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A PLAN C FOR PLAN B: A FEMINIST LEGAL RESPONSE TO THE WAYS IN WHICH BEHIND-THE-COUNTER EMERGENCY CONTRACEPTION FAILS WOMEN

*Amanda L. Allen**

Later I went back and asked the pharmacist why she wouldn't distribute [Plan B], and she said . . . it was against her religion, . . . And I asked her why, and she said, "I don't believe in abortion."¹

A society in which women lack control to plan when they have children is one in which women must remain second-class citizens.²

INTRODUCTION

On August 24, 2006, the Food and Drug Administration (“FDA”) approved Plan B, the brand-name drug sold for emergency contraception, for sale to pharmacy customers eighteen and over without a prescription.³ For the first time in FDA history, “a

* Fellow, Law Students for Reproductive Justice, 2008–2009. J.D., City University of New York School of Law, 2008. B.A., University of Minnesota, 2004. The author would like to thank Professor Caitlin E. Borgmann for her invaluable guidance in developing this Comment and for her position as an inspirational role model for feminist law students. The author would also like to thank Professor Ruthann Robson for her support and guidance through the writing and editing process. The author would finally like to thank the pro-choice activist community for its tireless efforts to improve access to emergency contraception. Making Plan B available without a prescription has helped to prevent unwanted and unintended pregnancies for countless women, including the author, and has facilitated the self-determination required to plan whether and when to have a family to women everywhere. For these reasons, access to Plan B is a legal issue that merits attention and requires continued examination and advocacy against discriminatory restriction of access.

¹ Interview with Carrie Baker, a Kroger customer who was refused Plan B in December 2006, June 12, 2007, http://www.youtube.com/watch?v=j5iicsr_19g (last visited Apr. 30, 2008).

² Cornelia T. L. Pillard, *Our Other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy*, 56 EMORY L.J. 941, 975 (2007).

³ See Letter from Steven Galson, Dir., FDA Ctr. for Drug Evaluation & Research, to Joseph A. Carrado, Vice President, Clinical Regulatory Affairs, Duramed Research, Inc., http://www.fda.gov/cder/foi/nda/2006/021045s011_Plan_B_APPROV.pdf. In its letter to the manufacturer of Plan B, which requested Plan B's approval for over-the-counter use, the FDA decided that “Plan B is safe and effective for use under the conditions set forth in the draft labeling submitted on August 23, 2006. This application is approved, effective on the date of this letter, to allow OTC availability of Plan B for consumers 18 years and older. Plan B remains available by prescription only for women 17 years and younger.” *Id.* at 2. The letter further determined that “[t]he sponsor and third party distributors, wholesalers, and chain drug companies will only

drug for which no prescription is required is available only in pharmacies and health clinics.”⁴ Further, by regulation, Plan B must be shelved behind the pharmacy counter; thus, a customer over the age of eighteen seeking this medication must still ask a pharmacist for it and show photo identification with proof of age in order to obtain it.⁵ A pharmacist with a “moral” or religious objection to emergency contraception can, therefore, still pose a barrier to a customer seeking to obtain it.⁶ My purpose in writing this Comment is to challenge both the actions of refusing pharmacists and the rule itself from a feminist legal perspective by mapping out a litigation strategy for women affected by the rule’s shortcomings.

In this Comment, I argue that the regulation permitting behind-the-counter sale of Plan B to customers over the age of eighteen precludes women from taking full advantage of the reproductive health services available to them, interferes with their right to choose whether and when to have children, and treats women differently than men as users of the medication while paradoxically on the same footing as purchasers. This Comment addresses two problems with the regulation. First, because the rule permits only behind-the-counter (rather than pure over-the-counter) sale of Plan B, pharmacists are in a unique position to decide whether they think the customer should receive the requested medication. Second, the rule surreptitiously adds an age requirement that was neither contemplated by the manufacturer

distribute Plan B to licensed pharmacies or other licensed healthcare clinics. As a result, Plan B will not be sold at gas stations or convenience stores. Given that Plan B will have both Rx and OTC [over-the-counter] labeling, the pharmacies will keep Plan B behind-the-counter.” *Id.* at 3.

⁴ Brief of Plaintiffs, *Tummino v. Von Eschenbach*, 427 F. Supp. 2d 212 (E.D.N.Y. argued Mar. 31, 2007) (No. CV 05-366 ERK/VVP), 2007 WL 1143253, at *1.

⁵ *Id.*; see also Plan B: Questions and Answers, <http://www.fda.gov/cder/drug/infopage/planB/planBQandA20060824.htm> [hereinafter Plan B: Questions and Answers] (last updated Dec. 14, 2006). True over-the-counter medications, by contrast, are “drugs that are available to consumers without a prescription” and those that “can be used without the help of a health care practitioner.” Over-the-Counter Drug Products, <http://www.fda.gov/cder/handbook/otcintro.htm> (last visited Mar. 3, 2008). The FDA notes that over-the-counter drugs generally share the following characteristics: “[T]heir benefits outweigh their risks[;] their potential for misuse and abuse is low[;] [the] consumer can use them for self-diagnosed conditions[;] they can be adequately labeled[;] [and] health practitioners are not needed for the safe and effective use of the product.” Office of Nonprescription Products, <http://www.fda.gov/cder/Offices/OTC/default.htm> (last visited Mar. 3, 2008).

⁶ One study revealed 180 refusals of this nature in the six-month period surveyed in 2004. Editorial, *Moralists at the Pharmacy*, N.Y. TIMES, Apr. 3, 2005, at D2; see also *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245 (W.D. Wash. 2007) (granting a preliminary injunction enjoining enforcement of Washington State regulations prohibiting a pharmacist from refusing fill a lawful prescription for religious or moral reasons).

nor medically justified, which hinders the access of young women and women without the required identification.

Part I of this Comment begins with an overview of Plan B as a drug, including a brief summary of the passage of the rule that allows behind-the-counter sale of Plan B, and considers its role in a larger political movement in which conservative lawmakers have attacked a woman's right to choose whether and when to have children from every imaginable perspective—including opposition to ordinary contraceptives. Part I also provides a feminist legal perspective to restrictions on women's reproductive choice. Part II of this Comment considers three broad ways to think about challenging the problem of pharmacy refusals, using New York law as a model. This Part explores various theories of relief upon which women who have been denied over-the-counter emergency contraception by a pharmacist exercising moral, instead of medical, judgment may recover. Part II concludes by considering the First Amendment implications of holding pharmacists civilly liable for refusing to dispense emergency contraception. Part III of this Comment discusses a lawsuit which challenges the rule's age restriction, problematizing in particular the way in which the age restriction privileges *both* age (adults) and gender (male purchasers/non-users) in ways that are unrelated to the use of the drug or its risks. Part III concludes by reintegrating a feminist legal theoretical perspective to the argument that the age restriction is unwarranted and by reiterating the importance of a feminist legal agenda that can affect change in women's lives.

I. BACKGROUND

The problem of pharmacist refusals is situated culturally in a time in which interrelated fears of non-procreative sex and sexually independent women are particularly pervasive and politicized.⁷ It has not just been emergency contraception that has received vigorous opposition from the religious right; cultural conservatives steadfastly oppose comprehensive sex education and virtually all

⁷ See generally CRISTINA PAGE, *HOW THE PRO-CHOICE MOVEMENT SAVED AMERICA: FREEDOM, POLITICS AND THE WAR ON SEX* (2006). Page explicitly rejects the notion of isolated, individual pharmacists acting on their own moral imperatives in denying emergency contraception and instead points to a broader cultural phenomenon: "[T]hese are not random acts. Behind each are the force and rhetoric of the pro-life movement." *Id.* at 3–4. Page argues that the conservative right's stance on abortion has blossomed into a war on birth control, sex education, and non-procreative sex in general in an effort to "end the lifestyle in which people have sex just for pleasure." *Id.* at 6, 29.

forms of birth control, including the condom.⁸ Indeed, in a time where federal guidelines suggest women of child-bearing age, and the medical professionals treating them, to be “pre-pregnant,”⁹ it is not surprising that the religious right has supported measures that would prevent or severely debilitate access to emergency contraception. Opponents of over-the-counter emergency contraception have argued that it is unsafe,¹⁰ will help spread sexually transmitted diseases,¹¹ causes abortions,¹² and even will encourage women to

⁸ *Id.* at 83–97. Page argues that the anti-choice movement relies on faulty data to support its contention that condom use fails to protect against HIV transmission. *Id.* at 83–85. The pro-life movement often cites a “31% failure rate” statistic based on a flawed University of Texas study on HIV transmission rates and condom use that was later corrected by the Centers for Disease Control and Prevention. *Id.* at 83. Page argues that the pro-life movement ignores science because it “fears that the availability of effective disease-prevention methods will undermine its larger agenda, promoting a world in which people are either abstinent or making babies.” *Id.* at 85. *See also* Condom Warnings—Beware!!!, <http://www.prolife.com/condoms.html> (last visited Apr. 14, 2007) (claiming that “[t]he average condom failure rate in the 11 [University of Texas] studies for preventing transmission of the AIDS virus was 31%” and “a variety of studies have found that condoms have an ‘annual failure rate’ of 10% to 36% when it comes to preventing pregnancy”); UNITED FOR LIFE, COULD CONDOMS LEAK HIV? (2003), <http://www.unitedforlife.com> (follow Leaflets hyperlink) (last visited Feb. 24, 2007) (“Since women can only get pregnant during 5-7 days, (1/4) of their 28 day menstrual cycle, and cannot get pregnant during the other 21 days, these condom failure rates could be multiplied by four to get the ‘overall failure rate’ which gives at least a 60% failure rate for the average population of condom users and at least an 80% failure rate for young teenagers.”). This cultural conservatism is reflected in federal funding for abstinence programs. *See* Kim Shayo Buchanan, *Lawrence v. Geduldig: Regulating Women’s Sexuality*, 56 EMORY L.J. 1235, 1259-60 (2007) (describing “abstinence-only-until-marriage” programs which are “required to suppress all information about condoms and other modern forms of contraception, except failure rates.”).

⁹ January W. Payne, *Forever Pregnant: Guidelines: Treat Nearly All Women as Pre-Pregnant*, WASH. POST, May 16, 2006, at F1, available at http://www.washingtonpost.com/wpdyn/content/article/2006/05/15/AR2006051500875_pf.html (“New federal guidelines ask all females capable of conceiving a baby to treat themselves—and to be treated by the health care system—as pre-pregnant, regardless of whether they plan to get pregnant anytime soon.”).

¹⁰ *See, e.g.*, MOIRA GAUL & CHRIS GACEK, PLAN B: A GRAVE THREAT TO WOMEN’S HEALTH 1–2 (Family Research Council 2006), available at <http://www.physiciansforlife.org/content/view/1161/36/> (last visited Apr. 7, 2008) (citing concerns about the “clear lack of scientific studies on the long-term-effects of Plan B”). *See also* PAGE, *supra* note 7, at 110–11. During a December 2003 joint meeting of FDA advisory panels to review the Plan B application, panelist David Hager, the pro-life obstetrician-gynecologist and chair of the Physicians Resources Council at Focus on the Family, expressed grave concerns that the safety of emergency contraception had not yet been adequately established for a nine or ten-year-old girl. *Id.* at 105–10.

¹¹ PAGE, *supra* note 7, at 113 (noting that forty-nine pro-life members of Congress urged President Bush in a letter to reject Barr’s application to make Plan B available over the counter because “easier access to EC ‘may ultimately result in significant increases in cancer, infertility, and HIV/AIDS.’”). *See also* GAUL & GACEK, *supra* note

fabricate rape allegations in order to obtain emergency contraception in the hospital.¹³

In reality, the concerns of opponents of over-the-counter emergency contraception are largely overstated and serve to mask the need for unencumbered access to Plan B. Plan B is safe and effective.¹⁴ Plan B does not cause abortions.¹⁵ Plan B works by preventing the release of an egg from the ovary, or by preventing fertilization or implantation, and does not affect an already-fertil-

10, at 2 (claiming that STD rates have “skyrocketed” in countries where Plan B has been deregulated).

¹² See, e.g., Hearing Before the Nonprescription Drugs Advisory Comm. and Advisory Comm. for Reproductive Health Drugs (Dec. 16, 2003) (statement of Judie Brown, President of American Life League), available at www.fda.gov/ohrms/dockets/ac/03/transcripts/4015T1.doc. Brown stated in her testimony before the joint advisory committees to the FDA that emergency contraception “act[s] to prevent pregnancy by aborting a child. For this reason alone the pill should not be available under any circumstance and certainly not over the counter.” *Id.* at 204.

