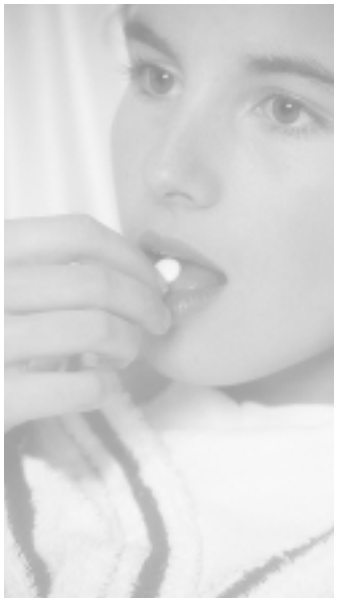
Preventing Pregnancy from Sexual Assault

Four Action Strategies to Improve Hospital Policies on Provision of Emergency Contraception



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National Sexual Violence Resource Center
Education Fund of Family Planning Advocates of NYS
Clara Bell Duvall Reproductive Freedom Project of the ACLU of Pennsylvania

Acknowledgments

This toolkit is the product of collaborative work by staff of three organizations:

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We dedicate our work to the thousands of rape victims whose lives we hope to improve by ensuring that they have the opportunity to prevent the additional trauma of unintended pregnancy.

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Introduction

Each year, an estimated 25,000 American women become pregnant following an act of sexual violence. As many as 22,000 of those pregnancies could be prevented through the prompt use of emergency contraception (often referred to as "the morning after pill"). Emergency contraception (EC) is a high dosage of regular birth control pills. It is a safe and effective FDA-approved method of preventing pregnancy after unprotected sex.

Yet only 20 percent of rape victims receiving treatment at hospital emergency departments actually received EC over a seven-year period in the 1990s, according to a national study. Surveys in several states have identified wide variations in hospital policies on providing EC to rape victims. In New York, a hospital survey found that as many as 1,000 rape victims a year were being sent away from emergency rooms without having received EC on site.

Leading national medical organizations recognize EC as part of standard rape treatment in hospital emergency departments. Yet, clearly, it is not. How can this essential aspect of emergency care for sexual assault victims be improved?

Three organizations have come together to produce this toolkit explaining how your organization can work to ensure that every sexual assault victim is offered the means to prevent pregnancy when she receives treatment at a hospital. The National Sexual Violence Resource Center (www.nsvrc.org) has approached this issue from the perspective of providing expertise in development and distribution of resources that will ensure sexual assault victims' right to quality health care. The Education Fund of Family Planning Advocates of New York State (www.fpaofnys.org) and the Clara Bell Duvall Project of the ACLU of Pennsylvania (www.aclupa.org/duvall) have brought to the partnership their expertise in women's reproductive health care and policies that ensure women's access to emergency contraception.

This toolkit describes four different options for organizations interested in working to improve the provision of EC at hospitals:

1. Legislation mandating that all hospitals offer EC to rape victims.
2. State administrative action or the issuance of regulations by state agencies that oversee hospitals.
3. Litigation on behalf of rape victims who are denied EC.
4. Voluntary action such as approaching hospitals and asking them to voluntarily improve their policies, providing training to service providers and increasing public awareness.

For each of these four approaches, the toolkit offers helpful practical tips and real-life examples of what community organizations have done. The appendices provide useful resources and references where more information can be found.

This toolkit offers basic information on rape, pregnancy and the use of emergency contraception to prevent pregnancy. It provides advice on how community-based organizations can conduct surveys to determine what the policies are at their local hospitals concerning the offering of EC to rape victims. The Duvall Project and the ACLU Reproductive Freedom Project have published a separate detailed manual, "E.C. in the E.R.: A manual for improving services to women who have been sexually assaulted," on hospital survey techniques. That manual and this policy toolkit are intended as companion pieces. For a copy of the manual, please contact either the ACLU Reproductive Freedom Project at rfp@aclu.org, or Carol Petraitis at Duvall@aclupa.org or 215-629-0111.

Each state is different. The best approach for one state may not work in another. Several factors are necessary to consider before initiating any of these proposed strategies. Please refer to the section titled: "Four Strategies to Increase Access to EC" in this toolkit. If you need help deciding on the best approach for your state, please contact The MergerWatch Project of the Education Fund of Family Planning Advocates of NYS at info@mergerwatch.org or 518-436-8408, ext. 214, or the National Sexual Violence Resource Center at www.nsvrc.org or 877-739-3895, ext. 104.

Stories of Victims of Sexual Assault

The following two stories are powerful testimonies about victims of sexual assault. The first story is written by a direct services provider who supervised a case of a 14-year-old girl, while the second story is provided by a brave sexual assault victim. Each story illustrates the importance of receiving EC during emergency department treatment; one by showing the harm of not receiving EC, the other by showing the positive impact receiving EC had on the victim. (The following stories are presented in the authors' own words.)

Failure to Receive EC

I am a Direct Services Supervisor for a sexual assault services center in southeastern Pennsylvania. In the summer of 2002, I supervised a case involving a 14-year-old girl who was sexually assaulted by an acquaintance. The teen's mother took her to the local emergency room where a physician in the children's medical department interviewed and examined her. At the conclusion of the examination, the doctor wrote a prescription for emergency contraception and instructed the mother to have it filled right away. The mother was Hispanic and spoke very little English, but she understood that she needed to have the prescription filled immediately.

Approximately 10 days later, the teen came in for a follow-up appointment with the doctor. It was at that time that we learned about their difficulties in getting the prescription filled. The girl said that after leaving the hospital between 3 and 4 a.m., both went to a 24-hour CVS pharmacy. It was the 14-year-old who had to do most of the talking and translating for her mother. When the mother presented the prescription, the pharmacist refused to fill the prescription because it was "too strong for her age." The pharmacist did not offer to help them by calling the physician or referring them elsewhere. The first thing in the morning, the mother and daughter went to a privately-owned pharmacy. Again, the pharmacist there would not fill the prescription or offer any help. In the end, they were not able to obtain any emergency contraception.

This Hispanic mother did not have a lot of money, so even if she had found someone to fill the prescription, it would have been a financial burden. One of the saddest things about this whole situation was putting the 14-year-old girl through the added trauma of being the one to ask the pharmacists for the emergency contraception and being denied their help.

In my view, we need to have a system that is more compassionate to young victims of sexual assault. If she had received emergency contraception in the hospital, she would have been spared a lot of unnecessary trauma.

Direct Services Supervisor
Pennsylvania

Stories of Victims of Sexual Assault

Successful Provision of EC

After midnight on July 8, 2002, while asleep in bed next to my 4-year-old son, I was accosted by an unknown man who handcuffed, blindfolded and kidnapped me from my home at gunpoint, threatening to kill me if I did not cooperate. I was driven to an unknown location, raped and – miraculously – returned to my front porch unharmed within a few hours' time. I was warned not to call the police or the man would return to kill both me and my son.

Because I was more afraid of not calling the police and having the stranger return to assault me again, I called the police department immediately. They arrived at my home shortly, and after a few brief questions, I was instructed to allow the paramedics who had accompanied the police to take me to the Sexual Assault Nurse Examiners (SANE) unit located at St. Joseph's Hospital in Albuquerque, so that they could examine and treat me for any harm that may have been inflicted during the assault.

At the SANE unit, I was provided emotional counseling, was physically examined, and questioned by the detective in charge of my case. I was given various antibiotics and preventive treatments for the possibility that I may have contracted a sexually transmitted disease during the assault. I was also given Plan B – an emergency contraception that, as I understand it, is 89% effective if taken within 72 hours after having unprotected sex.*

I feel very fortunate to have been taken to a place like the SANE unit after going through what was easily the most terrifying experience of my life. And I feel equally fortunate to have received the anti-STD treatments and emergency contraception that were provided. Knowing the emotional difficulties that I have had to surmount since the attack, I cannot imagine how much worse it could have been if I had to deal with an unwanted pregnancy.

I can say from personal experience that dealing with an unplanned pregnancy is difficult enough, much less in a situation where sexual assault is involved. One thing that has made my recovery from the attack much easier is that I have not had to deal with any residual effects – in other words, I have not had to deal with the trauma of recovering from serious injury, contracting a disease, or pregnancy.

Based on my experience, I urge legislators at any level to support emergency contraception legislation, making this crucial birth control available to all women who survive sexual assault.

Sexual Assault Victim
New Mexico

** Recent studies show the EC can be taken up to 120 hours after unprotected intercourse.*

Facts About Emergency Contraception for Rape Victims

Rape and Pregnancy

- An estimated 25,000 U.S. women become pregnant as a result of sexual assault each year. EC could be used to prevent as many as 22,000 of these pregnancies.[1]
- 12% of all women experience sexual assault in a lifetime and 4.7% of those assaults result in pregnancy.[2]
- An estimated 3 million unintended pregnancies occur in the U.S. each year. EC could prevent as many as 1.5 million, including as many as 800,000 pregnancies that result in abortion.[3]

Safe and Effective Pregnancy Prevention

- Emergency contraception is a safe and effective, FDA-approved method of preventing pregnancy after unprotected intercourse.[4]
- EC is time-sensitive. The sooner it is given, the better it works.[5]
- EC pills can be given in different ways. One approach requires giving a first dose within 72 to 120 hours of unprotected intercourse and a second dose 12 hours later. The second approach, which applies uniquely to progestin-only medications, entails giving the entire course of medication at one time within 72 to 120 hours after unprotected intercourse.[6]
- The side effects of EC are temporary and may include nausea, vomiting and breast tenderness. Plan B® appears to be associated with the fewest side effects.[7]
- According to the World Health Organization, EC will have no effect on an established pregnancy.[8] It is not the same thing as RU-486, the "abortion pill."

EC in the ER: Care for Rape Survivors

- The American Medical Association, the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists all recognize EC as part of standard rape treatment.
- Yet only 20% of rape victims receiving treatment at hospital ERs actually received EC over a seven-year time period in the 1990s, according to a national study.[9]
- Surveys in several states have found wide variation in hospital policies on provision of EC to rape survivors.
- As of this printing, four states – Washington, California, New Mexico, and New York – have enacted laws requiring hospitals to offer emergency contraception to rape victims. Illinois' law requires counseling of rape victims about EC, but not on site provision of the medication.

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[1] Stewart, F. and Trussell, J. "Prevention of Pregnancy Resulting from Rape," *American Journal of Preventive Medicine*. 2000. (19):228-229. An earlier estimate by Holmes (1996) is 32,000 pregnancies result from sexual assault.

[2] Holmes, M.M., Resnick, H.S., Kilpatrick, D.G., and Best, C.L. "Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women," *American Journal of Obstetrics and Gynecology*. 1996. 175:320-325.

[3] Trussell, J., et al. "Emergency Contraception Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives*. 1992. 14:269-273.

[4] Food and Drug Administration approval announcement. "Prescription Drug Products: Certain combined oral contraceptives for use as postcoital emergency contraception," *Federal Register*. Vol. 62, No. 37. February 25, 1997.

[5] Ellertson, C., Evans, M., Ferden, S., Leadbetter, C., Spears, A., Johnstone, K., et al. "Extending the time limit for starting the Yuzpe Regimen of emergency contraception to 120 hours," *Obstetrics and Gynecology*. 2003. 101(6):1168-71.

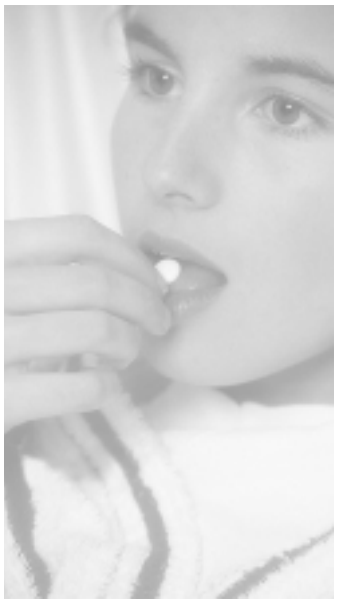
[6] von Hertzen, H. "Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial," *The Lancet*. 2002. 360:1803-09.

[7] American College of Obstetricians and Gynecologists. "Emergency oral contraception," *ACOG Practice Bulletin*. 2001. Washington, D.C.: ACOG.

[8] World Health Organization. Emergency Contraception: A guide to the provision of services," *Reproductive Health and Research*. 1998.

[9] Amey, A. and Bishai, D. "Measuring the Quality of Medical Care for Women Who Experience Sexual Assault with Data from the National Hospital Ambulatory Medical Care Survey," *Annals of Emergency Medicine*. June 2002. 39:6.

Assessing the Need



Assessing the Need in Your State

Is there a problem?

Are rape victims being offered emergency contraception (EC) when they seek treatment at hospitals in your state? Do policies on EC vary from hospital to hospital, leaving rape victims with "Russian roulette" health care that is excellent if they happen to go to one hospital and substandard if they end up at another facility?

Before attempting to pursue one of the strategies to improve access to EC described in this toolkit, organizations are encouraged to find out whether there is a problem in local hospitals and, if so, what kind of problem it is.

What kind of problem is it?

Here are some examples of the types of problems that could exist (with hospital provision of EC):

- Hospital staff are unaware of EC or have misconceptions about what it is.
- No hospital staff person is designated to inform rape victims about EC and offer it to them.
- The hospital pharmacy does not stock EC because "there is too little demand for it." Or, the pharmacy frequently runs out of the medication.
- Hospital staff write EC prescriptions for rape victims and send them out to pharmacies to obtain the medication.
- ER staff are allowed to refuse to provide EC if they object to it for moral or religious reasons, and the hospital has no policy to ensure that other staff step in to serve the needs of rape victims.
- The hospital has a policy against offering EC for religious reasons.
- There are few or no trained Sexual Assault Nurse Examiners (SANE)/Sexual Assault Forensic Examiners (SAFE) on the ER staff.
- Sexual assault advocates/counselors are not called by hospital staff when treating a rape victim.

The type of problem that exists could well determine the best approach to take in improving access to EC. For example, if hospital staff are not familiar with EC or are erroneously confusing it with RU-486, also known as the "abortion pill," the first step may be to undertake a campaign to educate hospital staff. If the problem is that rape victims are being sent out to pharmacies with prescriptions for EC, instead of receiving it immediately in the ER, the best approach may be to demonstrate that some of these pharmacies are not open 24 hours a day, do not stock EC regularly or are inaccessible for rape victims without automobiles.

How widespread is the problem?

A survey of hospitals asking about their policy on EC for rape victims will allow you to determine whether a problem exits, and if so, its scope. If the problem is limited to a handful of hospitals in a state, then the best approach may be to visit hospitals and address the issue on a case-by-case basis. Or, it may be that the problem is at a specific subset of hospitals, such as small facilities in rural areas. In that case, advocacy approaches might be tailored to the specific needs of those hospitals.

But if the problem is widespread, existing at dozens of hospitals across the state, then a more comprehensive policy approach – such as legislation or regulation – may be the most effective method to pursue.

Who can help assess the problem and potential solutions in your state?

