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Providing Emergency Contraception to Sexual Assault Survivors

Emergency contraception (EC) is a time-sensitive Federal Drug Administration (FDA)-approved form of contraception that prevents pregnancy. Timely access to EC is particularly important for survivors of sexual assault. Providing EC to survivors is an integral component of a comprehensive medical response to sexual assault—patients deserve autonomy over their own bodies and failure to provide EC denies patients this right and could force them to confront an unwanted pregnancy. Unfortunately, there are hospital emergency rooms—Catholic hospitals in particular—that do not provide information about or access to EC to survivors of sexual assault.

Fortunately, states are ensuring that EC information and provision aligns with medical experts' consensus on appropriate care for patients.[1] Twenty-two states and the District of Columbia have laws or regulations that require hospital emergency rooms to provide information about or access to EC to sexual assault survivors.[2] These laws are known as "EC in the ER" laws. Below is context for why EC in the ER laws are especially critical now and elements of a successful EC in the ER law.

EMERGENCY CONTRACEPTION PREVENTS PREGNANCY

While true commitment to reproductive freedom and bodily autonomy means access to all forms of birth control and abortion, it is also important to understand that EC does not cause abortions.[3] EC is a birth control option that prevents pregnancy after unprotected sex. There are currently three types of birth control methods that can be used as EC: levonorgestrol (Plan B), ulipristal acetate (ella), and the copper IUD (ParaGard).[4] Importantly, EC is not an abortifacient and does not end a pregnancy.

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Emergency Contraception in a Post-*Roe* World

Even before the Supreme Court overturned *Roe v. Wade* and allowed states to ban abortion, birth control access was already at risk, especially for EC. Legislators across the country purposely conflate abortion and certain methods of birth control, including EC, to undermine birth control access.[5] That kind of intentional misinformation about birth control has only become more widespread, and birth control access is now being targeted in new ways. For example, some state abortion bans are worded in such a way that they may be used to block EC access, leading to confusion or decisions to not provide EC.[6,7] At the same time, access to EC is even more critical for those who need it. EC in the ER bills can help alleviate some of these access concerns.

Elements of a Successful EC in the ER State Law

Information About and Provision of EC. Hospitals should provide information about EC and EC itself to all sexual assault survivors who want either or both. Providing EC to survivors during their hospital visit ensures timely access to time-sensitive medication. It also saves survivors burdensome additional trips to health care providers and pharmacies at a moment of crisis.

All Emergency Facilities Must Be Included. All emergency health care facilities must be included in EC in the ER laws.[8] A patient's health should always come first. Nearly all EC in the ER laws ensure all hospitals comply with the law's requirements, allowing timely access to health care for survivors.[9]

- Excluding Catholic hospitals could have dire consequences for many survivors of sexual assault. This is especially important given the increasing predominance of Catholic health systems across the US.[10] One in seven patients in the U.S. is cared for in a Catholic hospital.[11] In one year, Catholic hospitals had more than 20 million emergency room visits.[12]

- 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."[13]

- 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 states that "compassionate and understanding care should be given to a person who is the victim of sexual assault." The Directive goes on to specify, "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. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."[14] Some Catholic hospitals interpret this directive in an extreme manner in order to deny EC to sexual assault survivors when they most need it.[15] However, in 2010 the senior director of ethics for the Catholic Health Association made it clear that providing emergency contraception to rape survivors does not violate the directive.[16]

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. Both complaint-based and proactive enforcement mechanisms are critical to ensuring compliance with the law.

Complaint-based enforcement. Eight states—Hawaii, Minnesota, New Jersey, New Mexico, Oregon, Utah, Washington, and Wisconsin—have complaint-based enforcement mechanisms.[17] 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.[18]

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

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the hospitals to demonstrate compliance.