¹³ Julia C. Martinez, *Seeking Court Help on Amendment 41*, DENVER POST, Feb. 4, 2007, available at http://www.denverpost.com/opinion/ci_5157469. Martinez reported that Colorado State Senator David Schultheis, at a Senate Health and Human Services Committee hearing, “asked the sponsor of a bill requiring hospitals to give information on emergency contraception to rape victims how doctors ‘determine that a person actually did incur that sexual assault. Are they going to take the word of that individual?’” *Id.* Senator Schultheis was then reported to have said, “‘You could see individuals coming in that just wanted to make sure that last night’s [one-night] stand didn’t result in a pregnancy and basically say that they had been a sexual assault [victim]’ to get the contraceptive.” *Id.*

¹⁴ See, e.g., David G. Weismiller, *Emergency Contraception*, 70 AM. FAMILY PHYSICIAN 707, 710 (2004) (“the true effectiveness rate [of emergency contraception] is likely to be at least 75 percent.”). In terms of safety, “[n]o contraindications to hormonal emergency contraception exist.” David A. Grimes & Elizabeth G. Raymond, *Emergency Contraception*, 137 ANNALS OF INTERNAL MEDICINE 180, 183 (2002). See also Taunya English, *Emergency Contraception Does Not Reduce Unintended Pregnancy Rate*, HEALTH BEHAVIOR NEWS SERVICE, Apr. 17, 2007, <http://www.hbns.org/getDocument.cfm?documentID=1483> (last visited Feb. 11, 2008) (“advance provision of [emergency contraception] has no harmful effects in terms of risky sexual behaviors.”) (quoting Chelsea Polis, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health). Ms. Polis was lead reviewer on a study “evaluating advance provision of emergency contraception to explore effects on pregnancy rates, sexually transmitted infections, and sexual and contraceptive behaviors.” See Chelsea A. Polis et al., Review, *Advance Provision of Emergency Contraception for Pregnancy Prevention: A Meta-Analysis*, 110 OBSTETRICS & GYNECOLOGY 1379 (Dec. 2007).

¹⁵ See DURAMED PHARMACEUTICALS, INC., BARR PHARMACEUTICALS, INC., PRODUCT INFORMATION FOR PLAN B 7 (2006), available at <http://www.fda.gov/cder/foi/label/2006/021045s011lbl.pdf> [hereinafter PRODUCT INFORMATION FOR PLAN B] (“There is no medical evidence that Plan B would harm a developing baby. If you take Plan B accidentally after you are already pregnant, or it does not work and you become pregnant, it is not likely to cause any harm to you or your pregnancy. Plan B should not have any effect on a pregnancy after implantation.”) (original product packaging and information on file with author). See also Weismiller, *supra* note 14, at 709 (“The data do not suggest that use of oral contraceptives can interrupt an established pregnancy.”).

ized egg that has attached to the uterus.¹⁶ Plan B also has no known contraindications.¹⁷ Studies indicate that even the repeated use of emergency contraception is unlikely to be harmful.¹⁸ What is indisputably true about emergency contraception, besides that it is safe, effective, and prevents unwanted pregnancies, is its time-sensitive nature.¹⁹ Plan B must be taken “as soon as possible, but no later than [three] days . . . after unprotected sex.”²⁰ Especially for women living in rural areas and women who do not have access to convenient or inexpensive transportation, barriers such as pharmacist refusals and the identification requirement pose problematic obstacles to women seeking emergency contraception.²¹

Not only is emergency contraception completely safe and effective on an individual patient level, but its availability would also benefit society at large. It is estimated that the widespread use of emergency contraception could prevent approximately two million unplanned pregnancies and one million abortions each year in the

¹⁶ Plan B: Questions and Answers, *supra* note 5; *see also* Grimes & Raymond, *supra* note 14. Grimes and Raymond explain:

When taken before ovulation, emergency contraceptive pills prevent ovulation in some women Additional mechanisms proposed for medical emergency contraception regimens include changes to the cervical mucus that result in trapping of sperm; alterations in the transport of sperm, egg, or embryo through the reproductive tract; interference with corpus luteum function; and direct inhibition of fertilization.

Id. at 182.

¹⁷ Grimes & Raymond, *supra* note 14, at 183; *see also* Weismiller, *supra* note 14, at 710–11 (noting that, according to the World Health Organization, pregnancy is a contraindication, and the American College of Obstetricians and Gynecologists identify three possible additional contraindications).

¹⁸ Grimes & Raymond, *supra* note 14, at 186.

¹⁹ Weismiller, *supra* note 14, at 707 (2004) (“Immediate use of an emergency contraceptive reduces a woman’s risk of pregnancy to 1 to 2 percent.”). *See also id.* at 709.

²⁰ PRODUCT INFORMATION FOR PLAN B, *supra* note 15, at 6. However, there is evidence that Plan B works up to five days after unprotected sex. *See, e.g.*, Grimes & Raymond, *supra* note 14, at 183.

²¹ ACLU OF KENTUCKY, EMERGENCY CONTRACEPTION ACCESS: A SURVEY OF KENTUCKY PHARMACIES (Mar. 9, 2007), <http://aclu-ky.org/content/view/192/59> (last visited Apr. 28, 2008). The findings of the Kentucky ACLU after doing a survey of state pharmacies was that “[s]ix counties offered no access to Plan B at all. This is a serious problem for any woman seeking a time sensitive medication, but especially for women in rural areas where the closest pharmacy with Plan B in stock could be 100 miles away.” *Id.* *See also* NARAL PRO-CHOICE WASHINGTON FOUNDATION, 2008 EMERGENCY CONTRACEPTION ACCESS PROJECT REPORT, <http://www.prochoicewashington.org/assets/files/ecaccessprojectfactsheet.pdf> (“In rural areas, the distance between pharmacies can be a serious burden. The availability, time and cost of transportation are all factors that can negatively impact a woman’s ability to travel to multiple pharmacies in hopes of receiving a needed, time-sensitive medication.”).

United States alone.²² Convenient and unencumbered access to emergency contraception is also vital for survivors of rape.²³

Attempts to limit women's access to emergency contraception are not related to science, they are not about medicine, and they are not about protecting women's health. Beneath the rhetoric about drug safety and concern about sexually transmitted diseases (but without providing any real options about disease prevention beyond abstinence)²⁴ lies a deep-seated fear of sexually autonomous women making choices about their bodies and their lives.²⁵ The ideological encouragement and legal support of barriers to access to emergency contraception is a telling illustration of the religious right's thinly-veiled contempt for women.²⁶

A. *The Morning-After Conspiracy*²⁷

The process by which Plan B obtained behind-the-counter approval from the FDA was both highly politicized and highly gendered.²⁸ Distrust and disdain for women are apparent in the saga of Plan B's approval for behind-the-counter purchase. This section provides a brief overview of the irregularities in the FDA's decisionmaking regarding making Plan B available over-the-counter.²⁹

²² James Trussell et al., *Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies*, 24 FAM. PLAN. PERS. 269, 270 (1996).

²³ See Planned Parenthood—Refusal Clauses: A Threat to Reproductive Rights, <http://www.plannedparenthood.org/issues-action/birth-control/refusal-clauses-6544.htm> (last visited Mar. 3, 2008) (“An estimated 25,000 unintended pregnancies each year are a result of sexual assault. Approximately 22,000 of these pregnancies could be prevented if all women who were raped were provided with [emergency contraception].”).

²⁴ See, e.g., PAGE, *supra* note 7, at 69–70 (discussing abstinence-only programs in Texas during Bush's term as governor).

²⁵ See generally *id.* at 121–44 (“They [pro-life groups such as Population Research Institute] feared that women, availing themselves of family planning, might participate as equals in society. The real worry was that these women would become independent and ambitious, thinking and acting for themselves.”) *Id.* at 143.

²⁶ See *id.*

²⁷ The Morning-After Pill conspiracy is a “coalition of feminist organizations that have been leading the grassroots charge to make the morning-after pill available over-the-counter for all women.” DARA MAYERS, CTR. FOR REPRODUCTIVE RIGHTS, MORNING-AFTER PILL CONSPIRACY: INTERVIEW WITH ANNIE TUMMINO (2006), http://www.reproductiverights.org/crt_contraception_ec_tummino.html (last visited Apr. 28, 2008).

²⁸ See, e.g., Buchanan, *supra* note 8, at 1239–54 (arguing that “[s]exual regulation has always been gendered” as manifested in paternity laws, obscenity jurisprudence, and the criminalization of sex toys).

²⁹ For a more in-depth analysis of the FDA's process in reviewing the Plan B applications for over-the-counter approval, see PAGE, *supra* note 7, at 99–119. See also Gil-

Plan B was first approved for prescription use in 1999.³⁰ In 2001, the Center for Reproductive Rights, on behalf of a group of women's health and medical associations, filed a Citizen's Petition requesting that the FDA switch Plan B and another emergency contraceptive drug, Preven, from prescription to over-the-counter status.³¹ The FDA delayed action on this "switch" petition for five years and finally denied it on June 9, 2006.³² This denial was issued during discovery in *Tummino v. von Eschenbach*,³³ filed on January 21, 2005, in which plaintiffs challenged the FDA's failure to make Plan B available over-the-counter for women of all ages.

In April 2003, Women's Capital Corporation submitted an application to the FDA requesting the same relief from the FDA: approval of Plan B for pure over-the-counter ("OTC") use.³⁴ In December 2003, FDA's joint advisory committee voted to approve this application in a vote of twenty-three to four.³⁵ Additionally, FDA review staff "agreed that Plan B should be granted OTC status."³⁶ However, on May 6, 2004, the Acting Director for the FDA's Center for Drug Evaluation and Research signed a letter denying this application, in direct conflict with the recommendations of the two FDA committees.³⁷

The Government Accountability Office ("GAO") reviewed the FDA's "not-approvable" decision because of these inconsistencies.³⁸ In reviewing this decision, the GAO found that:

[F]our aspects of FDA's review process were unusual: officials who would normally have been responsible for signing an action letter disagreed with the decision and did not sign the not-approvable letter for Plan B; high-level management was more in-

lian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865, 876-82 (2007) (describing the deviation from standard FDA procedures for Plan B's over-the-counter application).

³⁰ Plan B: Questions and Answers, *supra* note 5.

³¹ Citizen's Petition (Feb. 14, 2001), *available at* http://www.reproductiverights.org/pdf/EC_petition.pdf.

³² Letter from Randall W. Lutter, Assoc. Comm'r for Policy and Planning, Food & Drug Admin., to Bonnie Scott Jones & Simon Heller, Ctr. for Reproductive Rights (June 9, 2006), *available at* <http://www.fda.gov/ohrms/dockets/dockets/01p0075/01p-0075-pdn001-vol348.pdf>.

³³ 427 F. Supp. 2d 212 (E.D.N.Y. 2006).

³⁴ U.S. GOV'T ACCOUNTABILITY OFFICE, FOOD & DRUG ADMIN., DECISION PROCESS TO DENY INITIAL APPLICATION FOR OVER-THE-COUNTER MARKETING OF THE EMERGENCY CONTRACEPTIVE DRUG PLAN B WAS UNUSUAL 1 (2005), *available at* <http://www.gao.gov/new.items/d06109.pdf> [hereinafter G.A.O. REPORT].

³⁵ *Id.* at 2.

³⁶ *Id.* at 2.

³⁷ *Id.* at 13.

³⁸ *See id.* at 3.

volved than for other OTC switch applications; conflicting accounts exist of whether the decision to not approve the application was made before the reviews were completed; and the rationale for the not-approvable decision was novel and did not follow FDA's traditional practices.³⁹

In addition to the decision's departure from the FDA's usual administrative procedures generally, the decision also departed from the FDA's particular patterns with respect to switch applications: the GAO concluded that "the decision not to approve the Plan B OTC switch application was not typical of the other 67 prescription-to-OTC switch decisions made from 1994 through 2004."⁴⁰

The fourth aspect of the FDA's decisionmaking that was unusual, according to the GAO, is perhaps most troubling. A part of the novelty of the decision involved the FDA's use of assumptions, not data, about adolescent use of Plan B.⁴¹ For example, in providing support for its decision to deny the switch application, the Acting Director of the Center for Drug Evaluation and Research ("CDER") expressed concerns that "increased access to Plan B could potentially result in an increase in unsafe sexual activity, particularly among younger adolescents."⁴² The CDER Acting Director also noted that younger adolescents constitute an "age group . . . that has a tendency to engage in risky behaviors because of their level of cognitive development."⁴³ This is particularly troubling because adolescents had, in fact, *been studied* to determine whether they could safely take Plan B—and the adolescents studied were able to comprehend the label just as well as adult women.⁴⁴ These assumptions have translated into decreased access to Plan B for young women.