Early legislative efforts to improve access to emergency contraception for rape victims were led by reproductive health advocacy organizations with years of experience in promoting policies concerning contraception. In some cases, these efforts neglected to include those groups with the most personal and comprehensive knowledge about the needs of rape victims. Rape crisis centers and anti-sexual assault coalitions had been working with the staff of hospitals on a voluntary basis to ensure that victims of sexual assault would receive EC.

Reproductive health advocacy organizations should be commended for their early efforts. However, success was impeded in some cases because EC in the ER was depicted as a choice issue rather than a victims' rights issue. The situation improved when the pro-choice and anti-sexual assault advocacy groups were able to form a united front in addressing EC in the ER as a victims' rights issue, recognizing that each group viewed the problem differently, but shared a common goal.

Recent efforts in at least three states - Pennsylvania, Washington and New York - have demonstrated the effectiveness of forming a coalition of anti-sexual assault advocates and reproductive health advocates to work together on assessing the need for improving hospital EC policies and then promoting the necessary policy changes. That is why we have included a special section focusing on the importance of building a coalition that includes both reproductive health groups and anti-sexual assault coalitions.

Building Coalitions of Reproductive Health and Sexual Assault Victim Organizations

Why it's important for groups to collaborate

In states where advocates have been able to achieve improvements in EC in the ER policies, strong networks between anti-sexual assault groups and pro-choice advocates usually have been the foundation of that success. We cannot emphasize enough how much these ties will enhance your potential.

One of the underlying goals of this toolkit is to help state-based advocates from both anti-sexual assault and pro-choice organizations develop lasting, working relationships to sustain us through whatever the political landscape and social climate sends our way. We need all the allies we can get. By reaching out beyond our usual boundaries, we can offer each other new perspectives and sources of expertise, new avenues for disseminating information about our respective causes and new insights into the obstacles women face every day.

We want to emphasize that in some states, these collaborations began and continue to work smoothly, while in other states early efforts were met with resistance. In some states, anti-sexual assault organizations felt they were not involved in the discussion. In these states, it took significant work for the groups to find areas of common interest and complementary working styles. We believe the collective wisdom of the partners in this effort can offer others insight to help avoid some of the pitfalls we have experienced. We are committed to your success.

> "That was an important issue of trust for us – hearing that the pro-choice community was willing to work with us."
>
> *- Suzanne Brown, Washington Coalition of Sexual Assault Programs*

WASHINGTON: Pro-choice and sexual assault victim organizations worked together to enact in 2002 the nation's first law mandating the provision of information about EC and the offering of medication on site in the state's hospital emergency departments. The conversation between the groups started after a 2000 NARAL survey showed there was no standard availability of EC for sexual assault victims in hospitals.

At first, because of funding and other legislative priorities, the sexual assault community was not ready to push for the bill. The pro-choice community agreed to delay the bill's introduction until the timing was right for the sexual assault community, creating a strong, trusting partnership. "That was an important issue of trust for us – hearing that the pro-choice community was willing to work with us," explained Suzanne Brown of the Washington Coalition of Sexual Assault Programs.

By 2002, the timing was right. The coalition framed the legislation as a bill for crime victims who deserve excellent medical standards of care, instead of as a pro-choice issue. This framing of the issue allowed a broader group of legislators to step forward in support of the measure. Sponsors of the bill were selected for their records as crime victims' advocates and advocates for quality medical care. Sexual assault advocates were out front on the bill, while pro-choice groups worked legislative contacts behind the scenes. The bill passed that same session.

A more detailed summary of how this partnership worked is available from the MergerWatch Project of the Education Fund of Family Planning Advocates of NYS at info@mergerwatch.org. Contacts in the state of Washington include: Pamela Crone at the Northwest Women's Law Center, pcrone@nwwlc.org, and Suzanne Brown of the Washington Coalition of Sexual Assault Programs, Suzanne@wcsap.org, as well as NARAL of Washington and Planned Parenthood of Western Washington.

NEW YORK: Family Planning Advocates of NYS (FPA) worked together with the New York State Coalition Against Sexual Assault (NYSCASA) to win passage of an EC in the ER bill in that state in June of 2003. The bill was first introduced in the 1999-2000 legislative session following a hospital telephone survey conducted by NARAL New York, which found that 54 percent of hospitals did not provide EC on site. The bill had been languishing in the legislature since 2000, passing the Democratically-controlled Assembly each year but failing to gain any momentum in the Republican-controlled State Senate. NYSCASA had been lukewarm in support of the bill, placing it behind other issues on the organization's priority list.

> "At last, rape victims treated at hospitals can count on having emergency contraception available on-site, without needless delays."
>
> *-JoAnn Smith, President and CEO of Family Planning Advocates of NYS*

Staff of the two organizations, FPA and NYSCASA, got to know each other by having lunch together, talking informally about their concerns and attending each other's statewide conferences in Albany, the state capitol. They also worked together behind the scenes to influence the provisions of an administrative manual, the *Protocol for Treatment of the Adult Sexual Assault Patient*, issued by the NYS Department of Health (NYS DOH) in May of 2002. The Protocol strongly recommended, but did not absolutely require, that hospital emergency departments dispense EC on site to rape victims.

In the summer of 2002, the two organizations decided to work together to survey the state's 210 hospital emergency departments to determine how they were implementing the NYS DOH protocol. They sent a joint letter and survey form to the hospitals in September and worked together to follow up and achieve a nearly 100 percent response rate. They announced the results at a press conference in January 2003, pointing out that while an impressive 85 percent of hospital emergency departments had adopted policies requiring that EC be dispensed, as many as 1,000 rape victims a year were still being sent away from hospitals without having received the medication.

The two groups lobbied together and featured the legislation at both their statewide lobby days. The bill passed the State Assembly once again and began to gain momentum in the State Senate, as additional sponsors and supporters were found. Following the successful model in the state of Washington, the New York coalition worked to frame the bill as a crime victims' measure. After a last-minute push in the closing days of the legislative session, the bill passed the State Senate and was signed into law by Republican Governor George Pataki in September 2003.

> "When a rape survivor walks through the door of any hospital, immediate, adequate and appropriate comprehensive care should be the response."
> *-Anne Liske, Executive Director of the New York State Coalition Against Sexual Assault*

> "New York's legislators have recognized the necessity of providing comprehensive and compassionate care to victims of rape. At last, rape victims treated at hospitals can count on having emergency contraception available on-site, without needless delays."
> *-JoAnn Smith, President and CEO of Family Planning Advocates of NYS*

PENNSYLVANIA: When Rebecca Simons, MD, approached Carol Petraitis of the Duvall Project in 1999 about collaborating on Simons' master's thesis, neither could have foreseen where the project would lead them. Petraitis had already begun exploring the issue of emergency contraception services for rape victims in Pennsylvania hospitals, and Simons elected to expand on this initial work with a statewide survey of emergency rooms. From her perspective as a public health physician, Simons recognized the intersection of pro-choice and sexual assault issues in her study. She felt that contact with sexual assault advocates would be valuable. This decision was a turning point in the Duvall Project's advocacy work.

Prior to conducting the survey, Simons and Petraitis contacted the local and state sexual assault coalitions for feedback. They first met with Barbara Sheaffer of the Pennsylvania Coalition Against Rape (PCAR) in Harrisburg in early 2000. "We didn't even know about SAFE nurses or their statewide training programs," Petraitis recalls. "We were lucky that Barbara was knowledgeable about emergency contraception. She was already on board." Sheaffer was able to confirm that a statewide survey had not yet been conducted, and with PCAR's support, Simons went forward with the project.

> "Over the course of time, both organizations recognized how much they learned, and continue to learn, from one another."
>
> *-Barbara Sheaffer, Medical Advocacy Coordinator, PCAR*

Nearly six months later, Petraitis and Simons returned to Harrisburg to share the survey results with PCAR and to plan the next steps. Both groups had additional collaboration in mind: "We asked ourselves how we could use this information to fulfill our goals," Petraitis explains, "but we also wanted to use it to combine efforts with PCAR." The disappointing survey results were a call to action

for both groups. As Sheaffer observes, "We knew EC provision in the ER was a problem, but we hadn't gauged how bad the situation was."

Within a few months, Duvall drafted letters to hospitals informing them how they had fared in the survey and included local sexual assault coalitions' contact information. In a round of follow-up letters to the hospitals the following year, Duvall included information PCAR had provided about an increase in funds for victims' compensation. "Carol was really expanding her work on EC to improve the situation for victims," Sheaffer notes.

Built on mutual trust and respect, the relationship between Duvall and PCAR has grown steadily since this initial project. Each group provides valuable information and support for the other. As Sheaffer explains, "The great thing about working with Carol is that Duvall is able to do things we don't have the time or resources for, like the survey and hospital letters." Likewise, PCAR is able to provide information about sexual assault treatment the Duvall Project lacks. Perhaps most significant, both organizations have incorporated the other's cause into its work. "Sexual assault is part of my work now, and that wasn't the case a few years ago," Petraitis says. "This remarkable change indicates how profound our collaboration is."

Conducting an EC in the ER Survey

Before you do any type of advocacy on EC in the ER, you should first try to gain a comprehensive understanding of what policies are already in place at the hospitals in your state. You may want to conduct a survey of emergency department policies on EC in the ER, if another group has not already done one, or if an existing survey is out of date.

The ACLU Reproductive Freedom Project and the Clara Bell Duvall Reproductive Freedom Project of the ACLU of Pennsylvania have collaborated to produce a manual containing step-by-step guidance for conducting a telephone survey of hospitals to determine if hospitals routinely provide EC in the ER. For detailed information and advice about doing a survey in your state using the Duvall/ACLU model or for a copy of the manual, please contact either the ACLU Reproductive Freedom Project at rfp@aclu.org, or 212-549-8579 or Carol Petraitis at duvall@aclupa.org, or 215-629-0111.

This EC in the ER policy toolkit is intended to be a companion to the ACLU survey manual, *EC in the ER: A Manual for Improving Services for Women Who Have Been Sexually Assaulted* and therefore does not duplicate the survey instructions included in that manual. However, we want to note that in some instances, advocates may want to consider an alternative survey method. The type of survey you choose to do will depend on many things, including how you plan to use the findings (such as whether you intend to use it to support a legislative proposal), the number and level of expertise of the staff members and/or volunteers you have available, and your knowledge of hospital policies going into the study. To discuss which survey method is best for your state, contact duvall@aculpa.org or info@mergerwatch.org. Below are the two types of surveys that our organizations used.

The Telephone Survey

The ACLU survey has the great advantage of being methodologically sound and thus not likely to be challenged by hospitals, legislators or the public. Moreover, because it is being used in several states, your results will be comparable to other states that have used the same method, contributing to a national picture of EC policies for sexual assault victims.

The disadvantages are that the work involved is fairly extensive and you may require some help with analyzing the results. If you choose to survey only a sample, or a "cross-section" of hospitals in your state, you will not have information about every hospital, which can be a disadvantage when preparing for grassroots work and for working with politicians.

The Duvall Project first surveyed a cross-section of hospitals. Later it used a second telephone survey (with fewer questions) to reach out to hospitals that were not in the original sample. This follow-up survey allowed Duvall to "fill in the gaps" and to collect information useful for grassroots efforts.

Written and Mailed Survey

One of the key advantages of sending a written survey form out to hospitals is that ER managers fill out the information and return it to you, leaving you with a permanent and indisputable record from the hospital. If hospital officials later contest the survey findings when speaking to news reporters or legislators, you can simply produce the form filled out by the hospital. There is never a case in which a hospital president can insist that a telephone surveyor misunderstood or misrepresented the

hospital's policy. This is extremely important for the credibility of advocacy organizations when using survey results to demonstrate the need for policy change, such as through legislation.

Mailing a written survey also can be easier than trying to reach busy hospital ER staff on the phone to conduct a survey. Therefore, you may be able to contact all the hospitals in your state and have a more complete record, which will be useful in trying to influence statewide policy change. New York advocates found that state lawmakers became more interested in the issue when they were able to view the policies at hospitals in their own districts. See Appendix 1 for a sample cover letter and written survey.

The disadvantage of the written method is that your survey results will show what hospital officials say their policies are, not what the hospitals may actually be doing in practice. Care must be taken to draft survey questions that get at the nuances of hospital policies, and some follow-up phone calls may be necessary to clarify the responses you receive.

Lastly, unless you get a very high response rate (like the 96 percent New York State advocates achieved through persistent follow-up), there could be bias in the results, because the hospitals that don't return the surveys may be exactly the ones with problematic policies.

"Mystery shopper" surveys

Some groups have used a "mystery shopper" method to survey hospitals on their provision of EC. This method involves calling a hospital posing as someone who needs EC and asking for the emergency room. The caller then asks whether the hospital would provide EC. This type of survey can be done more quickly than the written survey method or the more involved ACLU method. Some groups also feel this method produces a snapshot of what would actually happen to a woman seeking EC at each hospital. The main disadvantage of this method is that the results may not reflect actual policy. If the person who happens to answer the telephone in a busy ER is not actually knowledgeable about EC or treatment of rape victims, the answer could be inaccurate and subject to challenge by hospital administrators when survey results are released. Moreover, some advocates contend that the "Mystery Shopper" method is not an accurate account of what a rape victim would do. In general, women do not call an ER inquiring about the availability of EC after they have been sexually assaulted.

Related Survey of Pharmacies

In some states, hospital surveys have uncovered a high rate of emergency department personnel writing prescriptions for emergency contraception and sending rape victims out to pharmacies. If your hospital survey produces these kinds of results, you may want to follow up by surveying pharmacies. Because some hospitals in Pennsylvania commonly give prescriptions for EC to sexual assault patients (rather than providing EC on site), the Duvall Project surveyed pharmacists to determine how easy it might be to fill a prescription and how much pharmacists knew about EC products. The results were quite alarming with 13% of pharmacists confusing EC with RU-486 and over two-thirds saying a prescription could not be filled that day in their store. More complete information will be posted on Duvall's website: www.aclupa.org/duvall or in the October 2003 issue of the journal *Contraception*.

Survey of Pennsylvania Hospital Emergency Departments Summary of 2000 Findings

Conducted by Clara Bell Duvall Reproductive Freedom Project

Survey method and response rate

- 125 of 165 Pennsylvania hospital emergency departments, Catholic and non-Catholic, were contacted by telephone over a three-month period in the year 2000. This is 76 percent of general hospitals.
- Telephone interviews were conducted with emergency room personnel familiar with the treatment of rape victims.
- Survey consisted of 15 open-and close-ended questions designed to determine the services that were provided routinely and the EC protocol typically followed in cases of sexual assault.

Findings on providing emergency contraception on site

- 28 percent of hospitals surveyed routinely offer and provide EC on-site to victims of sexual assault (categorized as Appropriate Care).
- Six percent of Catholic hospitals were providing appropriate care versus 33 percent of non-Catholic hospitals.
- 51 percent of hospitals relied on the discretion of the physician on duty (categorized as Physician Dependent Care).
- 12 percent of all hospitals did not provide any EC services.
- Nine percent of hospitals have an unclear policy

Findings in rural counties and across Pennsylvania

- Seven counties in Pennsylvania do not have general hospitals, but an additional 34 counties have no hospitals with adequate EC policies. These 41 counties represent 61 percent of Pennsylvania's 67 counties.
- Of the 63 hospitals surveyed in western Pennsylvania, only 13 provide appropriate care, giving a woman a 1 in 5 chance of receiving appropriate services. Of the 62 hospitals surveyed in Eastern Pennsylvania, 23 provide appropriate care, leaving women with a 2 in 5 chance of receiving reliable care for pregnancy prevention.

