-counter access to 43% of the "patients" and 39% of the "doctors."

The presence of such barriers to obtaining EHC seems to suggest that caution is in order when assessing our proposal for revision of the current legal provisions in Italy. If, on the one hand, removing pharmacies' monopoly seems largely justified, on the other hand, we should be careful that women's access to EHC be secured (as demanded by institutions' positive duty to protect women's reproductive self-determination) and not threatened by other professional groups. This seems to require, at the very least, that institutions make an effort to ensure the availability of the largest possible number of outlets from which EHC may be obtained, following the French model presented above and expanding it to include supermarkets, drugstores and on-line clinics. The logic behind our suggestion is that the pluralization of the subjects that may dispense EHC contributes to reducing the impact of specific barriers to women's reproductive self-determination, and prevents its exercise being made dependent on the discretion of one category of individuals. Needless to say specific arrangements are in need of an empirically grounded support that we are unable to offer in the context of this paper. Our aim was to suggest a possible way to rethink the apparent dilemma between medical professionals' self-determination and that of women seeking EHC, and to overcome it through a strategy capable of avoiding the many problems of differential treatment, discussed in Section 7, implied by the resort to CO.

It is interesting to notice that some sectors of Italian civil society and part of the medical profession are already seeking direct and indirect ways to modify the current state of affairs. As anticipated in section 5, regional and local governments and SSN authorities took action in support of a woman's right to access to EHC, patients brought cases to

court and institutional representatives of the medical profession released public statements. In 2008, an association for women's rights set up an EHC-prescription hotline in four Italian cities. One hundred volunteer doctors made themselves available to prescribe EHC at nights and weekends. Almost eight hundred EHC prescriptions were written in three years (Vita di Donna 2011), and over half the callers turned to the hotline service because they had earlier been refused the prescription.

In addition, EHC can be obtained without involving any professional from an "online clinic," legally based in the UK, but with a website in Italian for the Italian public (http://www.121doc.it.) Because the online clinic is not legally based in Italy, no prescription is necessary to obtain EHC, which is delivered by express courier within 24 hours directly to the customer's address. However, discretion and efficiency come at a cost, as the medication is considerably more expensive than it would be if bought in an Italian pharmacy. Discrimination against poorer patients is one of the consequences of the barrier to access to EHC in Italy. Women's right to reproductive self-determination is a claim right, correlative to the institutions' positive duty to protect it. We therefore need rules and policies protecting the right to access to EHC of all women, regardless of their personal or financial situation. Specific provisions may include, for example, free distribution of EHC in schools and caps on the costs of the drug.

## 10. CONCLUSIONS

Underground CO exposes women to uncertainty in a matter crucial to their personal self-determination and makes them most vulnerable to disrespect, humiliation, and paternalistic interference with their rights. We do not suggest that this is the primary goal of doctors and pharmacists who engage in CO. However, it is an easily predictable consequence of underground CO, because women are given an equivocal message: officially, EHC is prescribed and distributed like any other medication, but the woman who tries to obtain it in practice could meet, and often does meet, barriers whose nature and importance are difficult to predict. This is intimidating, mortifying, and discouraging.

In this paper, we suggest that, unlike the way in which it is usually presented, the case of doctors' and pharmacists' refusal to provide EHC should not be addressed through the category of CO, in regard to which the relevant question to ask is whether the dissenters should be granted a statutory right to exemption or coerced into discharging their duty. The instrument of the recognition of a right to CO, we argue, is appropriately employed in a democracy to resolve conflicts between two contrasting moral duties both binding on the objector: a moral duty of conscience and a moral duty enforced by the law correlative to someone else's moral right. But, in this case, doctors' and pharmacists' professional duty to cooperate with the realization of a woman's right to reproductive self-determination is a mere consequence of the contingent current legal arrangement in Italy and by no means analytically derivable from the rights of women. Therefore, rather than focusing the discussion on whether we should grant doctors' and pharmacists' CO statutory recognition under the current legislation, this latter should be fundamentally questioned with a view to removing doctors' and pharmacists' monopolistic control over the provision of EHC in such a way that protects a woman's reproductive self-determination and prevents the question of doctors' and pharmacists' professional self-determination being engaged altogether.

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