Another aspect of the approval process that caused concern among reproductive rights advocates was President Bush's decision to fill the vacancies on the FDA's Reproductive Health Drugs Com-

³⁹ *Id.* at 13.

⁴⁰ *Id.* at 5.

⁴¹ It is crucial to ensure young women have access to contraceptive services, as various factors particular to young women, including age, income, and family relationships, interact in contributing to the prevalence of teen pregnancy.

⁴² G.A.O. REPORT, *supra* note 34, at 23.

⁴³ *Id.* at 23.

⁴⁴ PAGE, *supra* note 7, at 111 ("Females from twelve to fifty had been sampled, including seventy-six between twelve and sixteen years old. Adolescents understood 60 to 97 percent of the drug-product package directions and materials, at a comprehension level similar to that of women as a whole and one that easily met standards previously accepted for the approval of other over-the-counter drugs." (citation omitted)).

mittee with pro-life appointees,⁴⁵ appointments that played an important role in the FDA's delay in reviewing applications to bring Plan B over-the-counter.⁴⁶ Numerous statements, made by FDA officials, suggest that the decision-making process was influenced by conservative political and even religious ideologies, rather than the tenets of science and medicine. For example, Dr. W. David Hager, a pro-life obstetrician-gynecologist appointed to serve on the FDA's Reproductive Health Drugs Committee, gave a speech six months after the FDA's initial rejection of the over-the-counter switch application, saying:

I was asked to write a minority opinion that was sent to the commissioner of the FDA . . . I argued from a scientific perspective, and God took that information, and he used it through this minority report to influence the decision. Once again, what Satan meant for evil, God turned into good.⁴⁷

Another FDA official, Dr. Janet Woodcock, was reported to have told a group of FDA employees—regarding agency concerns about approving Plan B for over-the-counter use—that “‘we could not anticipate or prevent extreme promiscuous behaviors such as the medication taking on ‘urban legend’ status that would lead adolescents to form sex-based cults centered around the use of Plan B.’”⁴⁸

Overall, the way in which the FDA handled the over-the-counter switch application was palpably suspicious. Revealingly, U.S. Magistrate Judge Viktor Pohorelsky, in granting the *Tummino* plaintiffs' request to subpoena certain White House documents, ruled that the plaintiffs demonstrated a “strong preliminary showing of ‘bad faith or improper behavior’” by the FDA in its decision-making around Plan B.⁴⁹ Feminist legal theorists may view the FDA decision as indicative of more than just bad faith, however: the agency's conduct may be symptomatic of the broader dilemma

⁴⁵ *Id.* at 104–05.

⁴⁶ *Id.* at 104–06 (President Bush appointed Dr. Joseph Sanford, a physician who “refuses to prescribe the birth control pill because he believes it is ‘incompatible with Christian values’”; Dr. Susan Crockett, co-author of the essay, “Using Hormone Contraceptives Is a Decision Involving Science, Scripture, and Conscience”; and Dr. W. David Hager, who reportedly refuses to prescribe contraceptives to unmarried women, chairs the Physicians Resources Council at Focus on the Family, and advises Concerned Women for America and the Medical Institute for Sexual Health in their campaign against the condom).

⁴⁷ *Id.* at 117–18.

⁴⁸ See, e.g., Jon Carroll, Opinion, S.F. CHRON., May 15, 2006, at E8, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=/Chronicle/archive/2006/05/15/DDGKAIHDPR1.DTL> (quoting FDA official Janet Woodcock).

⁴⁹ 427 F. Supp. 2d at 231–32.

facing women's rights advocates in which, time and time again, legal norms disregard the realities and complexities of women's lives. At the very least, the ways in which the FDA decision privileged antiquated views about women's and girls' sexuality along with the ideological agenda of a conservative presidential administration over science, medicine, and women's health offers support for the feminist critique of the law as an inherently patriarchal institution.

B. A Feminist Critique of Barriers to Reproductive Choice

Feminist legal theorists argue that access to reproductive services is fundamental to women's equality.⁵⁰ In doing so, these feminists affirm that the ability to wholly control family planning affects a broad range of issues of import to women's lives, including education, employment opportunities, women's general health and well-being, and sexual freedom.⁵¹ Thus, a feminist legal analysis of reproductive rights examines and challenges the ways in which the laws burdening reproductive choice rely on archaic stereotypes of "women's place" in the home.⁵² Reproductive choice recognizes that women do not exist merely to care for others and recognizes women's decisional autonomy to make the best choices for themselves and their families.⁵³

⁵⁰ See Pillard, *supra* note 2, at 945 ("Reproductive rights, including the rights to contraception and abortion, play a central role in freeing women from historically routine conscription into maternity. It is reproductive rights that have begun to allow women to decide whether and when to follow the path of motherhood."); Catharine A. MacKinnon, *Reflections on Sex Equality under Law*, 100 *YALE L.J.* 1281, 1322–28 (1991) (citing *Morgenthaler v. The Queen*, [1988] 1 S.C.R. 30, 172 (Wilson, J., concurring)) ("Reproductive control is properly 'an integral part of modern woman's struggle to assert her dignity and worth as a human being.'"); Buchanan, *supra* note 8, at 1269 ("[L]aws [restricting a woman's access to contraception or abortion] burden women with the reproductive consequences of sex when they would otherwise be free to avoid them. With few exceptions, our laws do not do this to heterosexual men." (citation omitted)).

⁵¹ Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 *EMORY L.J.* 815, 819 (2007) ("[Reproductive choice] crucially affects women's health and sexual freedom, their ability to enter and end relationships, their education and job training, their ability to provide for their families, and their ability to negotiate work-family conflicts in institutions organized on the basis of traditional sex-role assumptions that this society no longer believes fair to enforce, yet is unwilling institutionally to redress.").

⁵² MacKinnon, *supra* note 50, at 1312–13 ("After childbirth, women tend to be the ones who are primarily responsible for the intimate care of offspring—their own and those of others. Social custom, pressure, exclusion from well-paying jobs, the structure of the marketplace, and lack of adequate daycare have exploited women's commitment to and caring for children and relegated women to this pursuit which is not even considered an occupation but an expression of the X chromosome.").

⁵³ See Siegel, *supra* note 51, at 819.

The feminist critique of barriers to women's reproductive choice also problematizes the patriarchal norms which simultaneously privilege women's domestic responsibility and tolerate men's sexual irresponsibility, and connect those norms to legal, social, and institutional barriers to reproductive choice. For example, legal scholar Cornelia Pillard notes that "[p]eople generally still view child rearing as women's gratification and their domain, and accept men's failure to do [so] and value it as personal, private choice, off-limits to criticism."⁵⁴ Similarly, legal scholar Kim Shayo Buchanan notes that "[t]he legal coercion of sexual morality is typically interpreted in a way that requires the control, surveillance, and punishment of women, but rarely of men."⁵⁵

Some feminists have argued that a sex equality standpoint on reproductive rights is crucial in that it enables people to see "how reproductive rights are a hinge pin between liberty and equality."⁵⁶ Constitutional law scholar Reva Siegel argues that "[a] sex equality analysis of reproductive rights views the social organization of reproduction as playing a key role in determining women's status and welfare and insists—custom notwithstanding—that government regulate relationships at the core of the gender system in ways that respect the equal freedom of men and women."⁵⁷ Siegel further argues that a sex equality standpoint on reproductive rights simultaneously problematizes the way in which "custom" shapes the sex roles of men and women and destabilizes the gendered norms that structure parenting.⁵⁸ Feminist legal scholar Catharine MacKinnon, also arguing from a sex equality standpoint, demands a recontextualization of pregnancy from the point of view of the pregnant woman.⁵⁹ Finally, the sex equality standpoint "appreci-

⁵⁴ Pillard, *supra* note 2, at 943. See also Buchanan, *supra* note 8, at 1239–40 ("While the law extends a marked solicitude to the right of men to have nonmarital sex without incurring unwanted reproductive consequences, it visits the legal, financial, health, and reproductive burdens of unmarried sex exclusively on women and attributes the disparate treatment to nature.") (citations omitted).

⁵⁵ Buchanan, *supra* note 8, at 1241.

⁵⁶ Pillard, *supra* note 2, at 941. Pillard continues, "Women need practical access to a range of reproductive choices to enjoy sex equality, yet they need equality to make reproductive decisions freely and in ways that are responsible to themselves, those they love, and the broader society." *Id.*

⁵⁷ Siegel, *supra* note 51, at 815.

⁵⁸ See *id.* at 817–18.

⁵⁹ MacKinnon, *supra* note 50, at 1309 ("Grounding a sex equality approach to reproductive control requires situating pregnancy in the legal and social context of sex inequality and capturing the unique relationship between the pregnant woman and her fetus. . . . The social conception of pregnancy that has formed the basis for its legal treatment has not been from the point of view of the pregnant woman, but rather from the point of view of the observing outsider, gendered male.").

ate[s] that there is both practical and dignitary significance to the decisional control that reproductive rights afford women, and that such control matters more to women who are status marked by reason of class, race, age, or marriage.”⁶⁰

Broadening the services considered to exist in the “bundle” of reproductive rights to include contraceptive equity issues necessarily recognizes that “the unwantedness of a pregnancy and the demand for abortion do not occur in a vacuum.”⁶¹ Feminists oppose laws which restrict access to contraception “to the extent that such laws presuppose or entrench customary, gender-differentiated norms concerning sexual expression and parenting.”⁶² Some feminists also stress the importance of contraceptive access because of the comparable benefits of pregnancy prevention over abortion.⁶³ Thus, in viewing contraceptive access issues with a feminist lens, it is clear that “[t]he law should clearly affirm women’s right to use contraception to control when and whether they become pregnant as an indispensable element of sex equality.”⁶⁴

Various aspects of the passage of the FDA rule permitting behind-the-counter sale of Plan B—from the time it took for the agency to review the switch application to the way the rule itself characterizes and patronizes young women—provide support for the feminist critique of legal standards which burden women’s reproductive choice. The slow pace the agency took in reviewing the various switch applications suggests that politics—not women’s health—are the primary motivation of governmental decision-making; these politics have a disdain for sexual autonomy and independence of women. The fact that the agency declined to follow its own procedures in order to impede access to Plan B demonstrates the government’s refusal to “[e]qually meet[] women’s health needs, whether they are the same as men’s or distinctive . . . [which] is a critical aspect of treating women as equal human beings.”⁶⁵ Finally, the behind-the-counter status granted to Plan B transferred the power from the hands of the woman-consumer to

⁶⁰ Siegel, *supra* note 51, at 819.

⁶¹ Pillard, *supra* note 2, at 943.

⁶² Siegel, *supra* note 51, at 821.

⁶³ See, e.g., Pillard, *supra* note 2, at 963 (“Compared to abortion, contraception is generally safer, easier on women’s bodies, more private, less expensive, and draws fewer religious or moral objections.”) (footnote omitted).

⁶⁴ *Id.* at 942.

⁶⁵ *Id.* at 964 (identifying contraceptive inequality based on gender in the context of health insurance coverage). See also MacKinnon, *supra* note 50, at 1323 (“Sex equality would be advanced if women were permitted to control sexual access to their bodies long before an unwanted pregnancy.”).

the hands of the pharmacist, without providing protections to women for pharmacist refusals. The next section explores the problem of pharmacist refusals—a problem whose roots lie in the FDA rulemaking itself, as the FDA without any medical rationale invented Plan B's behind-the-counter status.⁶⁶ This section explores this problem from a legal advocacy perspective, considering the various causes of action that could be asserted against a refusing pharmacist.

II. THE OBLIGATION OF PHARMACISTS TO DISPENSE LAWFULLY REQUESTED MEDICATIONS: EXPLORING THE CAUSES OF ACTION AVAILABLE AGAINST A REFUSING PHARMACIST

One of the ways in which the rule providing for behind-the-counter access to emergency contraception is flawed is that it provides an opportunity for pharmacists to let a religious or moral objection to emergency contraception interfere with their obligation to dispense lawfully requested medication. This section's aim is to provide a litigation strategy to challenge such pharmacist refusals in a number of different contexts, using New York state law as a model. Each theory of relief has its strengths and has its shortcomings, but they all strive to hold refusing pharmacists accountable for breaching a duty owed to the customer. In discussing the potential forms of relief for a pharmacy customer who has been refused Plan B, this section considers professional causes of action, including professional misconduct and patient abandonment or neglect; administrative causes of action; and private causes of action, including sex discrimination, wrongful conception, and breach of fiduciary duty. This section concludes by considering the relationship between the causes of action discussed and the First Amendment implications of challenging pharmacist refusals.