- In Illinois, hospitals are required to submit protocol for providing sexual assault survivors with information on EC to the Department of Public Health for approval.[19] In May 2005, the Illinois Department of Public Health initiated investigations into hospitals over concerns about unsatisfactory protocols.[20]

- Massachusetts law requires hospitals to report annually to the Department of Public Health the number of times EC is administered to sexual assault survivors.[21]

- The New Jersey Commissioner of Health must determine, at least annually, whether a health care facility is complying with the law.[22]

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.[23]

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.

Sufficient and Understandable Informational Materials about EC

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.[24]

- 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."[25]

Health care facilities must receive an adequate supply of informational 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 avail- able in sufficient quantities.[26] 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]."[27]

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. Especially since the Supreme Court overturned *Roe v. Wade* and states began making abortion illegal, training and information about EC for hospital personnel is crucial to combat misinformation about EC.

- 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 medication abortion and incorrectly said that it is not available in the US or in the state.[28]

- New Jersey and the District of Columbia require all personnel who provide care or information to sexual assault survivors to receive training.[29]

- 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."[30]

- One study found that among religiously affiliated hospitals surveyed, none reported any time spent during teaching afternoons or grand rounds on the topic of emergency contraception. The same survey showed that emergency contraception policies in a hospital setting were not clearly communicated in religious and non-religious settings, which caused confusion among providers about their hospital's rules for providing EC to patients.[31]

Involvement of All Stakeholders

For a successful EC in the ER law, working in collaboration with a wide variety of stakeholders in all stages of the process, including developing, implementing, and

monitoring the law is essential. Sexual assault programs and advocacy organizations in particular can provide valuable insights in the development of a robust law, as well as effective processes for implementation and compliance.

- 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 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.[32] It also requires that SANE be notified of complaints against non-compliant hospitals.[33]

- 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."[34]

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. This care is critical at all times, but especially now in an unprecedented crisis in access to reproductive health care.

FOOTNOTES

1 *Access to Emergency Contraception*, ACOG Committee Opinion. Number 542 (July 2017).

2 The states are Arkansas, California, Colorado, Connecticut, DC, Hawaii, Illinois, Louisiana, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, Virginia, Washington, and Wisconsin. Ark. Code Ann. § 20-13-1401 to 03 (West 2013); Cal. Penal Code § 13823.11 (West 2013); Colo. Rev. Stat. Ann. § 25-3-110 (West 2013); Conn. Gen. Stat. Ann. § 19a-112e (2009); D.C. Code § 7-2121, § 7-2125 (2009); Haw. Rev. Stat. § 321-512 A-D (West 2013); 410 Ill. Comp. Stat. § 70/2.2 (2009), see also Ill. Admin. Code tit. 77, §§ 545.20 .35, .60, .95 (2009); Act No. 513, 2022, La. Acts 40:1216, Mass. Gen. Laws Ann. ch. 41, § 97B (West 2013); Mass. Gen. Laws Ann. ch. 111, § 70E (West 2013); Minn. Stat. Ann. §145.4711 to 18 (2009); Nev. Rev. Stat. 449.1885 (20); N.J. Stat. Ann. § 26:2H-12.6b to 12.6g (West 2013); N.J. Stat. Ann. §52:4B-44 (West 2013); N.M. Stat. Ann. § 24-10D-1 to -5 (West 2013); N.Y. Pub. Health Law § 2805-p (McKinney 2009); Ohio Rev. Code Ann. § 2907.29 (2012); Or. Rev. Stat. § 435.254 (2009), see also OAR 333-505-0120 (2021); 28 Pa. Code §§ 117.51-117.58, see also 27 Pa. Code § 101.4 (Lexis Advance through the July 2022 supplement 572 changes effective through 52 PA.B. 2550, April 23, 2022), S.C. Code Ann. § 16-3-1350 (2009); Tex. Health & Safety Code § 323.004 (LexisNexis, Lexis Advance through the 2021 Regular Session of the 87th legislature, 2021 1st Called Session, 2021 2nd Called Session, 2021 3rd called session, and the 2021 & 2022 ballot propositions), Utah Code Ann. § 26-21b-201 (West 2013); Va. Code Ann. § 32.1-162.15:4, Wash. Rev. Code Ann. § 70.41.020, .350, .360 (2009), see also WAC 246-320-286; Wis. Stat. Ann. § 50.375 (2009), Wis. Stat. Ann. § 50.375 (LexisNexis, Lexis Advance through the 2021-2022 Legislative Session with the exception of Acts 234, 238, 251, 258, 261, 266, and 267). Arkansas, Colorado, Texas, and Virginia require only the provision of information about EC. Ark. Code Ann. § 20-13-1403 (West 2013); Colo. Rev. Stat. Ann. § 25-3-110 (West 2013); Ill. Admin. Code tit. 77, §§ 545.20, .35, .60, .95 (2009), Tex. Health & Safety Code § 323.004, supra., Va. Code Ann. § 32.1-162.15:4.