SAFE/SANE Programs

- 25 hospitals in Pennsylvania currently have SAFE/SANE programs in their emergency departments.
- Among hospitals with a SAFE/SANE program, 56 percent provide appropriate care. Only 21 percent of hospitals with no SAFE/SANE program provide appropriate care.

Survey of New York Hospital Emergency Departments Summary of 2002-2003 Findings

Conducted by New York State Coalition Against Sexual Assault & Family Planning Advocates of NYS

Survey method and response rate

- Joint letter and survey form sent to hospitals by FPA and NYSCASA on Sept. 12, 2002
- Surveyed 210 hospital emergency departments; 201 hospitals responded (96 percent response)
- Survey forms sent to four administrators at each hospital: CEO, General Counsel, Emergency Room Director and Nurse Manager.
- Follow-up letters and phone calls made and faxes sent to remaining non-responders.
- All survey findings list the hospitals' own statements about their official policies on dispensing EC in the ER. There was no attempt to independently verify the hospitals' statements, such as by calling hospital ERs pretending to be rape victims.

Policies on providing emergency contraception on site

- 171 hospitals (85 percent of the 201 responding hospitals) said it is their standard policy to dispense emergency contraception immediately, on site, to all rape victims who choose it after having been counseled.
- 24 hospitals (12 percent) said they do not have a standard policy of dispensing emergency contraception to rape victims.
- Six hospitals (three percent) were determined to have inconsistent policies on providing rape victims with emergency contraception.

Impact on rape victims

- As many as 1,000 rape victims a year may be sent away from hospital emergency departments without receiving emergency contraception. This number is based on the number of rape victims treated each year by hospitals without standard policies of dispensing emergency contraception.
- 16 New York counties have hospitals that do not have a standard policy of providing emergency contraception to rape victims. Women who are sexually assaulted in these 16 counties may not be able to obtain emergency contraception in a timely manner.

Responses from Catholic hospitals

- Of the 210 emergency departments surveyed, 38 were located in Catholic hospitals.
- 36 responded, and two failed to respond.
- 27 (or 75 percent of the responding Catholic emergency departments) said it is their standard policy to provide emergency contraception to rape victims. Some stated they require a pregnancy test before the medication is dispensed.
- Nine (or 25 percent) of the respondents said they do not dispense emergency contraception to rape victims.

Choosing a Strategy to Increase Access to EC in Your State

What is the best way to ensure that hospital emergency departments have policies of consistently offering emergency contraception to rape victims? The answer depends on the particular situation in your state.

Some factors to consider include:

- The policies and practices in your state's hospital emergency departments (based on the findings of your survey of EC in the ER), including the percent of hospitals not offering EC to rape victims and the policies of those hospitals (rural, urban, religious).

- The resources (personnel, time and money), skills (such as medical, legal or political) and missions of the groups in your coalition.

- The political climate in your state (such as liberal, conservative, anti-choice) and how powerful the opposition might be to your efforts to promote consistent statewide policy on EC in the ER.

Use this assessment of your situation in deciding which of the following approaches would work best for you:

- **Legislation:** Supporting state legislation that would mandate that EC be offered to rape victims at all hospital emergency rooms.

- **Administrative action:** Approaching the executive branch agency in your state that is responsible for regulating hospitals (usually a state Department of Health) and asking for promulgation of a protocol or regulation requiring that EC be offered in the ER. It could also involve the enforcement of existing regulations or laws.

- **Litigation:** Bringing a lawsuit against a hospital or physician on behalf of a rape victim or victims who were not informed about or offered EC to prevent pregnancy.

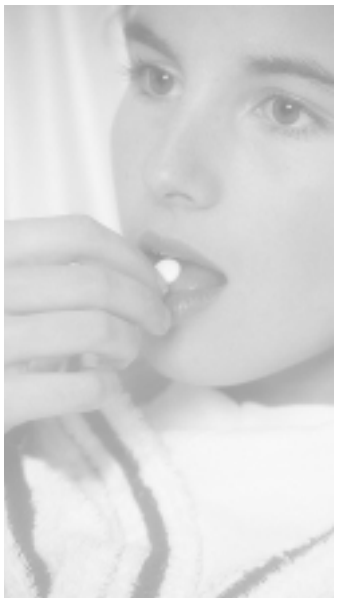
- **Voluntary change:** Approaching individual hospitals or a hospital association and asking for voluntary adoption of policies, pursuing public awareness campaigns and addressing EC with the range of professions that work with victims of sexual assault.

In the sections that follow, we explain each approach and give tips for deciding which one (or sequence of approaches) will most likely succeed in your state. Please realize that you may begin with one approach and then decide that you are ready for the next step.

For instance, in New York State, early attempts at enacting an EC in the ER bill (legislative approach) stalled. This lack of progress led to dialogue and the formation of a stronger choice-sexual assault alliance. Together, the groups worked to influence the State Health Department to address the issue of EC in the ER in the department's protocol for hospitals treating sexual assault patients (administrative approach). A survey conducted following issuance of the Protocol found that quite a few hospitals still were not offering EC to rape victims consistently. Release of the survey results gave new momentum to the EC in the ER legislation. The bill passed both houses of the legislature in June 2003 and was signed by the Governor in September 2003.

Likewise in Pennsylvania, several years of voluntary measures - informing hospital emergency departments about their rankings in the EC in the ER survey, developing a web page advertising this information, developing guidelines for SARTs (sexual assault response teams), editorials, press conferences, and so on - led to an increase in the percentage of hospitals providing appropriate care for EC in the ER (from 28 percent up to 46 percent). Now the state has elected a pro-choice governor and advocates recognize that a legislative or administrative approach may be more feasible than it has been for many years.

Strategy 1: Legislation



Legislation

Introduction

Often, legislation is the first approach pro-choice advocacy groups consider when trying to address a policy problem, such as hospitals' failure to offer emergency contraception to rape victims. Strategizing sessions quickly move to agreement that "There oughta be a law!"

But, there are definite pros and cons to taking the legislative route that should be carefully considered ahead of time. Pro-choice groups should seek the views of coalitions against sexual assault, which may prefer to begin with a voluntary approach to hospitals.

Advantages:

- **The public process of introducing, debating and enacting such a law often educates and motivates organizations** and members of the public about the issue, thus raising public awareness about emergency contraception.
- **The desired policy is enacted into state law**. It becomes the uniform policy for all hospitals in the state and cannot be changed except by another piece of legislation.
- **Passage of a law represents a public expression of the state's values**, such as that rape victims are entitled to comprehensive medical care, including access to medication that can prevent pregnancy.
- **Seeking passage of legislation presents an opportunity to cultivate relationships with lawmakers** for use in future policy campaigns. EC in the ER legislation has the particular advantage of allowing pro-choice advocates some positive contact with those legislators whose voting records are anti-choice, but who can be swayed on this issue because of their concern about treatment of crime victims.

Disadvantages:

- **Enactment of legislation often is a slow process.** It can take several years for the issue to become a priority for state legislative leaders. Typically, the proposal must first go through what is known as a "softening up" process, in which legislators and policy analysts become more familiar with the identified problem and comfortable with the solution proposed by the legislation.
- **Legislative action is a very public process in which sides on a controversial issue can become polarized and vocal.** If this polarization is too extreme, and the rhetoric on both sides becomes too strident, legislators will be reluctant to take on the issue, preferring to side-step it, especially in an election year.
- **Legislators asked to take action on a bill mandating access to emergency contraception for rape victims will likely face opposition from powerful institutions**, including state Catholic conferences (citing religious objections), state hospital associations (opposing any new mandates on what hospitals must do) and state medical associations (opposing any legislation perceived as taking away a doctor's discretion in deciding upon medical treatment). Advocates for EC in the ER policies must be prepared to effectively counter the lobbying of these organizations, which often have close working relationships with legislative leaders and contribute to their campaign funds.

- **The legislation may be amended or watered down by legislators attempting to please everyone.** For example, legislators may be tempted to grant requests from Catholic hospitals to rewrite EC in the ER legislation so that hospitals are allowed to refer rape victims elsewhere for emergency contraception, provide them with prescriptions which must be filled at outside pharmacies or merely provide information about EC. You should assess the likelihood of encountering and defeating these types of amendments before deciding whether or not to proceed with legislation.

Please note: Some anti-sexual violence coalitions may have to limit lobbying efforts due to federal or state funding restrictions.

Evaluating your readiness to seek legislation

Before deciding to pursue EC in the ER legislation, you may want to evaluate your state's readiness for such legislation by answering the following questions:

- **Do you have documented evidence of a problem?** If you have not yet conducted a survey of the EC policies at the hospitals in your state, you should do that first. See the section titled "Conducting an EC in the ER Survey" in this toolkit for guidance.
- **Is the problem widespread?** Can you demonstrate that the problem exists at a number of hospitals spread out across your state in various geographic regions? This will be necessary to attract broad enough support in your legislature. If the problem exists at only a few hospitals, or is concentrated in one area of the state, you might first try approaching those hospitals to seek voluntary improvements in their policies.
- **Is the political climate favorable for consideration of the legislation?** If one or both houses of your state legislature is controlled by anti-choice lawmakers who are hostile to emergency contraception, or if your Governor is anti-choice, you will face an uphill struggle to enact legislation. You may want to consider trying an administrative or voluntary action approach first. Be sure to research whether any similar legislation has been introduced in the past and, if so, why it did not succeed. You should also research whether there is an existing "refusal" or "conscience" law in your state that would automatically exempt from compliance any hospitals that object to EC for religious or moral reasons. (If you need assistance with this research, contact The MergerWatch Project at info@mergerwatch.org or the ACLU Reproductive Freedom Project at rfp@aclu.org).
- **Have you formed a coalition of interested advocacy groups**, including pro-choice and sexual assault victim organizations? It is important to form such a coalition *before* you begin drafting legislation and seeking its introduction.
- **How powerful are the forces likely to oppose your legislation?** In some states, religious groups opposed to EC or hospital associations opposed to new mandates are so powerful that they can block such legislation or have it amended in a way that is not acceptable to your coalition. In such a state, administrative or voluntary actions might be tried first.
- **Do you have enough resources (people, time and money) to pursue a legislative approach effectively?** Ideally, to promote legislation you should have a strong, motivated and dedicated coalition and sufficient resources for such things as: developing, printing and distributing fact sheets and talking points; traveling to the state capitol to lobby; printing and mailing postcards of support to key legislators; paying for phone calls from supporters to key legislators; and taking out advertisements in newspapers. Staff people and volunteers are also crucial to the success of your campaign. Assembling these resources will help ensure that your legislation will be taken seriously and that you will be able to withstand attempts to defeat or amend the bill in a way not acceptable to your coalition.
- **Have you identified potential key sponsors of the legislation** in both houses who will be committed to actively working for passage of the bill? You will want to avoid having sponsors who put their names on the bill, and claim credit for introducing it, but then do little to ensure passage of the measure. The sponsors should be educated about what amendments or compromises to the legislation would be unacceptable to your coalition.

Key steps in preparing a legislative campaign

Based on the experiences of advocates working for passage of EC in the ER legislation in several states, including Washington and New York, we have identified some of the steps that are important in preparing a successful legislative campaign on this issue.

1 **Choose legislative sponsors wisely.** Pro-choice groups may want to recruit legislative sponsors who would be perceived as "not the usual pro-choice spokespeople." In the state of Washington, the EC in the ER coalition deliberately chose a crime victims' advocate as the sponsor in one house and a physician in the other. In New York, the key Senate sponsor was pro-choice, but also a Republican from a Catholic family of 16. The choice of sponsors can help with step number 2. Work with anti-sexual violence partners in selecting such sponsors.

2 **Frame the issue as one of crime victims' rights and comprehensive emergency medical care for crime victims.** It will be much easier for legislators identified with law-and-order criminal justice issues to support your bill if they perceive it as a crime victims' issue, not a reproductive rights bill. (As a result, those lawmakers who do oppose it on anti-choice grounds will appear especially extreme.)

3 **Divide up the necessary tasks according to organizational strengths within your coalition.** In some states, pro-choice organizations have been more politically active and have had more experience lobbying at the state capitol, so they have taken the lead in lobbying activities. By contrast, sexual assault groups have more knowledge about rape victims and hospital emergency department procedures, so they have taken the lead as public spokespeople for rape victims. These rape victim advocates typically have also had strong connections to legislators who are viewed as crime victims' advocates.

4 **Make a campaign plan that sets out the lobbying activities you will undertake to introduce and promote the bill.** Be very specific. Spell out how your coalition will seek co-sponsors and supporters for the legislators and how you will track the likely vote count in each house. Identify those legislators you believe will need more convincing than others and prepare lobbying teams to visit them. Divide up the tasks and monitor your progress on a weekly basis. Identify the kinds of grassroots support you will need and the methods you are going to use to activate these supporters, such as through e-mail alerts, phone calls and mailings.

5 **Plan the media activities you will need to undertake to gain public support.** It usually is a good idea to hold a news conference when new legislation is introduced in order to explain why it is needed and gain momentum started on the enactment process. Devise ways to tailor the issue for newspapers in different parts of your state by using your hospital survey to point out local hospitals with poor or inconsistent policies on EC in the ER. If possible, identify and support a rape victim who is willing to talk about the need for access to emergency contraception at hospitals, or use the stories in this toolkit. Identify a sexual assault nurse examiner (SANE)/Sexual Assault Forensic Examiner (SAFE) or sexual assault advocate/counselor who could talk from personal experience about the treatment of rape victims at emergency departments. Prepare sample letters to the editor for your supporters to send in to local newspapers. Plan to visit the editorial boards of key newspapers to ask for their editorial support for your proposed legislation. The NARAL ProChoice America Foundation also recommends establishing a "rapid response" team approach to the media to quickly counter the misconceptions about EC that make their way into mainstream news stories.

6 **Anticipate your opposition.** With help from organizations who have encountered opposition in other states, you can identify your likely opponents (such as Catholic conferences and state hospital associations) and anticipate the arguments they will make. Prepare talking points and rebuttals in advance to counter their arguments. (See samples of bill memos, a question-and-answer sheet,

opposition testimony and rebuttal in Appendix 1). You may even want to meet with these opponents ahead of time to see if there are any steps you could take to deflate their opposition, while remaining true to your goals in introducing the bill.

7 **Identify your "bottom line."** Make sure to have a detailed conversation at the outset about what your coalition will accept in terms of proposed amendments to the legislation. For example, if your "bottom line" is that all hospitals should dispense EC on site to rape victims, then you should be prepared to reject a proposed compromise that allows some hospitals to give rape victims a prescription that they must fill at an outside pharmacy. (Review the discussion of suggested legislative language in the following section to help anticipate amendments that are undesirable.) Your coalition must be prepared to walk away from the bill and oppose its enactment if the likely compromise violates your agreed-upon bottom line. Educate your legislative sponsors about your "bottom line" and obtain their agreement on rejecting undesirable proposed amendments and if necessary, withdrawing the bill.