A. *Professional Causes of Action*

On August 15, 2006, the New York Civil Liberties Union (“NYCLU”) filed a complaint with the Office of the Professions at the New York State Department of Education, the state agency responsible for regulating the licensing of pharmacists and the investigation of professional misconduct, against three pharmacists who refused to refill prescriptions for emergency contraception prescribed by a medical professional.⁶⁷ The complaint alleges respon-

⁶⁶ See generally G.A.O. REPORT, *supra* note 34, at 15–16 (providing a timeline for the major events relating to the initial over-the-counter switch application for Plan B).

⁶⁷ N.Y. CIVIL LIBERTIES UNION, REPRODUCTIVE RIGHTS PROJECT, RE: COMPLAINTS BY

dent pharmacists violated “the New York State pharmacy laws and regulations, professional guidelines, and New York State Human Rights Law.”⁶⁸ Although emergency contraception is now available behind the counter for patients over the age of eighteen, the professional causes of action alleged in the complaint are viable theories of relief for women who have been refused emergency contraception when they try to obtain it from a pharmacist.

To file a complaint against a pharmacist, an aggrieved customer may fill out a complaint form available at the Office of the Profession’s web site.⁶⁹ The relief available under a professional cause of action is professional sanctions.⁷⁰ A pharmacist found guilty of professional misconduct⁷¹ or patient abandonment or neglect⁷² is subject to the sanctions prescribed in New York Education Law § 6511, including suspension, revocation, or annulment of license and fines.⁷³

1. Professional Misconduct

In New York, it is professional misconduct for a pharmacist to “[p]ractice the profession . . . beyond its authorized scope.”⁷⁴ Pharmacists are authorized to refuse to dispense a prescription if, in their professional judgment, “potential adverse effects, interactions or other therapeutic complications could endanger the health of the patient.”⁷⁵ This language suggests that the scope of a pharmacist’s discretion is confined to the health and safety of the patient.

Denial of over-the-counter emergency contraception based on the pharmacist’s moral or religious beliefs is clearly beyond the authorized scope of the profession, as such beliefs are not at all re-

MARC HELLER, CLAUDINA ASHELMAN-OWEN & COLLEEN SHAW AGAINST MATT WEAVER, ANDREA BARCOMB & LISA MCGUINNESS (Aug. 15, 2006), *available at* http://www.nyclu.org/pdfs/rtp_ec_complaints_complaintletter_081506.pdf [hereinafter N.Y.C.L.U. compl.].

⁶⁸ *Id.* at 1.

⁶⁹ OFFICE OF THE PROFESSIONS, N.Y. STATE EDUC. DEP’T, PROF’L. DISCIPLINE COMPLAINT FORM (Oct. 2006), <http://www.op.nysed.gov/opd-complaint.pdf>. See generally Office of the Professions, N.Y. State Educ. Dep’t, <http://www.op.nysed.gov/opd.htm> (last visited Apr. 28, 2008) (explaining New York’s professional discipline system and listing e-mail and telephone contact information). Complainants may also send an e-mail to conduct@mail.nysed.gov.

⁷⁰ N.Y. EDUC. LAW § 6511 (McKinney 2001).

⁷¹ *Id.* § 6509.

⁷² N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2(a)(1) (2005).

⁷³ N.Y. EDUC. LAW § 6511.

⁷⁴ *Id.* § 6509(2).

⁷⁵ N.Y. COMP. CODES R. & REGS. tit. 8, § 63.6(b)(8)(i)(e) (2003).

lated to the health of the patient.⁷⁶ Thus, pharmacists who refuse to provide customers emergency contraception, without providing immediate and realistic alternatives, are committing professional misconduct and are subject to the sanctions prescribed by regulation. For example, the respondent pharmacists named in the NYCLU complaint allegedly refused to honor the complaining patients' refill prescriptions because women needing emergency contraception were "being irresponsible" and that obtaining emergency contraception "should be inconvenient" for women.⁷⁷ In doing so, the respondent pharmacists were substituting their own subjective and judgmental opinions about the patient for that which is authorized by law—professional judgment relating to the patient's health. As the NYCLU argued, these types of assumptions "are based on unjustified and unsupported judgments about the women's sexual behavior"⁷⁸ and "impl[y] the view that women who need [emergency contraception] deserve to get pregnant."⁷⁹

Pharmacists' refusals of this type are inherently embedded with these types of problematic assumptions about the customer's sexual "irresponsibility" or practices and as such are beyond the authorized scope of the pharmacists' practice. Additionally, refusals based on sincerely held religious opposition to emergency contraception likely also amount to professional misconduct because such opposition is not related to the health of the patient. Accordingly such pharmacist refusals likely constitute professional misconduct under New York rules and regulations.

2. Patient Abandonment or Neglect

Committing unprofessional conduct as defined by state rules or regulations is also grounds for sanctions prescribed by New York Education Law § 6511.⁸⁰ For example, it is professional misconduct for a pharmacist to "abandon[] or neglect[] a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care."⁸¹ A guideline interpreting this provision provides that refus-

⁷⁶ *But see Stormans*, 524 F. Supp. 2d at 1266 (granting preliminary injunction enjoining regulation requiring pharmacists to dispense medications even if the pharmacist has a religious or moral reason to refuse to do so on the issue of free exercise of religion). For a more in-depth discussion of *Stormans*, see *infra* Part II.D.

⁷⁷ N.Y.C.L.U. compl., *supra* note 67, at 6.

⁷⁸ *Id.* at 9.

⁷⁹ *Id.* at 10.

⁸⁰ N.Y. EDUC. LAW § 6509(9) (McKinney 2001).

⁸¹ N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2(1) (2005).

ing to fill a prescription without providing a prompt referral constitutes “abandonment and neglect” within the meaning of the regulation.⁸² This guideline provides that “the pharmacist has a professional obligation to take appropriate steps to avoid the possibility of abandoning or neglecting a patient” when that pharmacist recognizes a moral belief will pose a barrier to filling a patient’s prescription.⁸³ Thus a pharmacist’s morally based refusal to allow a customer to purchase Plan B, without ensuring that another pharmacist can provide the customer with Plan B as soon as possible, would likely constitute unprofessional conduct proscribed by New York rules and regulations.

A customer who was denied emergency contraception, then, could file a complaint with the Office of the Professions alleging the pharmacist committed professional misconduct and abandoned or neglected a patient. A customer may want to do this in order to save the time and expense of litigation: filing a complaint is simple and does not require an attorney.⁸⁴ On the other hand, the prospect of professional sanctions—which include suspension, revocation, or annulment of the pharmacist’s license and fines⁸⁵—may not feel like an adequate remedy for a woman who has been denied emergency contraception, as they may punish the refusing pharmacist but do nothing to remedy the harm she personally suffered.

B. Administrative Remedies

1. Unlawful Sex Discrimination in Public Accommodations

By New York regulation, it is illegal to discriminate on the basis of sex in a place of public accommodation.⁸⁶ A pharmacy is governed under these regulations as a place of public accommodation, as the statute governs “wholesale and retail stores and estab-

⁸² Memorandum from Lawrence H. Mokhiber, Executive Secretary, Pharmacy Bd., N.Y. State Office of the Professions, to Supervising Pharmacists Policy Guideline Concerning Matters of Conscience (Nov. 18, 2005), <http://www.op.nysed.gov/pharm/conscienceguideline.htm> (last visited Mar. 3, 2008).

⁸³ *Id.*

⁸⁴ *See supra* note 69.

⁸⁵ N.Y. EDUC. LAW § 6511.

⁸⁶ N.Y. EXEC. LAW § 296(2)(a) (McKinney 2007). “It shall be an unlawful discriminatory practice for any person, being the owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation, resort or amusement, because of the . . . sex . . . of any person, directly or indirectly, to refuse, withhold from or deny to such person any of the accommodations, advantages, facilities or privileges thereof” *Id.*

ishments dealing with goods or services of any kind.”⁸⁷ A woman who was refused emergency contraception in a pharmacy could argue that such denial constitutes sex-based discrimination in a place of public accommodation in violation of New York state law.⁸⁸

The provisions of the state anti-discrimination law are enforced through the New York State Division of Human Rights (“DHR”). To file a complaint with the DHR, the aggrieved person must submit a complaint which indicates the name and address of the person alleged to have committed the unlawful discriminatory practice complained of and describing the discriminatory practice.⁸⁹ The agency then has 180 days to determine whether there is probable cause to believe that the respondent engaged in unlawful discriminatory practice.⁹⁰ If the probable cause standard is met, the respondent will then be required to report to a hearing conducted by the DHR.⁹¹ After the hearing, the DHR commissioner has 180 days to determine whether the respondent committed the alleged unlawful discrimination.⁹² The statute also prescribes a one-year statute of limitations.⁹³ Complainants may obtain judicial review of agency orders, including cease and desist orders, orders awarding damages, and orders dismissing complaints.⁹⁴

New York courts also have jurisdiction to hear claims of unlawful discrimination.⁹⁵ However, once a complainant elects the administrative forum by filing a complaint with the DHR, a judicial action on the same complaint is generally barred.⁹⁶ There are

⁸⁷ N.Y. EXEC. LAW § 292(9).

⁸⁸ See N.Y.C.L.U. compl., *supra* note 67, at 13. In their complaint, the NYCLU alleged that refusal to honor refills of emergency contraception prescriptions constitutes sex discrimination because only women use emergency contraception. The NYCLU further analogized refusal to honor refill prescriptions of emergency contraception to refusal to provide insurance coverage for contraception, which some courts have found violates federal law under Title VII. *Id.* at 13–14.

⁸⁹ N.Y. EXEC. LAW § 297(1); see also N.Y. COMP. CODE R. & REGS. tit. 9, § 465.3(c) (2007).

⁹⁰ N.Y. EXEC. LAW § 297(2)(a).

⁹¹ *Id.* § 297(4)(a).

⁹² *Id.* § 297(4)(a).

⁹³ *Id.* § 297(5).

⁹⁴ *Id.* § 298.

⁹⁵ *Id.* § 297(9). The private cause of action based on sex discrimination is discussed in Section IV, *infra*.

⁹⁶ *Id.* § 297(9); see also *Johnson v. County of Nassau*, 411 F. Supp. 2d 171, 184 (E.D.N.Y. 2006) (holding that court lacked subject matter jurisdiction over plaintiff’s discrimination claim because plaintiff chose to have his claim adjudicated by the DHR); *State Div. of Human Rights v. Luppino*, 35 A.D.2d 107 (N.Y. App. Div. 1970) (New York legislature intended, by giving individuals a choice between suing in court or seeking administrative relief, to limit persons to out-of-pocket damages when they elect the administrative remedy).

three exceptions to this rule: the election of remedies rule does not apply where the division dismissed a complaint on the grounds of administrative convenience, on the grounds of untimeliness, or on the grounds that the election of remedies is annulled.⁹⁷

In order to have standing to file a complaint alleging unlawful discrimination, the complainant must be an “aggrieved person” within the meaning of the statute.⁹⁸ Courts have interpreted the statute’s “aggrieved person” to mean “[an] individual who is the alleged victim of the alleged discriminatory practice.”⁹⁹ Additionally, organizations have institutional standing to file a complaint so long as the complainant is a “bona fide recognized organization representing that class with a specific interest in the litigation in question.”¹⁰⁰

In making the initial determination whether to proceed with a hearing, the DHR must determine whether there is probable cause to believe the alleged discriminatory practice occurred.¹⁰¹ A “rational basis” for sustaining the complaint is sufficient in order to satisfy this probable cause standard.¹⁰² If there is no probable cause to believe that the respondent has engaged in unlawful discriminatory practice, the DHR is authorized to dismiss the complaint.¹⁰³

If the commissioner finds that the respondent engaged in unlawful discriminatory practice, she retains broad discretionary powers to grant relief “reasonably related to the discriminatory conduct.”¹⁰⁴ The commissioner is authorized to issue a cease and desist order, award compensatory damages, and require a compli-

⁹⁷ N.Y. EXEC. LAW § 297(9).

