NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

PROVIDING EMERGENCY CONTRACEPTION TO SEXUAL ASSAULT SURVIVORS

Emergency contraception (EC) is an FDA-approved form of contraception that prevents pregnancy.[1] EC is an extremely time-sensitive drug that is most effective if used within the first 12 to 24 hours following birth control failure, unprotected sex, or sexual assault. Timely access to EC is particularly important for victims of sexual assault. Providing EC to survivors is an integral component of a comprehensive medical response to sexual assault – failure to provide EC as an option can deny survivors control over their bodies at a critical time and cause further trauma by forcing them to confront an unwanted pregnancy. Unfortunately, many hospital emergency rooms – Catholic hospitals in particular – do not provide information about or access to EC to survivors of sexual assault.

EC is often confused with the abortion medication, RU-486, or mifepristone, but EC cannot end a pregnancy. Studies show that EC works to prevent pregnancy in the exact same way that ordinary birth control pills do – mainly by prohibiting ovulation. Although the science is not 100% definitive, the best evidence indicates that EC works prior to fertilization.[2] If a woman is pregnant, EC will not work, and there will be no harm to either the woman or the fetus.[3]

Fortunately, states have begun to recognize that EC information and provision should be part of the minimum standard of care for victims of sexual assault. Fifteen states and the District of Columbia have laws that require hospital emergency rooms to provide information about or access to EC to sexual assault survivors.[4] These laws are known as "EC in the ER" laws. Below are elements essential to a successful EC in the ER law.

Elements of a Successful EC in the ER State Law

Information About and Provision of EC

Hospitals should provide information about EC to all sexual assault survivors, as well as the drug itself to survivors who want it. Providing EC to survivors during their hospital visit ensures timely access to a medication that is most effective if used within 12 to 24 hours of the assault. It also saves survivors burdensome additional trips to providers and pharmacies at a moment of crisis.

No Exceptions to the Law

All emergency health care facilities must be included in EC in the ER laws. None of the EC in the ER laws allow for exceptions – all health care facilities specified in the laws must comply.[5]

- Excluding Catholic hospitals could have dire consequences for many survivors of sexual assault. Catholic hospitals comprise 12.5% of all US hospitals.[6] In one year, Catholic hospitals had more than 16.6 million emergency room visits.[7]
- Offering EC to survivors is consistent with Catholic hospitals' statement of identity, which includes work to "foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable."[8]
- Catholic health facilities also hold themselves out as providing "compassionate, high-quality care,"[9] which for sexual assault survivors must include information about and access to EC.
- Requiring Catholic hospitals to provide EC does not conflict with the *Ethical and Religious Directives for Catholic Health Care Service*, which govern Catholic health facilities. Directive

36 specifically states, "A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization."[10] Although some Catholic hospitals interpret this directive in an extreme manner in order to deny EC to sexual assault survivors when they most need it,[11] Catholic ethicists point out that providing EC to rape survivors "does not violate church teaching as it currently stands."[12]

- Despite the Catholic Health Association's claim that Catholic hospitals regularly provide some form of contraceptive medication to prevent pregnancy in women who have been raped, studies have not found that to be the case.[13]

Enforcement

An enforcement mechanism provides a way to ensure that health care facilities are complying with the law in the state, as well as a method for taking action when a hospital is not in compliance. Complaint-based enforcement mechanisms empower survivors denied EC to report violations of the law and direct the state Departments of Health to investigate violations. Proactive enforcement mechanisms – such as monitoring, site visits, and reports – recognize that the burden should not rest solely on the survivor, who may be reluctant to come forward and file a complaint. Therefore, both complaint-based and proactive enforcement mechanisms are critical to ensuring compliance with the law.

Complaint-based enforcement. Seven states – Minnesota, New Jersey, New Mexico, Oregon, Utah, Washington, and Wisconsin – have complaint-based enforcement mechanisms. If the state department of health receives a complaint that a hospital is not complying with the law, the department must investigate the complaint and take appropriate action, including penalties such as fines or license suspension or revocation.