8 **Be patient.** It may take more than one year to pass a bill with acceptable language. Your coalition should agree to be patient and to walk away when the "bottom line" is breached. Examples of undesirable amendments would include those that exempt all religiously sponsored hospitals or mandate only the provision of information about emergency contraception. The coalition should not support a bill with unacceptable amendment language in the hopes of correcting the problem in future legislative sessions. The likelihood of actually achieving such improvements is usually slim.

Legislative Resources

Key elements of your bill's language

Appendix 2 of this toolkit includes samples of EC in the ER legislation recently enacted in several states, as well as a copy of the model legislation developed by the NARAL ProChoice America Foundation. Your coalition can examine these samples for ideas to use in drafting your proposed legislation. Here are some key elements to consider:

1. **The bill title:** Keep it short and descriptive of what you want to accomplish. The NARAL model bill suggests a title of "Emergency Care for Sexual Assault Victims Act." This model title emphasizes that the bill is about emergency medical care and about crime victims.

2. **Findings section:** Usually a piece of legislation starts with a list of what are known as legislative findings. The findings recite the important facts that lawmakers have considered in putting forward the legislation. Examples of the types of facts that should be included in the findings are:
    - Numbers of rape victims each year nationally and in your state.
    - Numbers and/or percentage of rape victims who become pregnant each year.
    - Number of unintended pregnancies among rape victims that could be prevented each year through timely use of emergency contraception.
    - Medical facts about emergency contraception, including that it is a safe and effective medication that has been approved by the Food and Drug Administration (FDA) and that it is more effective the sooner it is taken. (Caution: It is best to avoid mention of a specific time limit of EC effectiveness because research evolves. For example, research now suggests that EC can be effective for up to 120 hours, instead of the previously accepted 72 hours. You can substitute a phrase such as "EC medication should be taken as soon as possible within medically-recommended time frames.")
    - Number or percentage of hospitals in your state that do not have policies of consistently offering EC to rape victims (based on your survey findings).
    - Recommendations from medical associations that EC should be offered to rape victims and a clear statement that the legislature finds that all hospital emergency departments should offer it to rape victims.

3. **Definitions of terms:** This section of the legislation defines the terms that will be used in the text. Although this section may seem pro forma, you should pay close attention to the definitions. Here are examples of specific things to watch for in the drafting of the definitions:
    - What is emergency contraception? The NARAL model definition states "any drug or device approved by the Food and Drug Administration that prevents pregnancy after sex." Notice that the word "device" is included, to allow for potential use of an IUD. You may or may not wish to include IUDs in your legislation, since they are generally not used for rape victims (due to the trauma of sexual assault and potential to introduce an infection) and may attract opposition from Catholic conferences. The State of Washington legislation used this phrase: "any health care treatment approved by the food and drug administration that prevents pregnancy."
    - Who qualifies as a rape victim? Make sure that the definition you use ensures that a woman will qualify to receive EC in the ER as long as she says she has been raped. Watch out for suggestion that the patient must file a police report, or that there must be some evidence of rape.

- Which hospitals are covered by the legislation? It is best to specify those hospitals that provide emergency care to victims of sexual assault, so as to avoid making the language too broad and attracting opposition from hospitals without emergency departments.

4 **Bill requirements:** This is the "meat" of your legislation, the section in which you spell out the actual requirements you wish to impose on hospitals treating rape victims. In writing this section, you and your legislative sponsor will need to decide if you are amending an existing statute (most likely) and if so, which one. Typically, the bill will amend state statutes dealing with rape victims, crime victims, hospital regulation or public health. Your bill requirements, then, will be spelled out as amendments or substitutions to an existing law. Key elements of this section should include requiring hospitals to:

- Inform rape victims about the potential use of emergency contraception to prevent pregnancy from the assault. You may want to specify that the victim be informed both orally and in writing, and you may want to say that the written information must be medically accurate and objective (to avoid the use of biased and inaccurate fact sheets by hospitals objecting to EC).
- Provide EC on request. Offer the medication to rape victims and provide it to those who want it. You may want to specify that EC be provided "promptly" to ensure that there is no undue delay in administering this time-sensitive medication. (As mentioned above, try to avoid insertion of language suggesting it must be administered within a specific time frame, such as 72 hours, because evolving medical research already has extended the effective time-frame to 120 hours. If pressed, you could insert language about administering the medication within a medically-recommended time frame. See also the discussion about pregnancy tests and potential contraindications on pages 38 and 39.)

5 **Training and patient education:** You may want to include in your draft legislation language that requires hospitals to train emergency department staff about the new provisions for making emergency contraception available. You may also want to specify who will develop the written materials about EC to be handed out to patients. For example, you may want to specify that the state Department of Health, in consultation with advocates for sexual assault victims will develop informational materials. (See the NARAL model legislation in Appendix 2 for examples of such language.)

6 **Enforcement:** You may want to specify how the new law will be enforced, and what the fines will be for violations of the law. Be sure to suggest an enforcement method that is consistent with existing state regulation of hospitals, so as not to set up a system that is in conflict with existing practice and thus create a target of opposition from both hospitals and state health officials.

7 **Technical sections:** Make sure there is what is known as a severability clause in your legislation. This clause ensures that if any word or phrase of your law is struck down by a court, the rest of the law remains in effect. (See the NARAL model legislation for an example of how to word this.) Also consult with your legislative sponsor to determine a date on which the law would become effective, such as 120 days following enactment, keeping in mind hospitals and state officials will need some time to prepare for implementation.

The state-by-state chart in Appendix 2 highlights some of the specific provisions of enacted and proposed EC in the ER legislation in various states. Some of these proposed and enacted measures include provisions that should not be included in future bills. The chart is intended merely to illustrate the range of proposals in existence. For the latest update to this chart, go to www.mergerwatch.org.

Federal "EC in the ER" Legislation: CARE Act

While women's health advocates have been working to improve EC in the ER policies in states, there also has been an effort at the Congressional level to establish federal standards. Introduced by Representative Jim Greenwood (R-PA) and Senator Jon Corzine (D-NJ) in summer 2003, the Compassionate Assistance for Rape Victims Act (CARE) "requires hospitals, as a condition of receiving Federal funds, to provide emergency contraception to a woman who is a victim of sexual assault."

This federal legislation is similar to many state "EC in the ER" policies in that it would require hospitals to counsel rape victims about emergency contraception and dispense the medication on site to those victims who wish it. The legislation requires that hospitals that receive federal funds under any health-related program, must meet the following conditions in the case of: 1) a woman who presents herself and states she is a victim of sexual assault or is accompanied by someone who states she is a victim of sexual assault and 2) Any woman who presents at a hospital and who hospital personnel have reason to believe is a victim of sexual assault.

Key Features of the CARE Act[1]

Under the Act, hospitals would be required to:

- Promptly provide the woman with medically and factually accurate and unbiased written and oral information about emergency contraception, including information explaining that EC does not cause an abortion; and EC is effective in most cases in preventing pregnancy after unprotected sex
- Promptly offer EC to the woman, and provide EC upon her request;
- Provide information in clear and concise language that is readily comprehensible and is available in languages other than English as the Secretary of Health and Human Services may establish
- Provide these aforementioned services regardless of the ability of the woman or her family to pay for the services.

House Bill 2527 was referred to the House Subcommittee on Health on June 24, 2003. Senate Bill 1564, the identical companion bill, was referred to Senate Committee on Health, Education, Labor and Pensions on August 1, 2003. See Appendix 2 for a sample copy of the federal "EC in the ER" legislation.

[1] H.B. 2527 and S.B. 1564 were downloaded from http://thomas.loc.gov/ on September 30, 2003.

Responding to requests from Catholic hospitals for exemptions from the law

Overview

In several states where EC in the ER laws have been proposed, Catholic hospitals have asked lawmakers to be exempted from having to provide emergency contraception because of religious objections. Such an exemption is called a "conscience clause" by Catholic hospitals, using a term intended to focus policymakers' attention on hospitals' alleged religious "conscience rights." These exemptions have been renamed "refusal clauses" by women's health advocates, emphasizing the effect on patients when a hospital refuses to provide a requested or needed treatment such as emergency contraception.

The ACLU Reproductive Freedom Project, the Education Fund of Family Planning Advocates of New York State and numerous other reproductive rights organizations have closely examined these requests for exemptions and come to the following conclusion:

No hospital should be permitted to refuse to provide emergency treatment (including emergency contraception) to a rape victim because of institutional religious objections.

Here are the key reasons why these organizations have adopted that stance:

- **Hospital emergency departments routinely receive and treat patients of many faiths.** In many cases, these patients (including rape victims) have arrived by ambulance or in a police car and are unaware of any religious policies in place at the hospital. They have not chosen to receive health care restricted by religious doctrine. In fact, these hospitals are licensed by the state to serve entire communities. It would be unfair to allow a hospital to impose its religious beliefs on patients who do not share that faith.

- **Religious or moral objections should never entitle a health care provider to refuse to give adequate medical treatment to a patient in an emergency.** Rape victims are in need of emergency medical care and should be offered EC as part of this care.

- **Emergency contraception is time-sensitive.** The sooner it is taken, the more effective it is. Any delay that would be introduced by sending a rape victim elsewhere to obtain the medication, such as to a pharmacy or an outpatient clinic, would increase the chance of that victim become pregnant from the assault. Significant delay could prevent the victim from obtaining the medication in time.

- **Community hospitals, including those with religious affiliations, rely heavily on public money for their basic operating expenses.** A 2002 study released by the Education Fund of Family Planning Advocates of New York State reported that half the operating expenses of religious hospitals come from Medicare and Medicaid. Nationwide, religious hospitals receive more than $40 billion a year in public funds. When hospitals take public money and are licensed to serve the general public, they should not be allowed to refuse emergency care because of religious objections. To obtain a copy of this study, contact info@mergerwatch.org or 518-436-8408, ext. 214.

Responses of States

In states where advocates had attempted emergency contraception for rape victims legislation through mid-year of 2003, they had varying responses by lawmakers to Catholic hospitals' requests for exemptions (or outright opposition to the bills on religious grounds). Examples include:

- **In Illinois**, lawmakers balked at requiring Catholic hospitals to dispense emergency contraception and instead watered down the overall bill requirements. Hospitals are required only to provide information about EC to rape victims. Patients may be referred elsewhere to obtain the treatment.

- **In Maryland**, the legislature refused to act on a proposed EC in the ER bill and then also rejected a measure similar to the Illinois law that would have required hospitals only to provide information about EC. Objections from the state Catholic conference were the major reason for the legislature's inaction.

- **In Washington, California and New Mexico**, laws requiring all hospitals to dispense emergency contraception were enacted without any special exemptions for religious hospitals.

- **In New York**, the state Catholic Conference dropped its objections to the proposed EC in the ER bill only when the following language was added: "No hospital shall be required to provide emergency contraception to a rape victim who is pregnant." (This language is discussed in more detail in the question-and-answer section on Catholic hospitals' use of pregnancy testing.)

- **In Hawaii**, the governor vetoed an EC in the ER bill that had passed both houses of the Legislature on the basis that the measure should have included a religious exemption for Catholic hospitals.

Questions and Answers

Advocacy groups working for passage of EC in the ER legislation frequently encounter the following questions when state Catholic conferences and other anti-choice groups oppose the legislation or demand exemptions for Catholic hospitals. We have included some suggested answers, based on the experience of advocates in several states.

Q Does emergency contraception cause abortion?

A No, emergency contraception is *contraception, not abortion*. EC pills contain a high dose of ordinary birth control. EC is not the same thing as RU-486, also known as the "abortion pill."

Emergency contraception *prevents pregnancy from occurring in a short time period after unprotected sexual intercourse*. It does not cause an abortion and cannot "dislodge" an embryo or otherwise affect an existing pregnancy.

When the U.S. Food and Drug Administration (FDA) approved the use of birth control pills as emergency contraception in 1996, an FDA spokeswoman specifically stated: "These birth control pills are used to *prevent pregnancy*, not to stop it. *This is not abortion*."[1]

[1] FDA spokeswoman Mary Pendergast, quoted in "FDA Panel endorses 'morning after' pill," CNN website, posted June 29, 1996 at 12:25 a.m.

In fact, timely use of emergency contraception can *prevent the need for abortion*. A study by the Alan Guttmacher Institute estimated that in the year 2000 alone, use of EC prevented 51,000 abortions in the United States.

Q Why do anti-choice groups such as Feminists for Life and some state Catholic conferences insist on referring to EC as a "chemical abortion?"

A It is possible that some non-physicians mistakenly confuse emergency contraception with RU-486, the abortion pill. But again, those are very different kinds of medication.

There are also some groups and individuals who believe that pregnancy begins at conception (when an egg is fertilized), instead of when the fertilized egg is successfully implanted on the wall of the uterus (the medical definition). Because of this belief, these individuals and groups would deny a rape victim access to emergency contraception, arguing that EC may interfere with implantation and thus meet their non-medical definition of abortion. They fail to acknowledge that even without the use of EC, fertilized eggs often fail to become implanted. They also ignore new research showing that of the three potential mechanisms of action of EC (interference with ovulation, fertilization or implantation), that interference with implantation appears to occur infrequently and is the least likely mechanism of action.

We believe that the rape victim herself should be able to decide, based on her own religious or ethical beliefs, whether or not to use emergency contraception to prevent a possible pregnancy resulting from rape. This decision should not be taken away from her and given to legislators, hospital administrators or religious leaders.

Q Don't church leaders prohibit Catholic hospitals from offering any kind of contraception, as well as abortion? Wouldn't it violate the religious freedom of Catholic hospitals to force them to provide medical care they find morally objectionable?

A *The Ethical and Religious Directives for Catholic Health Care Services*, in which the U.S. Conference of Catholic Bishops lists which treatments may and may not be offered in Catholic hospitals, do prohibit the provision of contraception in ordinary circumstances. However, *Directive* No. 36 makes an exception for contraception when it comes to rape victims, stating that "a female who has been raped should be able to defend herself against a potential conception from the sexual assault."

> "Catholic teaching allows for the administration of emergency contraception within certain moral limits."

This exception was explained in an article in the September-October 2002 *Health Progress*, the journal of the Catholic Health Association of the United States, by Ronald Hamel, the association's senior director of ethics. The article states that "Catholic teaching allows for the administration of emergency contraception within certain moral limits. Measures taken to prevent conception in such cases fall outside the general prohibition against contraception because the assailant's act is a violation of justice, and any semen within the woman's body is considered a continuation of the unjust aggression against which she may licitly defend herself."

Directive No. 36, does however, include language that confuses the issue and has led a number of

Catholic hospitals to ban the provision of emergency contraception to rape victims. After affirming the right of a rape victim to protect herself from conception, the *Directive* states: "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 initiative or recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum."