⁹⁸ *Id.*

⁹⁹ *Weinstein v. Hosp. for Joint Diseases and Med. Ctr.*, 81 Misc.2d 366, 368 (Sup. Ct. Westchester Co. 1975) (holding that wife of person who was discriminated against is not an “aggrieved person” within the meaning of the statute).

¹⁰⁰ *Nat’l Org. of Women v. State Div. of Human Rights*, 34 N.Y.2d 416, 420 (1974); *see also* N.Y. COMP. CODE RULES & REGS. tit. 9, § 465.3(a)(1). In *Nat’l Org. of Women*, the complainant had institutional standing to challenge publisher of newspaper when the classified section contained separate “male” and “female” sections as “a bona fide and nationally recognized organization dedicated to eliminating discriminatory practices against women.” *Id.* at 419–20.

¹⁰¹ N.Y. EXEC. LAW § 297(2)(a).

¹⁰² *State Div. of Human Rights v. N.Y. State Drug Abuse Control Comm’n*, 399 N.Y.S.2d 541, 543 (N.Y. App. Div. 1977); *see also* *Mendoza v. State Div. of Human Rights*, 424 N.Y.S.2d 447, 448 (N.Y. App. Div. 1980) (remanding proceeding to the DHR because “[t]he inaccuracy and impreciseness in presentation of important evidence in the record resulted in a determination lacking the rational basis” required for dismissing a complaint pursuant to N.Y. EXEC. LAW § 297(2)).

¹⁰³ N.Y. EXEC. LAW § 297(2)(a).

¹⁰⁴ *N.Y. City Transit Auth. v. State Div. of Human Rights*, 78 N.Y.2d 207, 217 (1991).

ance report.¹⁰⁵ The courts' recognition of the broad discretion of the commissioner accords with "the extremely strong statutory policy of eliminating discrimination" and reflects the notion that a statutory remedy "involves a vindication of both the individual's interests and those of society."¹⁰⁶

A woman over the age of eighteen who is denied emergency contraception by a pharmacist who wishes to elect an administrative, rather than a judicial, remedy could file a complaint with the DHR alleging unlawful sex discrimination. Additionally, reproductive rights organizations are authorized to file complaints on behalf of women affected by this type of discriminatory conduct.¹⁰⁷

Electing the administrative remedy may make sense for a woman who wishes to avoid investing the time and expense required for a lawsuit, while allowing her to assert that the refusing pharmacist's conduct was unlawful and discriminatory. An affected woman would not need to hire an attorney or pay any court fees in order to file a sex discrimination complaint with the DHR. Additionally, this administrative remedy authorizes the DHR to award money damages, which may be more adequate relief, or feel like more "personal" relief, than the professional sanctions authorized when the complainant alleges professional misconduct. Electing the administrative remedy can be a frustratingly slow process—an aggrieved woman could wait almost a year to hear whether the agency agrees that the pharmacist committed unlawful discrimination¹⁰⁸—but may still be the fastest option for the woman.

¹⁰⁵ N.Y. EXEC. LAW §§ 297(4)(a)(i), (iii), and (vii).

¹⁰⁶ *N.Y. City Transit Auth.*, 78 N.Y.2d at 216; *see also* *Freudenthal v. County of Nassau*, 99 N.Y.2d 285, 291 (2003) ("[T]he Division is empowered to make an aggrieved party whole and, in the process, to eradicate the underlying discriminatory practices that resulted in injury.").

¹⁰⁷ *Nat'l Org. of Women v. State Div. of Human Rights*, 34 N.Y.2d 416, 420 (1974).

¹⁰⁸ N.Y. EXEC. LAW § 297(2)(a) ("Within one hundred eighty days after a complaint is filed, the division shall determine whether it has jurisdiction and, if so, whether there is probable cause to believe that the person named in the complaint, hereinafter referred to as the respondent, has engaged or is engaging in an unlawful discriminatory practice."); N.Y. EXEC. LAW § 297(4)(a) ("Within two hundred seventy days after a complaint is filed . . . the division shall cause to be issued and served a written notice, together with a copy of such complaint, as the same may have been amended, requiring the respondent or respondents to answer the charges of such complaint and appear at a public hearing before a hearing examiner at a time not less than five nor more than fifteen days after such service and at a place to be fixed by the division and specified in such notice.").

C. *Private Causes of Action*

1. Unlawful sex discrimination in public accommodations

A woman denied emergency contraception may, instead of electing the administrative remedy and filing a sex discrimination complaint with DHR, elect a judicial remedy.¹⁰⁹ The statutory scheme authorizes New York courts to exercise jurisdiction over a cause of action claiming unlawful discriminatory practice, so long as the plaintiff did not also file a complaint with the DHR.¹¹⁰ Although there is very little case law that addresses gender-based discrimination in public accommodations, the case law addressing other protected classes is instructive.

The burden is on the plaintiff to make a prima facie showing of discrimination.¹¹¹ The cases suggest that this burden is met if the plaintiff establishes that she was subjected to unequal treatment because of her membership in a class protected by New York Human Rights Law.¹¹² Gender is a protected class under this body of law.¹¹³ New York and federal constitutional precedent “establish[] that gender discrimination occurs when men and women are not treated equally and one gender is benefited or burdened as opposed to the other.”¹¹⁴

After the plaintiff makes her prima facie showing of unlawful discrimination, the burden then shifts to the defendant to show a “legitimate, non-discriminatory reason for the difference in treatment.”¹¹⁵ In the context of health care, disparate treatment based

¹⁰⁹ *Id.* § 297(9).

¹¹⁰ *Id.*

¹¹¹ *North Shore Univ. Hosp. v. Rosa*, 86 N.Y.2d 413, 419 (1995).

¹¹² *See, e.g., Elaine W. v. Joint Diseases North General Hospital, Inc.*, 81 N.Y. 2d 211, 216 (1993) (recognizing the court had consistently held “distinctions based solely upon a woman’s pregnant condition constitute sexual discrimination” under New York Human Rights Law protecting sex discrimination in public accommodations). *See also U.S. Power Squadrons v. State Human Rights Appeal Bd.*, 59 N.Y.2d 401, 413 (1983). In *U.S. Power Squadrons*, the DHR found that respondent corporation’s blanket refusal to extend membership to female applicants who are otherwise qualified constituted unlawful sex discrimination. *Id.* at 407. The court affirmed the agency’s finding, noting that “membership in petitioner is extended to all males who pass the basic piloting course, the actual and potential membership is more public than private and there is no plan or purpose of exclusivity other than sexual discrimination.” *Id.* at 413.

¹¹³ N.Y. EXEC. LAW § 291(2) (McKinney 2007) (“The opportunity to . . . the use of places of public accommodation . . . without discrimination because of . . . sex . . . is hereby recognized as and declared to be a civil right.”).

¹¹⁴ *Hernandez v. Robles*, 7 N.Y.3d 338, 375 (2006).

¹¹⁵ *North Shore Univ. Hosp.*, 86 N.Y.2d at 419; *see also Cahill v. Rosa*, 89 N.Y.2d 14, 25 (1996) (citing *Laverack & Haines, Inc. v. N.Y. State Div. of Human Rights*, 88 N.Y.2d

on medical necessity meets this standard.¹¹⁶ In *Cahill v. Rosa*, the plaintiffs alleged that defendants violated public accommodations law when they refused to treat patients who were known or suspected to be HIV-positive.¹¹⁷ There, the court held that a medical provider has an ability to refer patients elsewhere for treatment so long as they have a legitimate, non-discriminatory reason for doing so.¹¹⁸ The medical provider in *Cahill* did not satisfy this standard.¹¹⁹ Similarly, in *North Shore University Hospital v. Rosa*, the plaintiffs alleged that New York Public Accommodations Law was violated when defendant medical facility used heightened precautionary measures when it treated a patient it suspected had AIDS.¹²⁰ There, the court found that defendant's "strict isolation technique" under its infectious disease protocol was supported by medical justification and therefore constituted a "legitimate, non-discriminatory reason" for the difference in treatment.¹²¹ If the presumption of discrimination is rebutted, the burden shifts back to the plaintiff to establish that the reasons proffered were not the true reasons, but were a pretext for discrimination.¹²²

The court's rationale in *Elaine W. v. Joint Diseases North General Hospital*¹²³ is instructive in considering discrimination principles in the context of access to emergency contraception. In *Elaine W.*, the plaintiffs instituted an unlawful sex discrimination action alleging that defendant hospital's refusal to admit pregnant women into

734, 736 (1996) (finding a legitimate, non-discriminatory explanation in age discrimination suit when plaintiff was terminated due to "business setbacks").

¹¹⁶ *Cahill*, 89 N.Y.2d at 25; see also *North Shore Univ. Hosp.*, 86 N.Y.2d at 419–20 (citing *Elaine W. v. Joint Diseases N. Gen. Hosp., Inc.*, 81 N.Y.2d 211, 217 (1993)).

¹¹⁷ 89 N.Y.2d at 18.

¹¹⁸ *Id.* at 24.

¹¹⁹ See *id.*

¹²⁰ *North Shore Univ. Hosp.*, 86 N.Y.2d at 416.

¹²¹ *Id.* at 419.

North Shore [met their burden of demonstrating a legitimate reason for the difference in treatment] by showing that at the relevant time, its protocol was reasonable, medically warranted and consistent with its desire to protect patients and staff from the spread of infectious diseases. . . . Clearly, respondent's disease protocol was consistent with accepted medical practice in 1985 for treatment of patients known or perceived to be at high risk of infection of the then recently discovered, contagious and fatal disease and not a pretext for discrimination.

Id. at 419–20.

¹²² *Id.* at 419–20; see also *Johnson v. Lord & Taylor*, 807 N.Y.S.2d 367, 367 (N.Y. App. Div. 2006) (no unlawful racial discrimination when defendant articulated a legitimate, non-discriminatory purpose and plaintiff did not allege any competent evidence that defendant's nondiscriminatory explanation of the event was a pretext for racial discrimination).

¹²³ 81 N.Y.2d 211 (1993).

its drug detoxification program violated New York State Human Rights Law.¹²⁴ The court first noted that, in interpreting anti-sex-discrimination law, New York courts have consistently held that “distinctions based solely upon a woman’s pregnant condition constitute sexual discrimination.”¹²⁵ The court rejected the defendant’s argument that the disparate treatment was justified on medical grounds.¹²⁶ The defendant claimed that “North General excludes pregnant women because it believes it lacks the equipment to treat them safely, it has no obstetricians on its staff and it is not licensed to render obstetrical care.”¹²⁷ In rejecting this as a legitimate medical justification, the court noted that the burden rests on the actor drawing distinctions based upon pregnancy to prove that those “distinctions are based upon medical necessity, not upon generalizations associated with pregnant women.”¹²⁸ The court then held that the challenged policy constituted facial sex discrimination.¹²⁹

Refusal to provide emergency contraception constitutes sex discrimination under the reasoning of *Elaine W.* First, only women use emergency contraception; a pharmacist’s refusal to provide it results in “less comprehensive benefits being offered to women than those offered to men. Because only women use [emergency contraception], only women are refused prescriptions or refills based on pharmacists’ non-health related judgments regarding their sexual practices.”¹³⁰

Second, there is no medical justification for the disparate treatment. Because of the drug’s medically proven safety, there is no valid medical justification for refusing to provide emergency contraception.¹³¹ The court in *Elaine W.* explicitly rejected paternalistic or “well-intentioned” reasons to support a medical justification: “Many discriminatory practices develop improperly because of a paternalistic sense of what is ‘best’ for those who are discriminated against If there is no medical basis for the discrimination, the fact that it was undertaken with good intentions is

¹²⁴ *Id.* at 215.

¹²⁵ *Id.* at 216 (citations omitted).

¹²⁶ *Id.* at 215.

¹²⁷ *Id.*

¹²⁸ *Id.* at 217.

¹²⁹ *Id.* at 216.

¹³⁰ N.Y.C.L.U. compl., *supra* note 67, at 14.

¹³¹ *See, e.g.,* Weismiller, *supra* note 14, at 710 (no medical contraindications associated with emergency contraceptive use); Grimes & Raymond, *supra* note 14, at 183 (noting that emergency contraception is “very safe”).

irrelevant.”¹³² Absent a medical justification, a pharmacist’s refusal to dispense emergency contraception based on moral or religious reasons is based on the same sexist, paternalistic, or simply non-medical notions that the court found unacceptable in *Elaine W.*

There are obvious drawbacks to commencing a civil action against a refusing pharmacist: litigation is expensive and time-consuming. Litigation may simply not be an option for many women affected by a refusing pharmacist. However, reproductive rights organizations may wish to develop projects whose purpose is to gather information and engage in litigation of this nature. This would alleviate the burden of expense on the plaintiff while simultaneously setting crucial local or state precedent.