- New Jersey law also requires an annual report to the public, summarizing the complaints and actions taken.

Proactive enforcement. Complaint-based enforcement should be accompanied by proactive enforcement, which puts the onus on either the state to ensure compliance or on the hospitals to demonstrate compliance.

- In Illinois, hospitals are required to submit their protocol for providing sexual assault survivors with information on EC to the Department of Public Health for approval. In May 2005, the Illinois Department of Public Health initiated investigations into hospitals over concerns about unsatisfactory protocols.[14]
- Massachusetts law requires hospitals to report annually to the Department of Public Health the number of times EC is administered to sexual assault survivors.
- The New Jersey Commissioner of Health must determine, at least annually, whether a health care facility is complying with the law.
- In Minnesota and Wisconsin, the Department of Health – in addition to accepting and investigating complaints – must also periodically review hospital procedures to determine whether hospitals are in compliance.

Lack of Enforcement Mechanisms. A lack of enforcement mechanisms in state EC in the ER laws has been linked to low compliance and has frustrated advocates in those states.

- One study found 34% compliance among Catholic hospitals in California and proposed that the lack of an enforcement mechanism in the state's EC in the ER law may be the reason for the low compliance rate.[15]

- In a recent survey of advocates in states with EC in the ER laws, those in states without enforcement mechanisms reported not knowing whether hospitals are complying, expressed their desire for enforcement mechanisms, and recommended that other states considering EC in the ER measures include such provisions in the original legislation.[16]
- Because of the lack of proactive compliance mechanisms in the New Mexico EC in the ER law, a bill introduced in New Mexico (but never passed) would have requested the Department of Health to establish a tracking system to determine the success of the law.[17]

Sufficient and Understandable Informational Materials about EC

The information about EC presented to survivors of sexual assault must be medically accurate and culturally competent.

- New York law specifies that materials must be clear, concise, readily comprehensible, and in languages other than English.
- Oregon law specifies that materials must be "clearly written and easily understood in a culturally competent manner," meaning that materials must be "sensitive to the patient's faith, race, ethnicity and national origin."

Health care facilities must receive an adequate supply of the materials.

- Washington law mandates that the Secretary of Health must develop and produce materials relating to EC for distribution and use in all emergency rooms in the state, and mandates that these materials be available in sufficient quantities. Because of this requirement, the Washington Department of Health produced a one-page factsheet about EC, as well as a trifold wallet card, and initially sent 1000 copies to each hospital in the state.
- Oregon law requires the Department of Human Services to distribute materials about EC to all hospital emergency departments in the state, "in quantities sufficient to comply with the requirements of this [law]."

Training and Information about EC for All Hospital Personnel

Training and information about EC for all hospital personnel who interact with survivors of sexual assault is essential. This includes administrative personnel, particularly those who staff the phone and front desk and may be the first person with whom a survivor has contact.

- Studies have shown that many hospital staff may be unaware of or misinformed about EC, even in states with EC in the ER laws. In one study, staff confused emergency contraception with the abortion pill mifepristone and incorrectly said that it is not available in the US or in the state.[18]
- New Jersey requires all personnel who provide care *or information* to sexual assault survivors to receive training.
- The Massachusetts Department of Public Health developed a factsheet about EC for emergency department staff who provide care to sexual assault survivors.[19]
- Training for those who interact with sexual assault survivors should include sensitivity training. One study reported unsupportive and judgmental comments from those answering the phone at Catholic hospitals, such as "Go look in the Yellow Pages under abortion" and "We frown upon that."[20]

Involvement of All Stakeholders

For a successful EC in the ER law, all stakeholders should be involved in all stages of the process, including developing, implementing, and monitoring the law.