The *Directive* creates confusion because there is no test that could determine whether conception has already occurred and thus no way to predict accurately whether EC *would* work to prevent the implantation of a fertilized egg. Because of this problem, some Catholic hospitals have simply refused to provide EC. Other Catholic hospitals have been using what is known as the Peoria protocol (because it was developed at a Catholic hospital in Peoria, Il). This protocol involves giving an ovulation test to a rape victim and then refusing to provide EC if the test indicates ovulation has occurred, on the unproven theory that a fertilized egg might exist. Of course, advocates for rape victims point out that this might well be the exact moment when a sexual assault victim most needs EC to prevent pregnancy.

Recent thinking and writing about the issue within Catholic health circles, however, has produced a more helpful interpretation of *Directive* 36's requirements, in light of recent medical research and the outcry from rape victims' advocates over Catholic hospitals' denial of pregnancy prevention as a vital part of emergency care to sexual assault victims. Hamel, the senior ethicist of the Catholic Health Association, wrote that studies calling EC an "abortifacient" do not have definitive evidence to support their theories and that it is actually "highly unlikely" that EC destroys or interferes with the implantation of a fertilized egg.[2]

This new type of thinking appears to be reflected in the number of Catholic hospitals that offer emergency contraception to rape victims. For example, a statewide survey by Family Planning Advocates of NYS and the NYS Coalition Against Sexual Assault released in January of 2003 found that *75 percent of the 36 Catholic hospitals in New York State that responded to the survey stated they were already providing emergency contraception to rape victims.*

This pattern of greater willingness on the part of Catholic hospitals to provide EC to rape victims comes at a time when organizations such as The Education Fund of Family Planning Advocates have openly opposed the idea of granting any religious exemption to hospitals when it comes to providing emergency medical care. The reasoning is that the burden of the religious exemption then falls on the patient, who is in no position to immediately seek treatment elsewhere. For more information on "refusal clauses," see the ACLU's report, "Religious Refusals and Reproductive Rights."

Q Administrators of some Catholic hospitals say they must give a pregnancy test first, to make sure the rape victim is not pregnant, before they can administer emergency contraception. Should a pregnancy test always be a prerequisite to administering of EC?

A No. A pregnancy test is not necessary before a woman takes EC. While emergency contraception is not needed if a rape victim was pregnant at the time of the assault, it is also true that the EC will have no effect on the existing pregnancy. It cannot dislodge a pregnancy or cause an abortion.

However, many hospitals – both Catholic and non-Catholic – routinely give pregnancy tests to rape victims to detect pre-existing pregnancies (from prior to the rape). Knowledge of a pre-existing pregnancy is useful both for peace of mind of the rape victim (assuring her that the

[2] Hamel, R.P., and Panicola, M.R., "Emergency Contraception and Sexual Assault," *Health Progress,* Journal of the Catholic Health Association of the United States, September-October 2002 issue.

pregnancy is not from the rape) and for medical considerations, such as prescribing appropriate antibiotics, determining the safety of x-rays, and the need for HIV prophylaxis.

It appears increasingly that Catholic hospitals may be willing to provide EC if they first test for pregnancy. Father Michael Place, President of the Catholic Health Association, wrote in the July-August 2003 issue of the association's journal, *Health Progress*, that the Committee on Doctrine of the United States Conference of Catholic Bishops had been studying the issue. The committee, he wrote, "concluded that testing only for a pregnancy unrelated to the sexual assault is not inconsistent with *Directive* 36."

In essence, Father Place was advising Catholic hospitals that as long as they test a rape victim for a pre-existing pregnancy and find that she is not pregnant, then they can go ahead and provide EC to prevent a pregnancy from the sexual assault. This approach has potential to increase access to EC for rape victims.

Q So, should state EC in the ER legislation allow or even require hospitals to conduct pregnancy testing of rape victims before they are provided with EC?

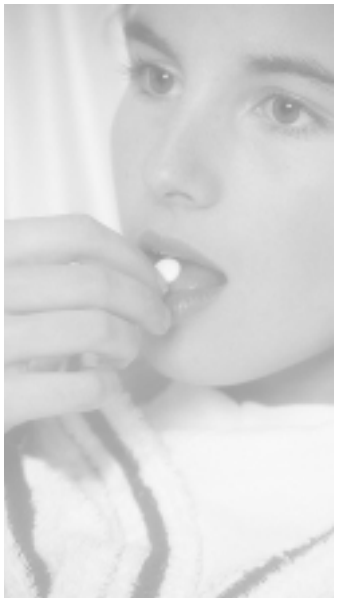
A EC in the ER legislation should not require a pregnancy test as a pre-requisite for use of emergency contraception. It is not medically necessary, and it could establish a precedent that would create barriers for women seeking EC outside of hospital emergency departments, such as at doctors' offices and clinics, or even at pharmacies in those states where pharmacists can directly dispense EC to patients. Such a requirement could also send the erroneous message that EC is an abortifacient.

In New York, language was added to the proposed state EC in the ER legislation at the last minute *allowing*, but not requiring, hospitals to refuse to provide EC if a rape victim is pregnant. This language was added at the request of the New York State Catholic Conference, which stated that pregnancy tests are routinely used at Catholic hospitals that treat rape victims. This compromise language was accepted by the bill sponsor and by advocacy groups because it was needed to ensure passage of the bill, and because, in the view of these advocates, it would have no practical effect. If a pregnancy test were positive, it would be showing a pregnancy from prior to the rape, and thus the rape victim would not need to take EC. (No pregnancy test can detect pregnancy or even fertilization from a sexual assault that has just occurred.) Moreover, these advocates felt confident (based on their working relationship with officials of the New York State Department of Health) that implementing regulations to be issued by the Department would include a medically-accurate definition of pregnancy (that it begins at implantation of a fertilized egg, not at conception or fertilization).

Advocacy groups working in states in which legislators, the Governor and/or state health officials are anti-choice or heavily influenced by conservative religious groups should be wary of this compromise language. In those states, it is possible that the legislation or a regulation could define "pregnant" as being equivalent to conception, and thus the law might allow religious hospitals to refuse to provide EC if they somehow believed that a rape victim had conceived. In general, it is better to avoid including the pregnancy language, if possible, as was the case in California, Washington and New Mexico.

To see how advocates in New York State pursued a legislative strategy, refer to Appendix 1 for sample bill memos, legislation and press releases.

Strategy 2: Administrative Action



Administrative Action

Introduction

A second method of improving access to emergency contraception for rape victims is an administrative approach, in which advocates ask an executive branch agency (such as a state Department of Health) to issue regulations, guidelines or protocols for hospitals to follow.

This approach may be desirable in your state if legislation would be difficult or impossible for political reasons. A prerequisite for the administrative approach is that your Governor and state Health Commissioner are receptive to the idea. The administrative approach also can be useful as a first step for coalitions that wish to proceed more slowly toward legislation.

Advantages:

- Action to improve access to EC can be taken more quietly, behind the scenes, in an administrative process, without a public confrontation with those opposing emergency contraception.
- Consideration of the measure will take place in an arena in which medical experts may weigh in more heavily, as opposed to a legislative arena, in which political concerns may override medical science.

Disadvantages:

- Administrative action does not carry the same force as legislation.
- Administrative protocols can be changed if Governors or Health Commissioners change and have different views about EC.
- Because administrative deliberations usually take place out of the public eye, the administrative agency can make compromises behind-the-scenes without your input or knowledge. Advocacy groups planning to promote administrative policies should be sure they have access to the administrators who will be writing the policy.

This section of the toolkit provides examples of administrative policies adopted in two states, New York and Ohio, with some discussion about the process by which the policies were issued and the perceived effectiveness of these measures.

The New York experience

In response to disparities in treatment of sexual assault victims in hospitals around the state, pro-choice and anti-sexual assault organizations approached the New York State Department of Health, which was in the process of revising its official hospital protocol for treating sexual assault victims. The advocacy organizations presented information about the efficacy and safety of emergency contraception (EC) in preventing pregnancy from sexual assault, and stressed the fact that EC is more effective the sooner it is taken. They noted the delays that can be caused when a hospital sends a rape victim elsewhere to obtain EC.

In May 2002, the NYSDOH issued a *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, an update from the 1991 protocol. By establishing a standard of care for providers throughout the state, the revised protocol requires all hospitals to establish and implement policies for the treatment of rape victims. The 2002 protocol included guidance for hospitals on STD testing, procedures for contacting rape victim advocates as well as collecting and maintaining forensic evidence utilizing the New York State standardized evidence collection procedures.

Significantly, the new protocol advised hospitals to counsel rape victims about emergency contraception and to either provide the medication on site or arrange for the rape victim to receive it from an alternate provider in a timely manner. The Protocol stopped short of simply requiring all hospitals to provide EC on site to rape victims, due to behind-the-scenes lobbying against such a provision by the New York State Catholic Conference, representing Catholic hospitals.

Key Features of the 2002 New York State Protocol:[1]

Sexual assault examiners in hospital emergency departments are expected to:

- Counsel female patients about pregnancy prophylaxis options (EC) and the importance of timely action.
- Ensure that patients are properly informed of the effectiveness rates, risks and benefits associated with medications and devices to prevent pregnancy after a sexual assault.
- Provide patients with accurate and appropriate information to make an informed choice regarding prophylaxis against pregnancy resulting from sexual assault.
- Ensure that services to obtain EC are made available without delay.

The Protocol does permit a hospital to elect not to provide emergency contraception. However, it clearly states that in such situations, *the hospital is responsible to make arrangements with another provider to dispense EC to the rape victim.* Such arrangements can include:

- Providing the patient with a prescription for the medication when it can be confirmed that is there is a pharmacy open and able to meet this need on a timely basis.
- Providing the patient with an order that can be honored on an ordered ambulatory basis by a facility clinic that is able to meet this need and is available to the patient; or,
- Referring the patient to a physician or a clinic where arrangements have been made for the patient to receive prophylaxis against pregnancy resulting from sexual assault.

[1] *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault.* New York State Department of Health. May 2002. http://www.health.state.ny.us/nysdoh/sexual_assault/index.htm.

This Protocol establishes that a patient must have access to prophylaxis. Moreover, a non-providing hospital must consider the patient's ability to secure the medication elsewhere on a timely basis. This will be accomplished by documenting that the patient:

- is physically and mentally able to pursue alternate options;
- is suitably attired to present at an alternate site; and
- has (as appropriate and necessary) transportation and resources needed to secure the treatment.

If any of the above criteria cannot be met, treatment must be directly provided by the initial hospital.

These conditions are crucial features of the NYS Protocol as they ensure that pregnancy prophylaxis (EC) is provided. Although the Protocol does not require hospitals to actually provide EC on site, it does at least provide for appropriate referral to an alternative site that can provide EC on a timely basis, *if* the woman is capable of getting there.

Pro-choice and anti-sexual assault advocates in New York State felt that the Protocol was an important step forward, but that it still stopped short of the ideal requirement that all hospitals should have to provide EC on site.

The Ohio experience

In Ohio, the Crime Victim Compensation Act requires that hospitals, that apply for state compensation, follow the *Protocol for the Treatment of Adult and Adolescent Sexual Assault Patients*, which is issued by the Ohio State Department of Health. Providers must adhere to this protocol, which was revised in 2002, to receive victim compensation funding in their medical facilities.

Key features of the Ohio Protocol for treating a sexual assault patient:[2]

- According to the Ohio Revised Code 2907.01[3], sexual assault encompasses rape and sexual battery, as well as any sexual penetration involving force or coercion against the person's will.
- The Protocol states that medical personnel must discuss and offer options for emergency contraception with the female patient who has been sexually assaulted.
- Treatment, however, is at the discretion of the health care provider with the permission of the patient.
- If the medical facility does not provide emergency contraception for religious reasons, the victim must be referred to another physician, facility or agency within 72 hours of the assault.
- Medical personnel should inform the patient that some medications may lessen the effectiveness of emergency contraception and determine if the patient is taking such medication.

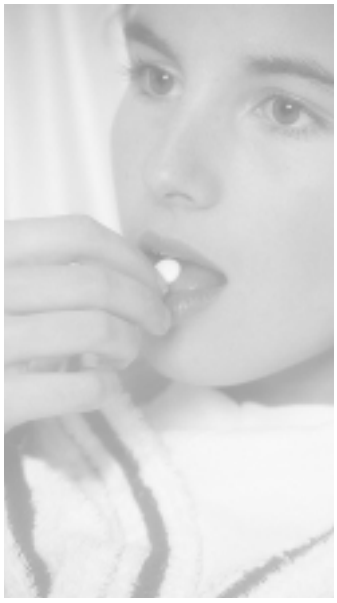
It is important to note that the Protocol does not in any way mandate providers to give emergency contraception. Moreover, the Protocol has a broad exemption and a referral process that, because of the timing, will not ensure that women can get access to EC in a sufficiently timely manner.

For a complete version of the Ohio protocol go to:
http://www.odh.state.oh.us/ODHPrograms/SADV/sadvprot.htm

[2] *Protocol for the Treatment of Adult and Adolescent Sexual Assault Patients.* Ohio Department of Health Sexual Assault Protocol, Revised July 2002.

[3] The Ohio Revised code can be found at http://onlinedocs.andersonpublishing.com/revisedcode/.

Strategy 3: Litigation and Legal Liability



Litigation and Legal Liability

Introduction

Litigation is another tool that could be used to improve hospital policies on providing emergency contraception to sexual assault survivors. A successful lawsuit over a hospital's failure to provide a rape victim with access to emergency contraception could prompt other hospitals to change their policies for fear of being sued.

This approach may be the most effective way to improve access to EC in states where legislation or administrative action has little chance of success and hospitals are intransigent in their refusal to provide EC to sexual assault survivors. However, advocacy groups considering litigation should be aware that it can be time-consuming and costly. Moreover, the success of such a lawsuit will rest not only on proving that EC is the standard of care, but also on finding a plaintiff who has become pregnant from a rape after not being informed about or offered EC at a hospital ER, and who is willing to describe the damage she suffered from the pregnancy (such as having to undergo an abortion).

It is worth noting, though, that even the *prospect* of a lawsuit may be enough to convince some hospital administrators and their attorneys to improve EC in the ER policies. Some advocacy groups have provided hospital administrators with materials showing that providing information about and access to EC is now endorsed by medical associations and pointed out the potential legal liability in failing to follow this standard.

Advantages:

- A successful lawsuit could prompt other hospitals to change their policies on EC.
- The threat of legal liability could be the only way to improve rape survivors' access to EC in states where legislative or administrative approaches are not likely to succeed.

Disadvantages:

- It is difficult to find a plaintiff who is willing to pursue a lawsuit.
- Litigation can be time-consuming process.
- There is no guarantee of success, and an unsuccessful lawsuit could even hurt the cause.

The Brownfield case: A rape survivor's lawsuit

Brownfield v. Daniel Freeman Marina Hospital,[1] is the only reported case in which a sexual assault survivor sued over a hospital's failure to counsel her about and provide access to emergency contraception. The plaintiff in the case, Kathleen Brownfield, sued the Daniel Freeman Marina Hospital, a Catholic-owned facility in California, after she was treated in the hospital's emergency department following a sexual assault and was not offered information about or access to emergency contraception.