2. Breach of Fiduciary Duty

A complaint filed in civil court alleging sex discrimination could also include a breach of fiduciary duty cause of action. Refusing to provide emergency contraception over-the-counter is likely a breach of the fiduciary relationship between the pharmacist and the customer. A New York state court explicitly held that a fiduciary relationship exists between a pharmacist and customer in *Anonymous v. CVS Corp.*¹³³ In reaching its conclusion that the pharmacist–customer relationship can correctly be characterized as a fiduciary relationship, the court in *CVS* also noted that pharmacists “do more than dispense a product. They are responsible for collecting otherwise confidential medical information, and providing drug advice to customers.”¹³⁴ New York state courts have also defined the applicable standard of care for pharmacists, finding that they must exercise “the highest practicable degree of prudence, thoughtfulness and vigilance commensurate with the dangers involved and the consequences which may attend inattention.”¹³⁵

Failure to provide emergency contraception to a customer who shows proof of age is a breach of the pharmacist’s duty to the customer. The reasoning of pharmacists who deny emergency contraception to women who request it is not based on any objective medical condition of the customer; rather, such reasoning is based on sexist and paternalistic assumptions about her, or is based on

¹³² *Elaine W.*, 81 N.Y.2d at 217–18.

¹³³ 728 N.Y.S.2d 333, 338 (N.Y. Sup. Ct. 2001) (finding that the principal characteristics of a fiduciary relationship, dependency and influence, are present in the transaction between pharmacist and customer).

¹³⁴ *Id.* at 337.

¹³⁵ *Hand v. Krakowski*, 453 N.Y.S.2d 121, 122 (N.Y. App. Div. 1982); *see also France v. State*, 506 N.Y.S.2d 254, 255 (N.Y. Ct. Cl. 1986).

non-medical religious motivations.¹³⁶ The FDA's Center for Drug Evaluation and Research's conclusion that "the available scientific data are sufficient to support the safe use of Plan B as an over the counter product, but only for women who are [seventeen] years of age and older"¹³⁷ indicates that, in the context of the pharmacist's duty of care, any "dangers involved" only apply to the age of the customer. Because the FDA has deemed emergency contraception to be safe and legal for women over the age of eighteen, the only duty the pharmacist owes to a customer requesting Plan B is to verify her age. Virtually any other determinations made by the pharmacist beyond age verification would be non-medical, because the FDA has explicitly approved emergency contraception's safety for women over the age of eighteen, without restrictions on frequency of use. The pharmacist's injection of his or her moral or religious beliefs, or assumptions about the customer's marital status or sexual proclivities, should have nothing to do with the pharmacist's obligation to exercise "the highest practicable degree of prudence, thoughtfulness and vigilance commensurate with the dangers involved"¹³⁸

3. Wrongful Conception Tort

A woman who became pregnant or had an abortion as a result of a pharmacist's refusal to provide emergency contraception may be able to sue the pharmacist on the tort theory of wrongful conception. New York courts recognize the tort of wrongful conception when a medical professional's negligence results in the birth of a healthy child;¹³⁹ however, the courts have so far not explicitly extended the wrongful conception tort to the context of failure to provide emergency contraception.

The New York Court of Appeals has implicitly indicated that the tort of wrongful conception is a viable cause of action when a physician or other medical professional's negligence causes an unwanted pregnancy that results in an otherwise healthy child.¹⁴⁰ Ad-

¹³⁶ See Page, *supra* note 7, at 105–19 (discussing scientific studies on the safety and effectiveness of Plan B and reviewing the pro-lifers responses).

¹³⁷ Lester B. Crawford, Comm'r, Fed. Drug Admin., *FDA Takes Action on Plan B* (Aug. 26, 2005), available at <http://www.fda.gov/bbs/topics/NEWS/2005/NEW01223.htm>.

¹³⁸ *Hand*, 453 N.Y.S.2d at 122.

¹³⁹ See *O'Toole v. Greenberg*, 477 N.E.2d 445 (N.Y. 1985).

¹⁴⁰ *Id.* at 447. The issue in *O'Toole* was whether plaintiffs, in a medical malpractice action, could receive damages for the ordinary costs of raising a normal, healthy child after a negligently performed tubal ligation procedure. *Id.* at 446. The court noted that the other branch of plaintiff's cause of action seeking damages for expenses in-

ditionally, four departments in the Appellate Division have held that a cause of action for medical malpractice when the physician's negligence results in the birth of a normal child states a legally cognizable claim.¹⁴¹ After an exhaustive review of the ways in which other jurisdictions have dealt with the wrongful conception tort, the court in *Weintraub v. Brown* concluded "there is widespread agreement among the several jurisdictions that have considered the issue that complaints alleging wrongful conception state a valid cause of action."¹⁴²

Many wrongful conception cases have been brought as a result of a negligently performed sterilization procedure. In *Miller v. Rivard*, the court recognized a wrongful conception cause of action when the defendant physician negligently performed a vasectomy.¹⁴³ In *Ziemba v. Sternberg*,¹⁴⁴ the court held a legally cognizable wrongful conception cause of action was stated when the defendant negligently failed to diagnose the plaintiff's pregnancy.¹⁴⁵ And in *O'Toole v. Greenberg*, defendants conceded that plaintiffs stated a legally cognizable wrongful conception cause of action for emotional damages and medical expenses associated with the pregnancy that resulted from a negligently performed tubal ligation.¹⁴⁶ Additionally, in *Miller*, the Appellate Division noted in dicta that New York courts recognize a pharmacist's negligent filling of a prescription for contraception can be the basis of a wrongful conception cause of action.¹⁴⁷

The court in *Ziemba* suggested there are two requirements to sufficiently state a wrongful conception cause of action: the defendant breached the applicable standard of care, and the defendant's

curred for the pregnancy, delivery, and postpartum care rendered to plaintiff and her child was not at issue. *Id.*

¹⁴¹ *Weintraub v. Brown*, 470 N.Y.S.2d 634, 637 (N.Y. App. Div. 1983).

¹⁴² *Id.*

¹⁴³ *Miller v. Rivard*, 585 N.Y.S.2d 523, 526 (N.Y. App. Div. 1992).

¹⁴⁴ *Ziemba v. Sternberg*, 357 N.Y.S.2d 265, 267 (N.Y. App. Div. 1974).

¹⁴⁵ *Id.* at 269; see also *Sala v. Tomlinson*, 422 N.Y.S.2d 506 (N.Y. App. Div. 1979) (action brought against physician for negligently performed sterilization operation).

¹⁴⁶ 477 N.E.2d at 446 n.2 (1985). The court noted that plaintiff's second cause of action—"based upon allegations of medical malpractice and [seeking] damages for physical and emotional injuries resulting from labor and delivery and the necessity of a second sterilization procedure"—was also not at issue on appeal, because defendants had conceded. *Id.*

¹⁴⁷ *Miller*, 585 N.Y.S.2d at 524 ("The gravamen of their suit is what courts and commentators have come to call 'wrongful conception' or 'wrongful pregnancy', i.e., the negligent performance of a sterilization or abortion procedure by a physician, or the negligent filling of a contraceptive prescription by a pharmacist, as a result of which the plaintiffs conceived and became the parents of a healthy but unwanted child." (citation omitted)).

negligence resulted in an unintended pregnancy.¹⁴⁸ The pharmacist owes an adult patient “the highest practicable degree of prudence, thoughtfulness and vigilance commensurate with the dangers involved and the consequences which may attend inattention.”¹⁴⁹ And, because the FDA has deemed emergency contraception to be safe and legal for women over the age of eighteen, the only duty the pharmacist owes to a patient requesting Plan B is to verify that she is in fact eighteen years of age. The pharmacist’s infusion of her moral beliefs into the Plan B transaction is an intrinsically non-medical determination. Because the FDA has explicitly approved emergency contraception’s safety for women over the age of eighteen, without restrictions on frequency of use, any other inquiry falls outside the duty of care the pharmacist owes the patient.

In terms of damages recoverable, the court in *O’Toole* explicitly held that plaintiffs in a wrongful conception suit may not seek damages for the ordinary costs of raising a healthy, normal child.¹⁵⁰ The court found that “the birth of a healthy child, as but one consequence of defendant’s tortious conduct, does not constitute a harm cognizable at law.”¹⁵¹ The court also based its holding on public policy, stating that “[t]o hold that the birth of a healthy child represents a legal harm would be to engage this court in the jurisprudentially improper task of recasting the immutable, intrinsic value of human life according to the financial burden thus imposed upon the parents.”¹⁵²

In *Weintraub*, the court indicated that New York adopts the approach espoused by a majority of other jurisdictions that have considered the wrongful conception cause of action, which is to award damages for medical expenses incurred during the pregnancy, but *not* for costs associated with raising the child.¹⁵³ The *Weintraub*

¹⁴⁸ *Ziemba*, 357 N.Y.S.2d at 269. The *Ziemba* court stated:

When, as here, it is asserted that, as one of the consequences of defendant physician’s lack of reasonable care, plaintiff was not advised of her pregnancy so that she could terminate it within a reasonable time, as she was entitled to do, and was advised by another physician when the pregnancy was discovered by him as to the danger involved in an abortion at that time, we believe the damages subsequently sustained by her and her husband may be the natural consequences of defendant’s malpractice for which recovery will lie.

Id.

¹⁴⁹ *Hand v. Krakowski*, 453 N.Y.S.2d 121, 122 (N.Y. App. Div. 1982).

¹⁵⁰ *O’Toole*, 477 N.E.2d at 446.

¹⁵¹ *Id.* at 448.

¹⁵² *Id.*

¹⁵³ *Weintraub v. Brown*, 470 N.Y.S.2d 634, 641 (N.Y. App. Div. 1983).

court concluded that “[t]here . . . is general agreement that the plaintiffs in a wrongful conception action may recover from the tort-feasor for the expenses of the unsuccessful sterilization procedure, the pain and suffering associated with the pregnancy, the costs of delivery, lost wages, and loss of consortium.”¹⁵⁴ The *Weintraub* court then noted that the majority of jurisdictions deny recovery of child-rearing costs for public policy reasons, to protect the child, and because calculating these damages would be unduly speculative.¹⁵⁵

The biggest obstacle the wrongful conception avenue of relief poses to a customer denied emergency contraception is finding a pregnant plaintiff who either has chosen to have the unwanted child or is willing to seek the cost of an abortion procedure as damages.¹⁵⁶ Thus, for privacy reasons, women may be reluctant to institute a wrongful conception suit. Additionally, complicated policy issues surrounding the notion of ascribing monetary value as damages associated with an unwanted child arise in the context of a wrongful conception claim.¹⁵⁷ For similar reasons discussed by the *Weintraub* court to support the bar on recovering costs associated with rearing a healthy child—that the courts should not adjudicate the birth of a healthy child as a legally cognizable “injury”¹⁵⁸—a woman denied emergency contraception may be reluctant to seek damages for pregnancy-related costs.

On the other hand, the wrongful conception cause of action—which does not characterize the actual birth of an unwanted child as a legally compensable injury—could be viewed as a practical method of obtaining relief for expenses incurred as a result of a pharmacist’s refusal to provide emergency contraception. One theory, which supports recovery under a wrongful conception claim, views “the lost parental opportunity to avoid conception or terminate a pregnancy as the legally cognizant injury, rather than expressly framing the child’s life itself as the injury.”¹⁵⁹ Thus, by

¹⁵⁴ *Id.* at 638 (citation omitted).

¹⁵⁵ *Id.* at 638–41.

¹⁵⁶ “The right to have an abortion may not be automatically converted to an obligation to have one.” *Ziembra v. Sternberg*, 357 N.Y.S.2d 265, 269 (N.Y. App. Div. 1974). Also, it is not unreasonable to conclude that a court should award abortion costs, since such costs do not carry the same policy concerns as do the costs of raising a healthy child.

¹⁵⁷ Kathleen A. Mahoney, *Malpractice Claims Resulting from Negligent Preconception Genetic Testing: Do These Present a Strain of Wrongful Birth or Wrongful Conception, and Does the Categorization Even Matter?*, 39 SUFFOLK U. L. REV. 773, 778 (2006).

¹⁵⁸ *Weintraub*, 470 N.Y.S.2d at 641.