- Washington law requires the formation of a task force, comprising representatives from community sexual assault programs, advocacy groups, medical agencies, and hospital associations to provide input on the development of educational materials and development of rules to implement the law. The Washington State Catholic Conference participated in the task force.
- New Jersey law codifies involvement of the state sexual assault coalition and the Sexual Assault Nurse Examiner (SANE) program in material development. It also requires that SANE be notified of complaints against non-compliant hospitals.
- Oregon law specifies that the Department of Human Services must produce materials "in collaboration with victim advocates, other interested parties and nonprofit organizations that provide intervention and support services to victims of sexual assault and their families."

Conclusion

EC in the ER laws ensure provision of EC on-site in sexual assault survivors' initial visit to emergency care facilities, thereby guaranteeing timely access to care and preventing additional burdens to survivors. EC in the ER laws should be passed in all states so that survivors of sexual assault receive the compassionate and comprehensive medical care they deserve.

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[1] U.S. Food and Drug Administration, FDA's Decision Regarding Plan B: Questions and Answers (May 2004), *at* http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm.

[2] *See* Frank Davidoff & James Trussell, *Plan B and The Politics of Doubt,* 296 J. AM. MED. ASS'N. 1775 (2006). Even if it does prevent implantation, the drug still does not end a pregnancy, because pregnancy is defined by the federal government and medically accepted authorities as beginning after implantation. *See, e.g.*, Protection of Human Subjects, 45 C.F.R § 46.202(f) (2001) (defining pregnancy as beginning after implantation), *available at* http://ohsr.od.nih.gov/guidelines/45cfr46.html#46.202.

[3] James Trussell et al., *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* (September 2007), http://ec.princeton.edu/questions/EC-review.pdf.

[4] The states are Arkansas, California, Colorado, Connecticut, DC, Illinois, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah, Washington, and Wisconsin. ARK. CODE ANN. § 20-13-1403 (West 2009); CAL. PENAL CODE § 13823.11 (West 2009); COLO. REV. STAT. ANN. § 25-3-110 (West 2009);CONN. GEN. STAT. § 19a-112e (2009); D.C. CODE § 7-2123 (2009); 410 ILL. COMP. STAT. § 70/2.2 (2009); ILL. ADMIN. CODE tit. 77, §§ 545.20, .35, .60, .95 (2009); MASS. GEN. LAWS ANN. ch. 41, § 97B (West 2009); MASS. GEN. LAWS ANN. ch. 111, § 70E (West 2009); MINN. STAT. §145.4712 (2009);N.J. STAT. ANN. §§ 26:2H-12.6b to -12.6g (West 2009); N.J. STAT. ANN. §52:4B-44 (West 2009); N.M. STAT. ANN. §§ 24-10D-1 to -5 (West 2009); N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2009); OR. REV. STAT. § 435.254 (2009); S.C. CODE ANN. § 16-3-1350 (2009); UTAH CODE ANN. § 26-21b-201 (West 2009); WASH. REV. CODE §§ 70.41.020, .350, .360 (2009); WIS. STAT. § 50.375 (2009). Arkansas, Colorado, and Illinois require only the provision of information about EC. Texas also has a law that could be interpreted to require the provision of information about EC to sexual assault survivors. However, the language in the law is unclear and there are no regulations that clarify whether this is required. TEX. HEALTH & SAFETY CODE ANN. §§ 323.001–.006 (Vernon 2009).

[5] Arkansas's and Colorado's laws allow individual health care professionals to refuse to provide information about EC if the refusal is based on their religious or moral beliefs, but does not exempt any religiously-affiliated hospitals from having to provide the information. Thus, the burden is on the hospital to make sure someone on staff will provide information about EC to sexual assault victims. Similarly, Connecticut's law allows health care facilities to contract with independent providers to ensure compliance with the law (so that religiously-affiliated hospitals would not have to have their own employees provide the medication), but independent providers must operate at the facility. The definition of "independent provider" includes physicians, physician assistants, registered nurses, or nurse-midwives who are trained to conduct forensic exams after sexual assaults.

[6] Catholic Health Ass'n of the U.S, Catholic Health Care in the United States (Jan. 2008), http://www.chausa.org/NR/rdonlyres/68B7C0E5-F9AA-4106-B182-7DF0FC30A1CA/0/FACTSHEET.pdf.