[1] *Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal. App. 3d 405 (1989).

Court papers give the following account of her treatment:

> Her mother asked for information concerning the "morning-after pill," a "pregnancy prevention treatment." Respondent hospital refused to provide information concerning this treatment, despite the fact that the appellant was at risk of pregnancy, because it was "a Catholic hospital." It also allegedly failed to inform appellant that if she chose to receive the treatment she should immediately contact her doctor or another emergency room in order to obtain it within the 72-hour period in which such treatment is effective. Appellant stated that she did not see her family doctor until more than 72 hours after the rape.

Although she did not become pregnant from the rape, Brownfield was upset that the hospital had placed her at risk of pregnancy because of its policy of not to offer sexual assault victims information about or access to emergency contraception. She filed suit seeking an injunction that would require the hospital to either stop treating rape patients or to counsel such patients about EC and provide access to the medication.

The court ruled that Brownfield would have had a viable claim for malpractice if she could show that emergency contraception was the standard of care, she would have taken the medication and she had been harmed by the hospital's failure. The court in this case equated harm with becoming pregnant from the rape.

In its decision, the court found that a hospital's duty to counsel a rape survivor about emergency contraception was based on a patient's right to self-determination. "The duty to disclose such information arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.' Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available."[2]

Although Brownfield did not ultimately win the lawsuit, the case puts hospitals on notice that a failure to counsel rape patients about EC and make it available exposes health care providers to legal liability.

Establishing a Legal Claim

Whether a lawsuit can be brought over a failure to make EC available or counsel a rape survivor about EC depends on state law. Each state has differing laws on the time frames in which a case can be brought, the evidence that can be admitted, against whom claims can be brought and what claims can be brought. For that reason this section is not intended to serve as legal advice or guarantee a favorable outcome in any case that may be brought.

Informed Consent

While the specific claims will vary depending on state law, a rape survivor who is not counseled about EC and becomes pregnant as a result of the rape may be able to file a lawsuit based on a lack of informed consent. The doctrine of informed consent is based on a patient's right to determine what happens to her or his body. This doctrine requires a physician or hospital to disclose enough information about medically relevant options and their risks so that a patient is offered "an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."[3]

[2] In this case the court noted that access to emergency contraception could have been ensured by transferring the patient to another medical facility or physician. A plaintiff may be able to show that providing a referral to another provider or offering a prescription does not constitute adequate care because EC is most effective the sooner it is taken.

[3] *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

Failure to counsel a sexual assault survivor about EC should be considered a breach of a patient's right to informed consent and a violation of a physician's duty to disclose all medically relevant treatment options, since it deprives a patient of information about an important and medically relevant option.

A Failure to Meet the Standard of Care

A patient may also be able to sue the treating physician and/or the hospital for failure to provide treatment that meets the standard of care. Typically, in order to win a malpractice suit claiming a patient was harmed by a failure to provide treatment meeting the accepted standard of care, four elements must be proven:

1. **The patient was owed a duty of care.**
This element is easy to establish. Doctors owe their patients a duty of care, especially emergency care, as do the hospitals that treat them. A patient should be able to show that the treating physician and/or hospital owed her a duty of care.

2. **The duty of care was breached.**
To meet this element of a claim, the plaintiff would need to first prove that *counseling a sexual assault patient about EC* is the standard of care, and that this standard was not met. In some cases, it may also be possible to show that *providing EC to a sexual assault victim* is also a standard of care, and that this standard was not met.

3. **The patient was harmed by the failure to meet the standard of care.**
To show that she was harmed by the failure to provide treatment meeting the standard of care, a patient would quite likely need to show that she had become pregnant as a result of the rape. While a woman may have a good argument that the worry of becoming pregnant is harm, the court in the Brownfield case found this was insufficient.[4]

4. **The harm was caused by the breach.**
To prove this element, a plaintiff would need to show that the harm (pregnancy resulting from the rape) was caused by the failure to be counseled on or offered EC. Because EC is highly effective in preventing pregnancy, especially if taken soon after unprotected intercourse, a victim would have a strong argument that harm was caused by the lost chance to prevent pregnancy from occurring.

Can a religious hospital be exempt from liability for refusing to make EC available?

A religious hospital may claim that counseling a rape survivor about EC or providing EC violates its religious beliefs. Such a claim should not be viewed as a barrier to litigation. Although the hospital in the Brownfield case was a Catholic institution, the court ruled that the institution's religious beliefs did not outweigh the woman's need for medical care, saying: "Implicit in the allegations of her complaint is the contention that appellant's right to control her treatment must prevail over respondent's moral and religious convictions. We agree."

Although it is not possible to predict how a given court may rule, it is important to remember that there are interests at stake other than a hospital's religious beliefs, including a patient's right to give informed consent and receive medically appropriate care. In any case in which competing interests are

[4] There may also be other bases for litigation found in consumer protection statutes such as unfair or deceptive practices. For more information on the use of consumer protection laws, see Elena N. Cohen & Alison Sclater, "Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care" (Washington, DC: National Women's Law Center, October 2003).

at stake, the court must weigh the interests when coming to its decision. The court in the Brownfield case decided that the patient's right to receive appropriate medical care outweighed the hospital's religious beliefs. Other courts, however, may reach different outcomes.

Can a religious refusal clause exempt a hospital from liability?

Most states have some form of refusal clause (often called a conscience clause) that allows medical institutions or providers (such as a doctor or nurse) to refuse to provide medical services to which they have a religious or moral objection. These refusal clauses generally allow providers to refuse to offer abortion or sterilization, although a few states have much broader clauses covering other types of medical treatment.

> "In the Brownfield case the court ruled that the state law allowing hospitals to refuse to provide abortion did not apply to emergency contraception, because it is a contraceptive."

Laws that allow hospitals to refuse to provide abortions should not insulate a hospital from liability for its failure to counsel a rape survivor and provide her access to emergency contraception. For example, in the Brownfield case the court ruled that the state law allowing hospitals to refuse to provide abortion did not apply to emergency contraception, because it is a contraceptive.

The court also noted that the state's exemption did not apply in emergency situations. Although there are some people and religious organizations that believe EC and other contraceptive medications are the equivalent of abortifacients, this is not accurate. Religious beliefs cannot change medical facts or definitions. The Resource section of this Toolkit includes authoritative sources that make it clear that EC is a contraceptive medication, not an abortifacient.

Even when a refusal clause is broad, and seemingly allows health care providers to refuse to provide any service to which they object, a court may interpret the statute in a way that avoids giving a hospital immunity from liability when a patient is harmed by a refusal to provide needed care. For example, a court may say the clause was not intended to apply to emergency room settings where the care needed is of a time-sensitive nature and the patient may not have a choice of where she is brought.[5] Courts may also conclude that broad refusal clauses should not apply to public hospitals or quasi-public hospitals.

The disadvantages of litigation

Although litigation is a potential tool in improving rape survivors' access to emergency contraception, it is a difficult approach to use for several reasons.

One limiting factor is the time in which a lawsuit must be filed. Although this is determined by state law, the time period in which suit must be filed is generally limited. Because of the trauma experienced by survivors of sexual assault, many women do not feel emotionally ready to sue in the allowed time frames.

[5] For more information on narrow judicial interpretations of refusal clauses, see "Religious Refusals and Reproductive Rights," ACLU Reproductive Freedom Project, 2002.

Another issue involves confidentiality. Some rape survivors wish to have their assault remain a private matter and would not want to expose themselves to the publicity a lawsuit may attract. (A rape survivor, however, may be able to file a lawsuit under a pseudonym to preserve her privacy.)

Litigation is also time consuming. Lawsuits can take several years to be resolved, especially given the appeals that are likely when the litigation involves controversial issues.

The risk of losing is also a disadvantage that must be considered. An unsuccessful suit could embolden bad behavior and create further obstacles to access. If a court finds that EC is not the standard of care, hospitals could refuse to offer it.

Still another issue concerns the goal of litigation. A rape survivor who may be interested in pursuing legal action should be aware that a successful lawsuit is unlikely to result in a large financial award. Advocates should explain that compensation from a successful lawsuit would be limited.

For these reasons, a rape survivor should never be badgered to file suit or made to feel guilty if she is not interested in pursuing legal action. For some women, however, litigation - and the potential to improve medical care for other sexual assault survivors - could be part of the healing process.

Assistance may be available to survivors who seek to file a lawsuit

Cost concerns may also deter some survivors from filing suit. Litigation can be expensive and the monetary relief from a successful suit is not likely to be great. Concern about legal costs should not, however, prevent a woman from proceeding; there are public interest law firms that would take a promising case without charging a fee.

If you should know of a survivor who may be interested in filing a lawsuit over a hospital's failure to offer EC, please contact MergerWatch at info@mergerwatch.org, for further information.

When a lawsuit isn't a possibility: Raising the issue of legal liability

While it may not be possible to find a plaintiff or to bring a lawsuit, advocates can raise the issue of potential liability with hospital administrators and attorneys. As the acceptance of EC as the standard of care among professional medical associations has grown, so too has the potential for a hospital to incur liability when those standards are not met. Advocates can raise the issue of liability when meeting with or writing to hospital administrators and attorneys. The risk of being sued, and the resultant bad publicity, may be enough of a deterrent to convince risk-averse hospital administrators to adopt policies that ensure sexual assault victims are counseled about and offered EC when they are treated in the hospital.

In order to show that providing EC at the time of treatment is an essential aspect of the care of rape survivors, advocates can discuss the timely nature of EC; it is more effective the sooner it is taken. Unnecessary delay in obtaining the medication increases the risk that a rape survivor may become pregnant due to the assault.

Advocates should also discuss the problems that a woman may face in obtaining the medication on a timely basis. Showing that a rape survivor may not be able to obtain EC in a timely manner will illustrate the importance of providing it at the time of treatment. For example, does the community have 24-hour pharmacies? Are there local pharmacists who refuse to dispense the medication? Which medications do local pharmacies stock?

In New York, advocates sent their survey materials to hospital CEOs and attorneys as well as to emergency department and nursing personnel. Advocates included hospital CEOs in the mailing to make sure they were aware of new state protocols that required hospitals either to provide emergency contraception to rape survivors at the time of treatment or ensure that the patient is able to obtain EC on a timely basis and to alert them to potential liability.[6] The cover letter sent to each hospital included the following warning:

> The New York State Coalition Against Sexual Assault and Family Planning Advocates believe the best and most responsible course of action for any hospital will be to immediately provide emergency contraception on site to any sexual assault survivor who elects to use the medication after being fully informed about her treatment options. Failure to do so will cause an unnecessary delay in treatment, increase the risk that the survivor will become pregnant and potentially expose the hospital to legal liability.

A number of hospitals reported that they were upgrading their policies on providing EC to rape victims after having received the survey. It is unknown how many of those changes were prompted by the liability warning.

Training medical professionals about the liability risks

One obstacle to patient access to EC is a lack of knowledge among medical professionals who treat rape victims. Educating medical professionals about EC and the risk of liability for not providing it may encourage these practitioners to adopt new protocols.

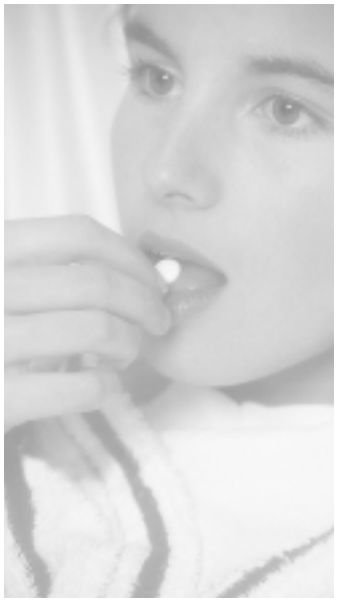
The Mississippi Coalition Against Sexual Assault has used a voluntary approach to ensure that rape survivors are counseled about EC when treated in the emergency department. (See the section on "Voluntary Change" for more information.) In training rape crisis workers and emergency department staff, the coalition discusses EC and how a failure to offer the medication may expose a health care provider to legal liability.

Similarly, a Sexual Assault Nurse Examiner (SANE) program based in an Ohio hospital trains emergency room residents on caring for sexual assault survivors. Part of the training curriculum includes a discussion of liability for not meeting the hospital's accepted standards of care. The SANE program teaches residents that if they have a personal objection to providing EC, there must be arrangements in place to ensure that patients are offered EC, in order to insulate the hospital and physician from liability.

Coordinators of the programs in Mississippi and Ohio have reported that hospital administrators and health care providers can often be convinced to update their policies when they are made aware of the guidelines issued by professional medical organizations that call for giving rape victims access to EC.

[6] The New York legislature has since passed legislation that requires hospitals to provide EC to those rape survivors who wish to take the medication.

Strategy 4: Voluntary Change



Voluntary Change

Introduction

Encouraging voluntary change in hospital policies can be the easiest way for state advocacy coalitions to begin improving rape victims' access to emergency contraception in emergency rooms. This method allows advocacy groups to avoid the publicity and/or politics that generally accompany legislative action. Voluntary approaches also can work more quickly than administrative or litigation strategies. In some states, anticipated opposition to legislative action makes the voluntary approach the only logical option—at least initially. For the most effective change on the voluntary level, these actions should be carried out collaboratively between the sexual assault and pro-choice coalitions.

Advantages:

- Efforts can be made on a small scale and have immediate and beneficial results.
- Voluntary tactics serve to educate, generally creating a cooperative environment.
- Voluntary action can take place behind closed doors, avoiding public controversy.

Disadvantages:

- Voluntary action cannot be enforced.
- Hospital policies are subject to change, for any number of reasons, including when administrators change.
- Because hospitals often must be approached one-by-one or in small groups, the effort to create widespread change can be time-consuming.
- Large-scale trainings, mailings or outreach campaigns are expensive and time-consuming.

Methods that can be used to promote voluntary change include training those professionals who provide direct services to victims of sexual assault about including EC in rape treatment; encouraging hospital administrators to include EC in rape treatment protocol; and establishing public awareness campaigns about EC and sexual assault that can lead to patient requests for EC at local hospitals and/or hospitals voluntarily adopting policies to offer EC.

Training of Professionals Serving Rape Victims:

For comprehensive coverage, EC training should be given to all direct service providers that may come in contact with a rape victim seeking treatment.

Some communities have a Sexual Assault Response Team (SART). Typically, such a team includes sexual assault forensic examiners (SAFEs) or sexual assault nurse examiners (SANEs) – who are nurses specifically trained in forensic evidence collection and rape treatment – as well as sexual assault advocates/counselors, law enforcement representatives and prosecutors. The team determines how best to coordinate services to serve rape victims. SART coordination generally includes a protocol of response guidelines developed with additional input from organizations such as the state department of health, the state anti-sexual assault coalition, victim service providers, hospital administration, the state attorney general's office and others. Most SARTs also do regular trainings to keep up to date on

providing the best care for victims of sexual assault. As part of their training curriculum, SAFE/SANEs receive training on emergency contraception. With a few exceptions, SAFE programs (that may be part of a SART) provide information about EC to victims and give EC to victims if they want it.