¹⁵⁹ Mahoney, *supra* note 157, at 780.

refusing to award damages for the cost of raising a healthy but unwanted child, as New York does, the legally compensable harm is characterized as the mother's experience, not the child's life.¹⁶⁰

D. Pharmacist Refusals and the First Amendment: The Impact of Stormans

In light of the court's decision in *Stormans, Inc. v. Selecky*,¹⁶¹ the private causes of action described above may become an increasingly useful tool for women denied emergency contraception by pharmacists. In *Stormans*, the plaintiffs are two pharmacists whose religious beliefs informed their view that life begins at conception, and who "claim a right of conscience to refuse to dispense Plan B, and to instead refer the patient to a nearby pharmacy that will dispense the drug."¹⁶² Plaintiffs challenged Washington state regulations which provided, in part, that:

Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies, or provide a therapeutically equivalent drug or device in a timely manner consistent with reasonable expectations for filling the prescription.¹⁶³

The Washington State Board of Pharmacy acknowledged that the regulations reflected a desire to provide definitive standards for pharmacists in situations where the pharmacist's moral beliefs were at odds with a patient's request for legally prescribed medications.¹⁶⁴ Accordingly, the Board concluded that the regulation prohibits a pharmacy from implementing a policy in which a pharmacist is permitted to refer a patient to another pharmacy to avoid filling a prescription the pharmacist objects to due to moral or ethical reasons.¹⁶⁵

Plaintiffs argued that the challenged regulations violate the Free Exercise Clause of the First Amendment.¹⁶⁶ Under that clause, the government "may not enact laws that suppress religious

¹⁶⁰ Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 151 (2005).

¹⁶¹ 524 F. Supp. 2d 1245 (W.D. Wash. 2007).

¹⁶² *Id.* at 1248-49.

¹⁶³ *Id.* at 1252 (quoting WASH. ADMIN. CODE 246-869-010 (2007)).

¹⁶⁴ *Id.* at 1253 (internal references omitted).

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* at 1256. Plaintiffs asserted other constitutional claims, but the court declined to reach them in granting the preliminary injunction based on plaintiffs' First Amendment claim. *Id.* at 1266.

belief or practice.”¹⁶⁷ Courts apply strict scrutiny to laws which facially discriminate against individuals because of their religious beliefs.¹⁶⁸ On the other hand, laws of general applicability—laws which are facially neutral with respect to religion—do not require a compelling governmental interest, “even if the law has the incidental effect of burdening a particular practice.”¹⁶⁹

In its First Amendment analysis, the court first determined whether the challenged regulations were facially neutral.¹⁷⁰ While the court determined that the challenged regulations were facially neutral,¹⁷¹ the court ruled that the “evolution of the regulations” demonstrated that they in fact targeted the religious practices of certain citizens and therefore could not be considered neutral.¹⁷² In turning to the general applicability analysis, the court ruled that the regulations were not of general applicability because they unconstitutionally targeted religious practice.¹⁷³ Thus, the court subjected the challenged regulations to strict scrutiny “[b]ecause the regulations appear to intentionally place a significant burden on the free exercise of religion for those who believe life begins at conception.”¹⁷⁴

The court then determined whether the regulations withstood the requisite strict scrutiny analysis. The defendants argued that two government interests support the constitutionality of the regulations. The first was promoting public health by ensuring timely access to Plan B.¹⁷⁵ The second asserted government interest was preventing sex discrimination.¹⁷⁶ The court ruled that “the interests promoted by the regulations *have more to do with convenience and heartfelt feelings* than with actual access to certain medications.”¹⁷⁷ In rejecting defendants’ first argument, the court noted that:

While it is obviously conceivable that a patient in need of Plan B could ultimately be denied access to the drug during its time of effectiveness, that eventuality is just as likely to occur for reasons that are wholly acceptable under the regulations: lack of money,

¹⁶⁷ *Id.* at 1257; *see also* U.S. CONST. amend. I.

¹⁶⁸ 524 F. Supp. 2d at 1254.

¹⁶⁹ *Id.* (citing *Employment Div., Dept. of Human Res. of Or. v. Smith*, 494 U.S. 872 (1990)).

¹⁷⁰ *Id.* at 1257–60.

¹⁷¹ *Id.* at 1258.

¹⁷² *Id.* at 1260.

¹⁷³ *Id.* at 1263.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* (emphasis added).

the drug is not in stock, no one has previously requested it, or the store is closed on Sunday. In short, lack of access to Plan B has thus far not been demonstrated, and the concerns that have been expressed about availability are not compelling.¹⁷⁸

The court also rejected defendants' sex discrimination argument, remarking that "[t]he United States Supreme Court has recognized that reasonable people disagree over when life begins, and the refusal to participate in an act that one believes terminates a life has nothing to do with gender or gender discrimination."¹⁷⁹ Remarkably, the court noted that "[t]he plaintiffs' objection to Plan B is not about gender, it is about the sanctity of life as defined by their religious teachings."¹⁸⁰ Accordingly, the court granted the preliminary injunction with respect to the plaintiffs' First Amendment claim.¹⁸¹

In light of *Stormans*, state measures enacted to ensure women have timely access to emergency contraception may be threatened. The First Amendment implications of consumer-protective state measures, such as those enacted by the Washington State Board of Pharmacy—particularly under the court's reasoning in *Stormans*, in which pharmacist refusals have "nothing to do with gender"¹⁸² and access to Plan B is characterized as a matter of "convenience"¹⁸³—endanger the constitutionality of such measures. Advocates should consider focusing on the private causes of action discussed in this section in determining the most viable place to continue fighting for access to emergency contraception.

III. A PLAN C FOR YOUNG WOMEN

The way in which the behind-the-counter rule permits pharmacist refusals is not the only objectionable aspect of the rule—the age restriction, too, must be analyzed from a feminist perspective. The FDA rule's age restriction is a prime example of what Buchanan has described as "[t]he state impos[ing] quasi-parental control over young women's sexuality."¹⁸⁴ Because "[m]ost adoles-

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* (citing *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 271–74 (1993)).

¹⁸⁰ *Id.* at 1264. The way in which the court is able to remove gender from its analysis is quite remarkable and is reflective of MacKinnon's argument that "women, because of their sex, are subjected to social inequality at each step in the process of procreation." MacKinnon, *supra* note 50, at 1309.

¹⁸¹ 524 F. Supp. 2d at 1266.

¹⁸² *Id.* at 1263.

¹⁸³ *Id.*

¹⁸⁴ Buchanan, *supra* note 8, at 1255 (italics omitted).

cents depend substantially on the public sector to help support their healthy sexual development and to protect them from sexual violence, disease, and pregnancy,”¹⁸⁵ a critique of the rule’s age restriction is critical. First, the age restriction was unsupported by any medical or scientific justification, which would indicate Plan B is less safe for adolescent users.¹⁸⁶ Second, it has “enormous consequences”¹⁸⁷ for young women who may not have health insurance, transportation to a clinic, or time to make an appointment within the recommended seventy-two hour period of time between unprotected intercourse and taking Plan B.¹⁸⁸ The restriction on young women’s access to Plan B without a prescription supports the argument that:

[C]ontemporary public policies on adolescent sexuality are being designed in ways that significantly limit young women’s access to information and health care regarding sexual behaviors and sexual desire; diminish the supports available to young women . . . ; limit the professional license of educators and health workers who typically support teens in their sexual and reproductive decision making; and circumscribe the options available to young women who experience sexual desire or sexual violence in the name of protecting the young.¹⁸⁹

Thus, because of the barriers young women face in accessing reproductive services, coupled with the lack of medical justification for the age restriction, “it is critical to examine the ways in which public policies concerning young women’s sexualities have been

¹⁸⁵ Michelle Fine & Sara I. McClelland, *The Politics of Teen Women’s Sexuality: Public Policy and the Adolescent Female Body*, 56 EMORY L.J. 993, 995 (2007).

¹⁸⁶ See G.A.O. REPORT, *supra* note 34, at 31 (“There were no safety issues that would require age-related restrictions that were identified with the original [new drug application] for prescription Plan B. FDA approved this application upon determining that Plan B met the statutory standards of safety and effectiveness, manufacturing and controls, and labeling.”); see also Brief of Plaintiffs, *supra* note 4, at 37 (“Dr. Beitz, Acting Director of the Office of Drug Evaluation III, reiterated her view that no age restriction was appropriate ‘[i]n the absence of new data to support’ such a restriction. Dr. Ganley, Director of the FDA’s Office of Nonprescription Products, likewise stated ‘[n]o new data was provided to suggest the restriction based on age is necessary.’ Dr. Jenkins, Director of the Office of New Drugs, similarly reiterated his prior position adding, ‘I am not aware of any new data that supports the need for an age restriction.’”) (citations omitted).

¹⁸⁷ Fine & McClelland, *supra* note 185, at 1016.

¹⁸⁸ *Id.* (“Young women must access medical care, get a prescription from a physician, and find a pharmacist who is willing to fill the prescription—all within the seventy-two hour window that emergency contraception needs to be taken in order to be effective. These obstacles represent serious constrictions on the reproductive freedom of those young women who have considerably less access to medical care, physicians, and pharmacies.”).

¹⁸⁹ *Id.* at 995 (format altered).

forged within religious and ‘moralizing’ discourses.”¹⁹⁰ This Part will briefly discuss *Carey v. Population Services International*,¹⁹¹ in which the United States Supreme Court laid the constitutional groundwork for minors’ right to access contraceptives. This Part will next discuss the relevance of *Carey* in light of the challenge to the behind-the-counter restriction brought in *Tummino v. von Eschenbach*.¹⁹² Lastly, this Part will employ a feminist theoretical perspective to support the argument against the age restriction, focusing on the way in which the responsibility and “shame” of sexual activity falls squarely and solely on the shoulders of young women while simultaneously assuming that men eighteen or older, who are under no circumstances approved as users of Plan B, are more qualified to make the decision to purchase the drug.

A. *The Carey Backdrop*

In *Carey*, the plaintiffs challenged a statute that criminalized the sale or distribution of a contraceptive to adolescents under the age of sixteen and required that distributors of contraceptives to those over the age of sixteen be licensed pharmacists.¹⁹³ Significantly, the Court affirmed the existence of a constitutionally protected right to decisional privacy, in certain important personal matters.¹⁹⁴ Thus, the Constitution affords protection for individuals to make private decisions about contraception.¹⁹⁵

The Court then announced that strict scrutiny must be applied to regulations which burden access to contraception:¹⁹⁶

[T]he same test must be applied to state regulations that burden an individual’s right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely. Both types of regulation “may be justified only by a ‘compelling state interest’ . . . and . . . must be narrowly drawn to express only the legitimate state interests at

¹⁹⁰ *Id.*

¹⁹¹ 431 U.S. 678 (1977).

¹⁹² 427 F. Supp. 2d 212 (E.D.N.Y. 2006).

¹⁹³ 431 U.S. at 681.

¹⁹⁴ *Id.* at 684–85 (“This right of personal privacy includes ‘the interest in independence in making certain kinds of important decisions.’ ” (citing *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977)). *Id.* at 684.

¹⁹⁵ *Id.* at 685.

¹⁹⁶ *Id.* at 686–87 (finding the decision to have children fundamental; thus warranting strict scrutiny analysis, and further that “[r]estrictions on the distribution of contraceptives clearly burden the freedom to make such decisions.”) *id.* at 687.

stake.”¹⁹⁷

The Court emphasized that there is no fundamental right to access to contraceptives per se, but that “such access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the holdings in *Griswold [v. Connecticut]*, *Eisenstadt v. Baird*, and *Roe v. Wade*.”¹⁹⁸ The Court importantly noted that “[n]othing in the record suggests that pharmacists are particularly qualified to give advice on the merits of different nonmedical contraceptives, or that such advice is more necessary to the purchaser of contraceptive products than to consumers of other nonprescription items.”¹⁹⁹

A plurality of the Court rejected the appellants’ argument that the statutory provision prohibiting the distribution of contraceptives to adolescents less than sixteen years of age was “constitutionally permissible as a regulation of the morality of minors, in furtherance of the State’s policy against promiscuous sexual intercourse among the young.”²⁰⁰ Instead, the plurality determined that “[s]tate restrictions inhibiting privacy rights of minors are valid only if they serve ‘any significant state interest . . . that is not present in the case of an adult.’”²⁰¹

Turning to the state interests offered by appellants, the plurality rejected the argument that “significant state interests are served by restricting minors’ access to contraceptives, because free availability to minors of contraceptives would lead to increased sexual activity among the young, in violation of the [state] policy . . . to discourage such behavior.”²⁰² Thus the plurality declined to adopt

¹⁹⁷ *Id.* at 688 (citing *Roe v. Wade*, 410 U.S. 113, 155 (1973)).