3 *See generally* Endler, et al., *Effect of Levonorgestrel Emergency Contraception on Implantation and Fertility: A Review*, 109 Contraception 8 (May 2022).

4 *See generally*, The American College of of Obstetricians and Gynecologists, *Emergency Contraception FAQs*, available at https://www.acog.org/womens-health/faqs/emergency-contraception.

5 National Womens's Law Center, *Don't Be Fooled: Birth Control is Already at Risk* (June 2022), *available at* https://nwlc.org/wp-content/uploads/2022/06/FactSheet_Attacks-on-birth-control-6.17.22.pdf.

6 *See generally* Neelam Patel, *Abortion "Trigger" Ban Statutes: Impacts on Plan B, Birth Control and IVF Treatments*, XXIII Georgetown Journal of Gender and the Law 3 (2022).

7 This uncertainty has led some hospital systems, like St. Luke's in Missouri, to stop offering EC because they believed Missouri's abortion ban also bans EC, although they reversed that policy shortly after they announced it. Taylor Johnson & Shain Bergan, *St. Luke's Locations Resume Offering Emergency Contraception Following Missouri Abortion Ban*, KCTV (June 29, 2022), *available at* https://www.kctv5.com/2022/06/29/st-lukes-hospital-no-longer-offering-emergency-contraception-following-missouri-abortion-ban/. The uncertainty also extends to health care providers. In Mississippi, a group of nurses who specialize in caring for sexual assault survivors contacted Attorney General Lynn Fitch for guidance on if the state's abortion ban restricted the nurses from providing emergency contraception to their patients. They did not receive a response. Isabelle Taft, *Sexual Assault Nurses Asked the AG's office if Plan B is Legal. They Never Got a Response*, Mississippi Today (Sept. 2022), *available at* https://mississippitoday.org/2022/09/14/sexual-assault-nurse-examiners-ag-communication/.

8 Arkansas's, Colorado, and Texas' 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 do not exempt any religiously-affiliated hospitals from having to provide the information. Ark. Code Ann. § 20-13-1403(b)(1) (West 2013); Colo. Rev. Stat. Ann. § 25-3-110(3)(a) (West 2013); Tex. Health & Safety Code § 323.005(c). 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. Conn. Gen. Stat. Ann. § 19a-112e(c)(2) (2009). The definition of "independent provider" includes physicians, physician assistants, registered nurses, or nurse-midwives who are trained to conduct forensic exams after sexual assaults. Conn. Gen. Stat. Ann. § 19a-112e(a)(6) (2009).

9 Only Pennsylvania and Illinois exempt some health care facilities from the states' EC in the ER laws. The Pennsylvania law allows for a hospital to not comply with the state's EC in the ER law for religious or moral reasons. If a hospital refuses to provide care, the patient must then immediately be transferred to a hospital that can provide emergency contraception. 28 Pa. Code § 117.57, *supra*. Similarly, Illinois law requires hospitals to either provide EC or transfer patients to a facility that can provide EC. 410 Ill. Comp. Stat. § 70/2.2, *supra*. It is important that survivors get this critical care. Allowing a hospital to be exempt from providing care a survivor seeks is burdensome to survivors and can result in survivors not getting the care they need.