Advocates might want to check with SAFE programs to see what the policy is on EC and to make sure they are giving the best and most current treatment. For example, an emergency department might still be providing combination EC pills when they could make things easier for the victim by providing Plan B®. They might also not know that both doses of Plan B® can be given at the same time. Because medicine constantly evolves, advocates will have to stay up to date on EC and make sure the SAFE/SANEs are up to date also.

Many communities, however, do not have a SART and protocol, and in those communities, many hospitals do not have SAFE/SANEs. The result is that rape exams may be performed by an emergency department nurse, doctor or resident who is most likely not trained in sexual assault forensic evidence collection or rape treatment protocol. Advocates should review what the exam and medication procedures are and find out who conducts the exams. Training should be provided to every staff person who provides sexual assault exams or forensic exams. It may also involve setting up a structure to improve EC access. For example, if nurses conduct most of the exam, a physician could write standing orders for those nurses to provide EC to victims. Other staff, such as residents should receive training on EC also.

Other direct service providers who should be included in trainings on EC for rape victims are rape crisis line/hotline operators, sexual assault counselors, hospital social workers, and staff of child advocacy and victim assistance centers. Training for direct service providers should review general information about EC and its importance in sexual assault treatment.

Training should cover the following topics:

- **The prevalence of pregnancy in victims of sexual assault:** About 5 percent of rapes result in pregnancy. Recent studies have estimated 25,000 to 32,000 women in the US become pregnant as a result of sexual assault each year.
- **How EC works:** Like birth control pills, EC prevents ovulation, fertilization or implantation of a fertilized egg, with implantation being the least likely mechanism of action, according to recent studies.
- **Why EC does not cause an abortion:** the medical definition of pregnancy is that it begins at the moment of successful implantation of a fertilized egg on the wall of the uterus. EC works before implantation, and thus prevents pregnancy. EC is not the same thing as RU-486, the "abortion pill."
- **The effectiveness of EC:** EC pills are 75 to 89 percent effective in preventing pregnancies that would otherwise have occurred, depending on which product is taken and how soon it is taken after unprotected sex.
- **Why EC should be part of the standard protocol of care for victims of sexual assault:** Victims should not be re-victimized by having to deal with a pregnancy resulting from rape, and the sooner EC is taken, the greater the effectiveness of preventing pregnancy.

Training should also review the procedure for offering of EC as part of proper sexual assault treatment:

- The patient should receive accurate and complete verbal and written information about EC in order to make an educated decision whether to take the medication.
- Before she takes EC, the patient should receive information about the likelihood of pregnancy. Some factors to consider are whether the patient is of childbearing age, if she uses regular hormonal contraceptives, if she has had a copper IUD inserted, if she has had a tubal ligation and if she knows she is already pregnant. (A pregnancy test often is part of rape treatment, but is not a prerequisite for EC because EC has no effect on an established pregnancy.)
- The emergency department should be encouraged to stock the type of EC that is most effective, has fewer side effects and has a lower medical risk, currently Plan B® and Preven."
- The emergency department staff should be trained on the latest research on EC and resources on staying up-to-date with new research as it is released, such as the 2002 studies showing the effectiveness window of EC to extend to 120-hours from the previous 72 hours and research showing that a single 1.5 mg dose of Plan B® is as effectives as two .75 mg doses taken 12 hours apart (meaning the complete regimen of EC can be administered in the emergency department).

Handouts should include:

- An EC fact sheet (refer to fact sheet at the beginning of this toolkit for a model)
- A list of birth control pills and regimens that will be effective as EC (a list is available at not-2-late.com, under EC Pill Brands Worldwide for the United States)
- List of policy statements from medical societies (available at www.aclupa.org/duvall/pubs/ecguidelines.html)
- Sample hospital protocol (See Appendix 3 for sample protocol)

Encouraging Hospitals to Voluntarily Improve Policies:

It is important to encourage hospital administrators to include the offering of EC as part of standard protocol for rape treatment in the emergency department. If a state has no law ensuring EC is routinely offered to victims of rape at all hospital emergency departments, policies may vary from hospital to hospital. At some facilities, it is up to the individual staff to administer EC, which may not happen because of the religious beliefs of a physician or nurse, misconceptions about EC or a general lack of knowledge about EC as part of rape treatment. This situation leads to inconsistency of care and leaves to chance the probability that a rape victim will be offered the means to prevent pregnancy. In theory, inconsistent care can be worse than a policy of not providing EC because the local rape crisis center would then know to make alternative arrangements to ensure access to EC.

Writing letters to hospital administrators is a great way to begin this process (see the sample letters in Appendix 3). An introductory letter should introduce your organization, tell the recipient about EC and explain why it should be a part of standard rape treatment. If your organization has surveyed hospital EC policies (which we recommend in this toolkit), you can include in the letter the results for each hospital and compare them with the statewide findings. When hospital administrators discover they are out-of-step with other hospitals, they may be more inclined to consider adding EC to their emergency protocol for treatment of rape victims.

The mailing might also include an EC fact sheet, medical society policy statements and language alerting hospitals to potential liability if a rape victim is not given proper treatment (see litigation section of this toolkit). A copy of state sexual assault treatment protocol/SART guidelines/SANE guidelines could be included as well. (Contact your state sexual assault coalition for a copy of the guidelines. A list of coalitions can be found in Appendix 4 of this toolkit.)

Special considerations for Catholic Hospitals: Catholic hospitals require a specialized approach because of religious and ethical restrictions. (See the separate sample letter in Appendix 3 of this toolkit.)

To all hospitals, packet/letters should be addressed to a number of people on the hospital staff, including:

- The hospital president/CEO
- Emergency department doctors
- Emergency department nurse manager

After sending your packet/letter, scheduling a follow up meeting may be a good idea, if you have the time and resources. The following pages discuss site visits advocates in NY made to hospitals to discuss EC for rape victims.

There are other ways to effect change in hospitals. You can promote the hiring and training of SAFE/SANEs. As discussed above, SAFE/SANEs are not the norm in hospital emergency departments, but offer expert care to victims of sexual assault. Since these nurses have been trained to treat sexual assault patients, they are likely to be aware of the need to promote EC as part of complete emergency department care for victims of sexual assault. Also, a hospital emergency department with SAFE/SANEs has committed staff to proper treatment of sexual assault, and thus is more likely to develop a comprehensive treatment protocol for victims that includes EC. The organization of a SART can also lead to awareness of the issue and proper hospital protocol. Consult with your state anti-sexual assault coalition or local rape crisis center to help ensure comprehensive care.

EC public awareness campaigns:

Public awareness/education campaigns are great tools for promoting change in hospital policies. They increase community/public awareness of emergency contraception and thus support for EC in the ER. With this support, you have a greater chance of achieving success through any of the four strategies for action.

A public awareness/education campaign is generally an ongoing effort to bring public attention to the issue. Awareness campaigns on EC in general can also be beneficial because EC is widely unknown or misunderstood by the general public.

Some ideas for beginning a public awareness/educational campaign include:

- **Develop and distribute educational materials/fact sheets on EC and sexual assault**
  Many organizations have publications on EC and EC in the ER available free of charge or for a small fee that you can purchase. (www.pcar.org, www.prch.org, not-2-late.com, and choice organizations such as Planned Parenthood, NARAL, and others.) A quick search on the web will also give you all the information you would need to develop your own fact sheet or pamphlet.

- **Include discussion of EC in organization publications/website**
  If your organization has a newsletter or a website, include a section or article on EC and why it is an important part of treatment for victims of sexual assault.

- **Include EC discussion at public events**
  Give a presentation on EC and sexual assault at conferences, include EC as part of training/workshop sessions when appropriate, add EC as an issue your organization wants to address using any four of the strategies outlined in this toolkit. There are many ways to share EC information with your audience.

Following up on EC in the ER survey results: Site visits to hospital ERs in New York State

Sometimes face-to-face meetings with hospital administrators can produce positive change in emergency department policies on the dispensing of EC. Women's health advocates in New York State found that was the case when they made a series of site visits to hospitals in the spring of 2003.

Members of Save Our Services-Long Island, a coalition working to preserve and expand access to reproductive health services, visited a series of hospitals in New York's downstate region. The hospitals had either failed to respond or had provided inconsistent responses to a statewide written hospital survey on ER policies regarding the offering of emergency contraception to sexual assault victims. The advocates met with either hospital administrators or ER staff, depending on who was available at each hospital.

Approach

A non-confrontational educational approach was used. The advocates began by presenting each hospital representative with a written summary of the EC in the ER statewide survey conducted by Family Planning Advocates of NYS and the New York State Coalition Against Sexual Assault. They highlighted the high percentage – 85 percent – of hospitals that had stated they had standard policies of offering EC to rape victims.

Advocates then discussed the policy of the hospital being visited and compared its policy to the recommended standard of care for rape victims under the New York State Department of Health Protocol for Treatment of the Adult Sexual Assault Patient, as well as to the anticipated mandate under the EC in the ER legislation that was then pending.

The advocates reviewed basic information about how EC works and the time-frame in which it is effective. In at least one visit, hospital medical staff appeared not to be aware that EC is not the same thing as RU-486, the "abortion pill." When requested, the advocates discussed specific EC products, including Preven® and Plan B®. In one case, the visit turned into an "in-service training" for interested hospital staff.

Results

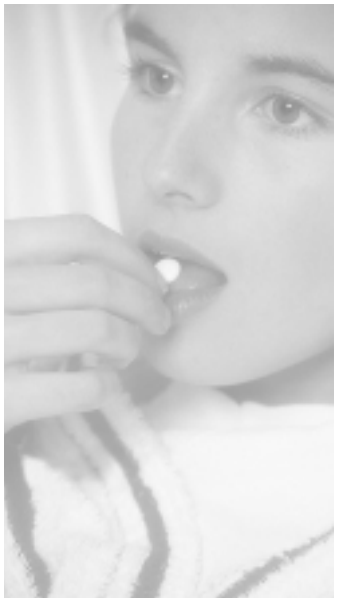
At two hospitals that had failed to return surveys, advocates learned that the ER staff appeared to be actually dispensing EC to rape victims, but did not want to fill out the survey for internal administrative reasons. In two additional cases, the advocates obtained promises that emergency contraception would be added to the treatment regimen for rape victims.

At one hospital, advocates learned that EC was not stocked in the hospital pharmacy. A physician present at the meeting with advocates requested information on brands of EC, which advocates sent to him. He followed up by sending a request to the pharmacy that Plan B® be stocked.

At the second hospital, the advocates found that institutional religious policies had been preventing the dispensing of EC, but that the hospital had just been taken over by a nonsectarian system. The president of the nonsectarian system pledged to introduce EC in the ER at the formerly religious hospital.
While the site visits were time consuming and labor intensive, the advocates concluded that face-to-face meetings with decision-makers proved effective in assessing and improving the status of delivery of EC in the ER. These meetings also provided the opportunity to educate medical staff about the effectiveness of EC and to address any misconceptions about how it works. To find out more, contact SOS-LI coordinator Sarah Miller at Sarah.Miller@ppnc.org

To see sample hospital letters, protocol and training materials, refer to Appendix 3 for voluntary change resources.

Appendix 1: The New York Experience



nyscasa
new york state
coalition against
sexual assault

September 12, 2002

Dear (CEO, General Counsel, ER Director, Nurse Manager, Director of Education and Training):

The New York State Coalition Against Sexual Assault and Family Planning Advocates of New York State are working together to promote high quality care for sexual assault survivors receiving treatment at hospital emergency departments.

We are writing to follow up on the recent issuance by the New York State Department of Health of a revised and improved P*rotocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. Your hospital should have received a copy of this *Protocol* in the mail this summer. If you have not, you can obtain one by calling Kathy Martin at the Department of Health at 518-474-3336. The *Protocol* can also be downloaded from the Department of Health website at: www.health.state.ny.us/nysdoh/sexual_assault/index.htm

We want to call to your attention a specific section of the Protocol (pp. 36-40, copy attached), which explains the expected standard of care for provision of emergency contraception to prevent pregnancy following a sexual assault. For sexual assault survivors, the risk of unintended pregnancy is a serious concern. Fortunately, that risk can be significantly reduced with immediate use of emergency contraceptive pills (ECPs).

Emergency contraception, which is a term for a high dose of ordinary birth control pills, is a safe and effective FDA-approved method of pregnancy prevention when used within 72 hours after unprotected intercourse. Because it is more effective the sooner it is taken, emergency contraception should be offered to sexual assault survivors during treatment in hospital emergency departments. Any delay in its use increases the risk of pregnancy. The recently issued NYS DOH *Protocol* spells out the following standards of professional practice:

A. Counsel patients about their options for prophylaxis against unintended pregnancy and the importance of timely action. *Optimally, the treatment should be initiated within 12 hours after the assault;*

B. Ensure patients are properly informed of the effectiveness rates, risks and benefits associated with interventions to prevent pregnancy resulting from sexual assault;

C. Provide patients with appropriate information to make an informed choice regarding pregnancy prophylaxis, and *ensure that such services are provided or made available to the patient without delay.*

The *Protocol* does allow a hospital to elect not to directly provide pregnancy prophylaxis. However, the *Protocol* clearly states that in such a situation: "The provider retains the responsibility to make arrangements with another provider to render such services without delay. Such arrangements must be documented in the patient's medical record. They must ensure that the patient's confidentiality is respected and that the patient is not subjected to unnecessary examination or assessment resulting in undue delay in administering any prophylaxis." Please refer to pages of the attached *Protocol* for complete details.

The New York State Coalition Against Sexual Assault and Family Planning Advocates believe the best and most responsible course of action for any hospital will be to immediately provide emergency contraception on site to any sexual assault survivor who elects to use the medication after being fully informed about her treatment options. Failure to do so will cause an unnecessary delay in treatment, increase the risk that the survivor will become pregnant and potentially expose the hospital to legal liability.

Because we feel certain you share our concern for the well-being of sexual assault survivors, we want to offer assistance in ensuring that your hospital meets the standards of care outlined in the NYS DOH *Protocol*. Please call us at 518-482-4222 for NYSCASA or 518-436-8408 for FPA to request information or assistance.

We will continue to follow up with your hospital to inquire about procedures for providing sexual assault survivors with emergency contraception. We ask that you take a few moments to complete and return the attached form. You can fax it to us at 518-436-1048, or mail it in the enclosed self-addressed, envelope. We thank you for your time and cooperation in this matter.

Sincerely,

Anne Liske
Executive Director
NYSCASA, Inc.

JoAnn M. Smith
President and CEO
Family Planning Advocates

EMERGENCY CARE FOR SEXUAL ASSAULT SURVIVORS

To help us promote high quality care for sexual assault survivors, we ask that you complete this survey and return it in the enclosed envelope or by fax. Please circle your response for the following questions and provide further information when asked:

Hospital Name: _____

Name of person filling out survey and contact information:

_____

_____

1. Has your office received the newly released New York State Department of Health protocol entitled, *Protocols for the Acute Care of the Adult Patient Reporting Sexual Assault*?