¹⁹⁸ *Carey*, 431 U.S. at 688–89. See generally *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965) (holding that the right to privacy protects married couples’ decision to use contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438, 454–55 (1972) (holding that the right to privacy in one’s decision to use contraceptives extends to unmarried persons); *Roe v. Wade*, 410 U.S. 113, 164–65 (1973) (holding that “(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician. (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”).

¹⁹⁹ *Carey*, 431 U.S. at 691.

²⁰⁰ *Id.* at 692–96.

²⁰¹ *Id.* at 693 (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75 (1976)).

²⁰² *Id.* at 694.

the view that “minors’ sexual activity may be deterred by increasing the hazards attendant on it.”²⁰³ The plurality was particularly concerned with the fact that “[a]ppellants assert *no medical necessity* for imposing a medical limitation on the distribution of nonprescription contraceptives to minors.”²⁰⁴

B. *Rethinking Carey in Light of Plan B’s Age Restriction: Tummino v. von Eschenbach*

In *Tummino*, the plaintiffs sought a court order directing the FDA to give Plan B unrestricted over-the-counter status.²⁰⁵ The plaintiffs charged that:

Only women (and men, for whom Plan B has no approved use) who are willing to present government-issued identification proving that they are at least 18 years of age will be able to obtain Plan B from pharmacies without a prescription. Other women, including all women under 18 and women who either do not have government-issued proof of age or are unwilling to display it to pharmacy staff, must have a prescription in order to obtain Plan B.²⁰⁶

In support of switching Plan B from behind-the-counter to pure over-the-counter status, the plaintiffs argued that “[t]he approved instructions for using Plan B can be comprehended adequately by all women of child-bearing age without the assistance of a physician or other learned intermediary.”²⁰⁷ The *Tummino* plaintiffs set forth four theories which each charged that the behind-the-counter regime was unconstitutional; this Comment will discuss the argument that the rule’s age restriction violates the constitutional right to decisional privacy.²⁰⁸

²⁰³ *Id.*

²⁰⁴ *Id.* at 697 (emphasis added).

²⁰⁵ Brief of Plaintiffs, *supra* note 4.

²⁰⁶ *Id.* at 1–2.

²⁰⁷ *Id.* at 9 (citation omitted).

²⁰⁸ The plaintiffs’ remaining three constitutional theories were that the FDA rule constitutes an impermissible gender-based classification in violation of the equal protection clause; it violates the fundamental rights branch of the equal protection clause; and that it violates the constitutional right to informational privacy. Brief of Plaintiffs, *supra* note 4, at 60. Neither the *Tummino* plaintiffs nor this author consider the First Amendment implications of the identification requirement, but this is another theory advocates should pursue. See *Watchtower & Bible Tract Soc’y of N.Y. v. Village of Stratton*, 536 U.S. 150, 153, 165–66 (2002) (invalidating ordinance which makes it a misdemeanor to engage in door-to-door advocacy without first registering with the mayor and receiving a permit containing canvasser’s name which must be displayed to residents on demand. The Court in *Watchtower* found the ordinance was unconstitutional because it is “offensive—not only to the values protected by the First Amendment, but to the very notion of a free society—that in the context of everyday

The plaintiffs in *Tummino* argued that Plan B's age restriction violates the constitutional right to decisional privacy delineated in *Carey*.²⁰⁹ In assessing whether the age restriction meets the test required by the *Carey* plurality—that “[s]tate restrictions inhibiting privacy rights of minors are valid only if they serve any significant state interest . . . that is not present in the case of an adult”²¹⁰—the plaintiffs argued that the government failed to meet this burden because of the lack of scientific authority regarding the necessity to restrict behind-the-counter access of Plan B to persons under the age of eighteen.²¹¹ In support of this argument, the plaintiffs charged, “[s]urely the scientific support for an age restriction cannot be ‘compelling’ when every major public health organization, all the internal usual decision makers at FDA, and one of the world’s leading experts on Plan B all agree that the scientific justifications for the age restriction are spurious.”²¹²

Next, the plaintiffs argued that, even if the government’s argument that the age restriction is supported by a significant state interest to protect public health, the behind-the-counter regime is not narrowly tailored to that state interest.²¹³ This is because:

[A]llowing men [eighteen] and over to buy Plan B without a prescription, while simultaneously restricting the availability of Plan B so severely for women of all ages, as the [behind-the-counter] regime does, is so hopelessly unrelated to any scientific evidence or other possible justification that it renders the entire regime a travesty.²¹⁴

This argument highlights one of the most problematic aspects of the rule. That is, the age restriction allows male non-users over the age of eighteen to purchase the drug, while limiting female users under the age of eighteen to access the drug only with a doctor’s prescription. In doing so, “[t]he FDA’s rejection of unrestricted OTC status for Plan B and the structure of the BTC regime both perpetuate outmoded stereotypes of women as less capable of making rational judgments than men and as incapable of following simple instructions.”²¹⁵ Feminists must persistently challenge these types of stereotypes—especially to the extent that they purport to

public discourse a citizen must first inform the government of her desire to speak to her neighbors and then obtain a permit to do so.”).

²⁰⁹ Brief of Plaintiffs, *supra* note 4, at 62.

²¹⁰ *Carey*, 431 U.S. at 693 (internal quotation omitted).

²¹¹ Brief of Plaintiffs, *supra* note 4, at 64.

²¹² *Id.*

²¹³ *Id.* at 65.

²¹⁴ *Id.* at 66.

²¹⁵ *Id.* at 44–45 (citations omitted).

be “neutral.” That is, the fact that anyone, male or female, over the age of eighteen can purchase Plan B without a prescription is in fact highly gendered.

The age restriction perpetuates sexist stereotypes in two ways. First, it holds young women solely responsible for sexual activity shared with a partner.²¹⁶ Analogously, in making its determination that young women needed to be deterred from “promiscuous” behavior, the FDA impermissibly considered the drug’s impact on personal behavior—something the FDA has never done in reviewing switch applications.²¹⁷ This is not unlike Kansas Attorney General Phil Kline’s interpretation of a child-abuse-reporting statute known as the “Kiss and Tell” law.²¹⁸ The interpretation primarily operated to ascribe shame to young sexually active women by requiring health care professionals to report their adolescent patients to the state whenever the professional suspected the patient was sexually active—regardless of whether the professional believed such activity constituted abuse. As Buchanan argues, “[a]lthough the [Kiss and Tell] regulation nominally applied to both young women and young men, this restriction disproportionately exposes sexually active young women to governmental surveillance and punishment.”²¹⁹ Both the Kansas “Kiss and Tell” law and the age restriction attached to Plan B’s behind-the-counter regime are illustrative of the way in which “[t]he explicit pairing of law and

²¹⁶ Fine & McClelland, *supra* note 185, at 1014-15 (“[T]he continued restrictions of young women’s access highlights one of the important ways that young women are held solely responsible for the consequences of sexual activity. With the new FDA decision, a young woman who experiences unplanned or forced sexual intercourse must first see a doctor (at her own cost) to obtain a prescription during the 72-hour window when emergency contraception is most effective; second, she must find a pharmacist who is willing to fill the prescription; and third, she must pay for the drug (again, at her own cost).”).

²¹⁷ Brief of Plaintiffs, *supra* note 4, at 43 (“The FDA cannot identify another occasion in which it considered how its approval of a drug would effect on personal behavior of those who would use it. Indeed, the FDA did not consider the effects on sexual behavior of men when it approved Viagra and other erectile dysfunction drugs, and approved Plan B itself as a nonprescription drug for sale to men 18 and over without any data concerning, much less consideration of, the effect it might have on the sexual or contraceptive behavior of such men.”) (internal citations omitted). *See also* Buchanan, *supra* note 8, at 1264 (“The unprecedented delay in the agency decision-making process and the eventual age requirement rested, at least in part, on concern expressed by political appointees on the FDA panel that nonprescription availability of the morning-after pill might lead to ‘promiscuity’ among young women.”).

²¹⁸ *See* Kan. Op. Att’y Gen. No. 2003-17 (June 18, 2003), available at <http://ksag.washburnlaw.edu/opinions/2003/2003-017.htm> (last visited Mar. 10, 2008). Kan. Stat. Ann. § 38-1522 (2006). The statute was enjoined in *Aid for Women v. Foulston*, 427 F. Supp. 2d 1093, 1116 (D. Kan. 2006) (order granting permanent injunction).

²¹⁹ Buchanan, *supra* note 8, at 1267.

religious ideology has transformed the role of law and public policy in young women's lives from a supportive function to one that censures young women for their sexual behavior."²²⁰

Second, the age restriction reflects sexist stereotypes in that it suggests that men—so long as they are over the age of eighteen—are somehow more capable than minor women or women without the required identification of making the decision to purchase Plan B, although men are not approved for actual use of the drug.²²¹ The way in which the behind-the-counter scheme privileges the male non-user/purchaser over the adolescent user supports MacKinnon's argument that "the theme of the laws of . . . reproduction is male control of, access to, and use of women,"²²² in that allowing men to purchase Plan B, which they will then pass on to the female user, ascribes to men a certain degree of power in the process. This critique of the age restriction is feminist, then, in that it is "skeptical of the traditions, conventions, and customs that shape the sex and family roles of men and women."²²³

Ensuring timely access to emergency contraception for women of all ages is crucial in order to reduce unwanted pregnancies and to provide appropriate support and services to rape victims. Making Plan B available over-the-counter is particularly important for young women and poor women.²²⁴ Psychology professor Michelle Fine and graduate student Sara McClelland eloquently summarize why reproductive rights advocates should not ignore the gendered implications of the age restriction:

What seems evident from the FDA decision is that public ambivalence about young women's sexuality was used as a way of restricting the reproductive choices for all women. This is not a small point. It signals how young women are increasingly being

²²⁰ Fine & McClelland, *supra* note 185, at 995.

²²¹ See Brief of Plaintiffs, *supra* note 4, at 46 ("[B]y rejecting as insufficient evidence that non-prescription availability of Plan B would not affect adolescent women detrimentally by changing their contraceptive behavior, while simultaneously approving non-prescription availability of Plan B for adult men without any studies showing how availability affects men's sexual behavior, the BTC regime reinforces an outmoded stereotype of women as less capable than men of making their own sexual and contraceptive decisions.").

²²² MacKinnon, *supra* note 50, at 1301.

²²³ Siegel, *supra* note 51, at 817.

²²⁴ See Buchanan, *supra* note 8, at 1256–57 ("The young and poor women who face the greatest stigma for sexual activity and the highest barriers to access and information about contraception and abortion also have the highest rates of unintended pregnancy, abortion, and unintended birth.") (relying on Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 93–94 (2006)).

used to reinscribe female sexual behavior as inappropriate and dangerous at the same time as access to contraception is being curtailed. Young women were used as a lightning rod in constructing the story of how Plan B would “increase promiscuity” or affect sexual risk taking, thereby limiting access to a form of contraception that has been proven safe and effective. The example of Plan B should serve to illustrate how young women’s sexuality is increasingly described as dangerous and their sexual and reproductive freedoms constricted. *Young women’s rights should serve as a warning to all women*; the same arguments that are used today to circumscribe the sexual rights of adolescents can (and have already been) used to circumscribe the rights of all women tomorrow.²²⁵

In the preceding passage, the authors make an important point that the age restriction did not occur in a vacuum; it occurred at a time in which the sexual rights of women are persistently being undermined by an administration that prioritizes politics and ideology over women’s health.

In identifying and analyzing two of the behind-the-counter rule’s shortcomings—the way in which it allows for pharmacist refusals, and the way in which it violates young women’s right to decisional privacy—this Comment attempts to provide litigation strategies that are responsive to the varying degrees to which a woman affected by the rule can be involved. At the same time, this Comment attempts to incorporate a feminist legal perspective into the conversation about the inadequacy of the behind-the-counter rule in order to highlight, in particular, the ways in which both governmental and private decision-making are imbued with traditional notions about women and sexuality. In a culture in which a court held that a pharmacist’s refusal to provide women with urgently-needed medication “has nothing to do with gender or gender discrimination,”²²⁶ it is even more important that feminist legal activists challenge affronts to reproductive choice in increasingly innovative ways.

²²⁵ Fine & McClelland, *supra* note 185, at 1017–18 (emphasis added) (citation omitted).

²²⁶ *Stormans*, 524 F. Supp. 2d 1245, 1263 (W.D. Wash. 2007).