10 *See generally* Community Catalyst, *Bigger and Bigger: The Growth of Catholic Health Systems* (2020), *available at* https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf.

11 Catholic Health Ass'n of the U.S., *U.S. Catholic Health Care* (2021), https://www.chausa.org/docs/default-source/default-document-library/2021-the-strategic-profile-_sb_final.pdf?sfvrsn=8939f6f2_2.

12 *Id.*

13 Catholic Health Ass'n of the U.S., *A Shared Statement of Identity,* http://www.chausa.org/mission/a-shared-statement-of-identity, (last visited Mar. 16, 2021).

14 United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018). Please note, the full text reads: "Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. 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. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.*"

15 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. *See* Ronald P. Hamel & Michael R. Panicola, *Emergency Contraception and Sexual Assault*, Health Progress (Sept.-Oct. 2002), https://www.chausa.org/publications/health-progress/article/september-october-2002/emergency-contraception-and-sexual-assault (referring to the Peoria Protocol as the "ovulation method."). Four states–Connecticut, Hawaii, 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. Conn. Gen. Stat. Ann. § 19a-112e(b)(3) (2009); Haw. Rev. Stat. § 321-512(c) (2013); Minn. Stat. Ann. §145.4712(b) (2009); Wis. Stat. Ann. § 50.375(4) (2009). Connecticut's law specifies the only approved tests are pregnancy tests approved by the United States Food and Drug Administration, which would not include an ovulation test. Conn. Gen. Stat. Ann. § 19a-112e(d) (2009).

16 Ron Hamel, *Thinking Ethically About Emergency Contraception*, Health Progress 62, 65 (Jan.-Feb. 2010).

17 Haw. Rev. Stat. § 321-513 (2017); Minn. Stat. Ann. §145.4713 (2021); N.J. Stat. Ann. § 26:2H-12.6f (2019); N.M. Stat. Ann. 24-10D-5 (West 2013); Or. Rev. Stat. § 435.254(3) (2011); Utah Code Ann. § 26-21b-301 (WEST 2013); Wash. Rev. Code Ann.. § 70.41.360 (2022); Wis. Stat. Ann. § 50.375(5) (2019).

18 N.J. Stat. Ann. § 26:2H-12.6j (2009).

19 410 Ill. Comp. Stat. § 70/2.1(b) (2009).

20 Elaine Hopkins, *Illinois Probes Hospitals' Rape Care,* J. Star (Ill.). May 25, 2005.

21 Mass Gen. Laws Ann. ch. 111, § 70E (West 2013).

22 N.J. Stat. Ann § 26:2H-12.6f (2019).

23 Minn. Stat. Ann. §145.4713 (2021); Wis. Stat. Ann. § 50.36(4) (2009).

24 N.y. Pub. Health Law § 2805-p(3) (2014).

25 Or. Rev. Stat. § 435.254(2)(c) (2011); Or. Rev. Stat. § 435.252(2) (2009).

26 Wash. Rev. Code Ann. § 70.41.350(2) (2009).

27 Or. Rev. Stat. § 435.254(2)(c) (2011).

28 Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 Annals of Emergency Med. 105, 108 (2005).

29 N.J. Stat. Ann. § 26:2H-12.6d (2021); D.C. CODE § 7-2124 (2009).

30 Ibis Reproductive Health & Catholics for A Free Choice, *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms* 14 (2002).

31 *Rubin*, et al., *Hospital Religious Affiliation and Emergency Contraceptive Prescribing Practices,* 96 American Journal of Public Health 1398 (Sept. 2006).

32 N.J. Stat. Ann. § 26:2H-12.6e (West 2013).

33 N.J. Stat. Ann. § 26:2H-12.6f (West 2013).

34 Or. Rev. Stat. § 435.254(2)(a) (2009).