[7] *Id.*
[8] Catholic Health Ass'n of the U.S, A Shared Statement of Identity for the Catholic Health Ministry (2009), http://www.chausa.org/Pub/MainNav/ourcommitments/Mission/sharedstatement.htm (last visited Jan. 13, 2009).
[9] Catholic Health Ass'n of the U.S., Mission (2009), http://www.chausa.org/Pub/MainNav/ourcommitments/Mission/overview.htm (last visited Jan. 13, 2009).
[10] Nat'l Conference of Catholic Bishops and U.S.Conference of Catholic Bishops, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICE, 4th ed. (2001), *available at* http://www.usccb.org/bishops/directives.shtml.
[11] Unfortunately, some Catholic hospitals take an extreme view of Directive 36 and apply what is known as the Peoria Protocol, which was developed by staff at the OSF St. Francis Medical Center in Peoria, Illinois. The Peoria Protocol calls for ovulation testing of a sexual assault survivor, despite the unreliability of ovulation testing. Under the Protocol, if the survivor could be ovulating, she should not be offered EC. In other words, it is only when the woman most needs EC that Catholics hospitals following the Protocol will deny it to her.
Three states, Connecticut, Minnesota, and Wisconsin, allow hospitals to administer pregnancy tests to sexual assault survivors; hospitals are allowed to refuse to provide EC if the pregnancy test is positive. Connecticut's law specifies that pregnancy tests approved by the United States Food and Drug Administration are the only approved tests that can exempt any healthcare facility from compliance with the law, thus implicitly denying Catholic hospitals the ability to perform an ovulation test.
[12] Michael R. Panicola & Ronald P. Hamel, *Conscience, Cooperation, and Full Disclosure*, 87 HEALTH PROGRESS (Jan.–Feb. 2006), *available at* http://www.chausa.org/Pub/MainNav/News/HP/Archive/2006/01JanFeb/default.htm.
[13] *Compare* Catholic Health Ass'n of the U.S, The Catholic Health Ministry in the United States (Aug. 2003), *with* Chelsea Polis, Kate Schaffer, & Teresa Harrison, *Accessibility of Emergency Contraception in California's Catholic Hospitals*, 15 WOMEN'S HEALTH ISSUES 174 (2005); Ibis Reproductive Health & Catholics for a Free Choice, COMPLYING WITH THE LAW? HOW CATHOLIC HOSPITALS RESPOND TO STATE LAWS MANDATING THE PROVISION OF EMERGENCY CONTRACEPTION TO SEXUAL ASSAULT PATIENTS (2006); Ibis Reproductive Health & Catholics for a Free Choice, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS (2002).
[14] Elaine Hopkins, *Illinois Probes Hospitals' Rape Care*, J. STAR (Ill.), May 25, 2005.
[15] Polis, Schaffer & Harrison, *supra* note 13, at 176.
[16] Education Fund of Family Planning Advocates of NYS, Clara Bell Duvall Reproductive Freedom Project-ACLU of Pennsylvania, National Sexual Violence Resource Center, HOSPITAL PROVISION OF EMERGENCY CONTRACEPTION FOR VICTIMS OF SEXUAL ASSAULT: A RETROSPECTIVE ANALYSIS FROM STATES WITH EC IN EMERGENCY ROOM LAWS (Spring 2006).
[17] H.J.M. 19, 46th Leg., 2d Sess. (N.M. 2004).
[18] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS OF EMERGENCY MED. 105, 108 (2005).
[19] Mass. Dep't Pub. Health, KEY FACTS ABOUT EMERGENCY CONTRACEPTION FOR EMERGENCY DEPARTMENT STAFF WHO PROVIDE CARE TO SEXUAL ASSAULT AND RAPE SURVIVORS (May 26, 2006), *available at* http://www.mass.gov/Eeohhs2/docs/dph/quality/healthcare/ec_provider_fact_sheet.pdf.
[20] Ibis Reproductive Health & Catholics for a Free Choice, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 14 (2002).