YES **NO**

2. Approximately how many sexual assault survivors are treated at your emergency department each year?

A) 0-10 **B)** 10-50 **C)** 50-100 **D)** 100-200 **E)** 200+

3. Sexual Assault Forensic Examiners (SAFE) and Sexual Assault Nurse Examiners (SANE) are specially trained health professionals who perform a comprehensive evaluation and assessment, collect high quality evidence and provide expert testimony in cases where the crime of sexual assault is reported.

Do you have a SAFE or SANE program?

YES **NO**

4. Who is responsible in your hospital to counsel sexual assault survivors on the potential use of emergency contraception to prevent pregnancy?

_____

5. Is it standard policy for the hospital to dispense emergency contraception on site to sexual assault survivors?

YES **NO**

A. Are there any exceptions to this policy based on the discretion of the provider on duty?

YES **NO**

B Are there any exceptions to this policy based on the time of day a survivor is seen, for example, after the pharmacy is closed?

YES **NO**

6. If you do not provide emergency contraception, how do you fulfill your responsibility to "make arrangements with another provider to render such services without delay?" Do you send the patient to:

A) a pharmacy with prescription **B)** a family planning clinic

C) another hospital **D)** a primary provider's office

E) other (please describe): _____

7. Do you provide referrals for follow-up counseling to sexual assault survivors?

YES **NO**

Periodically, we offer professional training and information. If you would like to take advantage of this opportunity please provide us with contact information for the following staff members:

	Name	Proper Title	Phone Number
Nurse Manager			
Director of Emergency Medicine			
Director of Education and Training			
Hospital Chief Counsel			

<u>If you would like further information sent to you, please check as many of the following categories as appropriate:</u>

- ❑ *Sexual Assault and Health Care fact sheet*
- ❑ *Emergency Contraception in the ER fact sheet*
- ❑ *A listing of Sexual Assault Forensic Examiner programs by county*

Please return survey to:
FPA
17 Elk Street
Albany, NY 12207
Or FAX to: 518-436-1048

If you have any questions about this survey, or need clarification, please contact Maria or Ronnie at (518) 436-8408

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January 27, 2003

Survey shows gaps in NY hospital treatment for sexual assault survivors
Lawmakers, advocates cite need for dispensing of emergency contraception

As many as 1,000 rape victims a year are sent away from hospital emergency departments in New York State without having received emergency contraception (EC) pills to prevent pregnancy, a new statewide survey has found. Sexual assault survivor and pro-choice advocates released the survey results today and joined state lawmakers in calling for mandated hospital dispensing of EC as a key element of improved health services for rape victims.

"It is inexcusable that rape victims are being denied immediate access to a safe and extremely effective method of preventing pregnancy," said JoAnn Smith, President & CEO of Family Planning Advocates of New York State (FPA). "Emergency contraception works better the sooner it is taken, yet traumatized sexual assault survivors are being delayed in obtaining it when they are sent out of the hospital to pharmacies or clinics."

NYSCASA and FPA worked together to contact 205 hospital emergency departments, asking for their official policies on counseling rape victims about pregnancy prevention and dispensing emergency contraception on site. A total of 196 responses were received (a 95 percent response rate). The majority (165 or 85 percent) of the emergency departments responding to the survey reported that is their standard policy to offer and dispense emergency contraception on site to survivors of sexual assault.

However, 28 hospitals (14 percent of the responding hospitals) that treat a combined total of nearly 1,000 rape victims a year reported that they do not have a standard policy of dispensing emergency contraception. Some give prescriptions, which rape victims must then fill at local pharmacies, while others send women to private doctors, family planning clinics or other hospitals. Another three hospitals (less than 1 percent) have policies to dispense EC, but allow exceptions, such as when a physician on duty objects for moral or ethical reasons.

"Rape is a crime that is a violent, traumatic and intimately personal violation, in which all sense of personal control and decision-making has been ripped apart," said Anne Liske, Executive Director of NYSCASA. "When a rape survivor walks through the door of any hospital, immediate, adequate and appropriate comprehensive care should be the response."

Lawmakers call for enactment of legislative mandate

Two state lawmakers said they will push for enactment this year of legislation they are sponsoring requiring that all hospital emergency departments inform rape victims about emergency contraception and dispense it on site. Presently, state Department of Health guidelines call for hospitals to inform rape victims about use of emergency contraception to prevent pregnancy, but allow hospitals to decline to actually dispense the medication.

"It is time to end the run-around for rape victims in New York State," said Assemblywoman Susan John, D-Rochester, whose EC bill (A15) has passed the Assembly the last three years.

"After surviving the trauma of a rape, it is unthinkable that a woman should be denied emergency contraception," said State Senator Nicholas Spano, R-Yonkers, the lead Senate sponsor of the EC legislation (S202). "My legislation would require that all New York hospitals provide information about emergency contraception, and provide it when requested. Rape is clearly one of the most abhorrent crimes in today's society. We must not deny the victim's right to emergency contraception, and I will fight until my bill becomes law."

Reproductive health experts cite safety, effectiveness of emergency contraception

Many physician organizations are actively advocating for increased access to emergency contraception. "We strongly believe that emergency contraception is an essential aspect of comprehensive health care and should be easily accessible to all women, including those who have been sexually assaulted," said Dr. Irene Sills, a professor at Albany Medical College, representing Physicians for Reproductive Choice and Health. Emergency contraception prevents pregnancy, she said, explaining that the medication – a high dose of ordinary birth control pills – does not interrupt an established pregnancy and so does not cause an abortion.

"Emergency contraceptive pills (ECPs) have the potential to reduce the number of unintended pregnancies by half and to halve the need for abortion," said James Trussell, Ph.D, Director of the Office of Population Research at Princeton University and a speaker at FPA's annual conference taking place in Albany. "In particular, ECPs could reduce the number of unintended pregnancies following rape from 25,000 to only 3,000 each year nationwide."

Karen Coleman, RN, coordinator of the Sexual Assault Nurse Examiner (SANE) program for Victims Assistance Services in Westchester County, said there is no excuse for hospitals to fail to dispense EC. "If a patient had stepped on a rusty nail and an emergency department failed to give her a tetanus shot, everyone would be outraged," she said. "We should be equally disturbed when a patient is denied access to emergency contraception."

The complete list of emergency departments surveyed, with their responses, is attached. It is also posted on the Family Planning Advocates website (www.fpaofnys.org) under the "latest buzz" section, so that consumers can check to see if their local hospitals dispense emergency contraception.

STATE OF NEW YORK

15--A

R. R. 8

2003-2004 Regular Sessions

IN ASSEMBLY (Prefiled) January 8, 2003

Introduced by M. of A. JOHN, GOTTFRIED, HOYT, CLARK, KOON, PAULIN, HEASTIE, BRADLEY, GIANARIS -- Multi-Sponsored by -- M. of A. BRENNAN, CHRISTENSEN, A. COHEN, M. COHEN, COOK, R. DIAZ, DINOWITZ, EDDINGTON, ENGLEBRIGHT, ESPAILLAT, GALEF, GORDON, GREEN, JACOBS, LAFAYETTE, MARKEY, MAYERSOHN, MILLMAN, ORTIZ, PHEFFER, POWELL, J. RIVERA, SCARBOROUGH, SIDIKMAN, SMITH, STRINGER, THIELE, TOWNS, WEISENBERG -- read once and referred to the Committee on Health -- reported and referred to the Committee on Rules -- passed by Assembly and delivered to the Senate, recalled from the Senate, vote reconsidered, bill amended, ordered reprinted, retaining its place on the special order of third reading

AN ACT to amend the public health law, in relation to emergency treatment of rape survivors The People of the State of New York, represented in Senate and Assem- bly, do enact as follows:

Section 1. Legislative findings and intent. The legislature finds that the victimization of women through rape is compounded by the possibility that the rape survivor may suffer an unwanted pregnancy by the rapist. The legislature further finds that access to emergency contraception and timely counseling are simple, basic measures that can prevent this additional victimization. The federal Food and Drug Administration has approved the use of emergency contraception as safe and effective in the prevention of pregnancy. Medical research strongly indicates that the sooner emergency contraception is administered, the better the chance of preventing unintended pregnancy.

Therefore, the legislature deems it essential that all hospitals that provide emergency medical treatment provide emergency contraception as a treatment option to any woman who seeks treatment as a result of an alleged rape.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD01796-03-3

§ 2. The public health law is amended by adding a new section 2805-p to read as follows:

§ 2805-p. Emergency treatment of rape survivors. 1. As used in this section:

(a) "Emergency contraception" shall mean one or more prescription drugs used separately or in combination to be administered or self-administered by a patient to prevent pregnancy within a medically recom-

mended amount of time after sexual intercourse and dispensed for that purpose in accordance with professional standards of practice and determined by the United States Food and Drug Administration to be safe.
(b) "Emergency treatment" shall mean any medical examination or treatment provided by a hospital to a rape survivor following an alleged rape.
(c) "Rape" shall mean any act defined in section 130.25, 130.30 or 130.35 of the penal law.
(d) "Rape survivor" or "survivor" shall mean any female person who alleges or is alleged to have been raped and who presents as a patient.
2. Every hospital providing emergency treatment to a rape survivor shall promptly:
(a) provide such survivor with written information prepared or approved, pursuant to subdivision three of this section, relating to emergency contraception;
(b) orally inform such survivor of the availability of emergency contraception, its use and efficacy; and
(c) provide emergency contraception to such survivor, unless contraindicated, upon her request. No hospital may be required to provide emergency contraception to a rape survivor who is pregnant.
3. The commissioner shall develop, prepare and produce informational materials relating to emergency contraception for distribution to and use in all hospitals in the state, in quantities sufficient to comply with the requirements of this section. The commissioner may also approve informational materials from medically recognized sources for the purposes of this section. Such informational material shall be in clear and concise language, readily comprehensible, in such varieties and forms as the commissioner shall deem necessary to inform survivors in English and languages other than English. Such materials shall explain the nature of emergency contraception including its use and efficacy.
4. The commissioner shall promulgate all such rules and regulations as may be necessary and proper to implement the provisions of this section.

§ 3. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided that the commissioner of health is authorized and directed to promulgate any rules and regulations, and develop, produce and distribute any materials necessary to implement the provisions of this act on or before such date.

Family Planning Advocates of NY
17 Elk Street
Albany, NY 12207-1002
Phone: (518) 36-8408
Fax: (518) 436-0004

Memorandum in Support

Re: A. 15A – (John, et. al.)
S. 202A – (Spano, et. al.)
AN ACT to amend the public health law, in relation to emergency treatment for rape survivors.

Rape survivors already suffering physical and emotional trauma from an assault are only further victimized when denied the means to prevent unwanted pregnancy. This legislation would ensure the availability of emergency contraception (EC) for every rape survivor who seeks treatment in a New York State hospital emergency room.

Every hospital providing emergency treatment to a rape survivor would be required to promptly provide her with written information about EC, as approved by the State Department of Health; orally inform her of the availability of this medication, its use and efficacy; and provide the medication promptly, upon her request.

EC is a safe and effective, FDA-approved method of preventing unintended pregnancy following unprotected sex. Medical research strongly indicates that the sooner EC is administered, the better the chance of preventing unintended pregnancy. EC has no effect on an established pregnancy.

Hospital emergency rooms are often the first point of medical contact for rape survivors and should provide full services to those who seek care. A recent survey released by Family Planning Advocates of New York State and the New York State Coalition Against Sexual Assault found that 12% of New York hospitals do not offer EC in their emergency departments and 3% have inconsistent policies and practices on its provision. A total of 16 New York counties have hospitals that do not have a standard policy of providing EC to rape survivors. As many as 1,000 rape survivors a year leave New York hospitals without having received emergency contraception, the survey found.

Some hospitals give rape survivors prescription or referrals to alternate health care facilities or will not even inform a woman about the medication so she can decide whether or not to prevent a pregnancy. Once she has left the hospital, she may encounter barriers such as a lack of 24-hour pharmacies, a lack of money, credit cards or health insurance cards necessary to fill a prescription, lack of transportation, or even a fear that her confidentiality will be broken. The reality is that Planned Parenthoods and most other providers do not operate 24 hours a day.

Consistent provision of EC to rape survivors could prevent up to 22,000 of the estimated 25,000 unintended pregnancies as a result of rape in the U.S. each year. When a woman is treated in a hospital emergency room, she is entitled to full counseling on all possible options and immediate access to emergency contraception. **FPA strongly urges the legislature to pass this measure.**

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sexual assault

MEMORANDUM OF SUPPORT

RE: A 15A (John, et. al.)
S. 202A (Spano, et. al.)

AN ACT to amend the public health law, in relation to emergency contraception in cases of rape

This legislation would ensure the availability of emergency contraception for all sexual assault survivors seeking treatment as a result of a rape in New York State hospital emergency departments.

Article 23 of the New York State Executive Law is titled Fair Treatment Standards for Crime Victims. It sets forth basic standards for all agencies in the state that comprise "the criminal justice system" when it comes to the provision of services to victims of crime. The Department of Health is deemed a "crime victim-related agency" under this law and is expected to see that its agents "ensure that crime victims routinely receive emergency social and medical services as soon as possible." The law places particular emphasis on the importance of "adequate and appropriate" services for "crime victims with special needs," including victims of "sex-related offenses."

For a victim of a sexual assault, determination of risk and provision of pregnancy prophylaxis and prophylaxis for sexually transmitted infections including HIV are essential pieces of the needed health care. Each of these are "adequate and appropriate" components of the forensic medical exam and should be fully offered and provided "as soon as possible" to all sexual assault victims who present at any emergency department for services. Accurate and thorough information to make informed choices about medical treatment options is one of the most important steps in stabilizing the physical and mental well being of sexual assault survivors.

Under the proposed legislation, emergency rooms serving victims of sexual violence would be required to make emergency contraception information and medication available as part of the standard care provided to victims who present following a rape. New York State would then be providing "adequate and appropriate," comprehensive emergency care to rape victims who seek services at any of the state's hospital emergency departments according to the Fair Treatment Standards for Crime Victims.

The New York State Coalition Against Sexual Assault urges both houses of the legislature to support this legislation

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Testimony presented to The NYS Assembly Committee on Health, January 14, 2003
Anne Liske, Executive Director, New York State Coalition Against Sexual Assault

Chairman Gottfried and members of the Assembly Health Committee, thank you for the time to speak with you today regarding a health issue for survivors of sexual assault. My name is Anne Liske, Executive Director of the New York State Coalition Against Sexual Assault. The Coalition provides advocacy, technical assistance and training to New York's 76 Department of Health-funded Rape Crisis Centers and other agencies providing services to those who have experienced sexual violence and their families.

My testimony today references legislation proposed by Assemblywoman Susan John which establishes that emergency rooms serving victims of sexual violence would be required to make Emergency Contraception information and medication available as part of the standard care provided to victims who present to a hospital following a sexual assault.

When a victim of a crime, any crime that results in physical injury seeks or is assisted in seeking medical assistance for those injuries, the expectation is that the system(s) responding do everything that is medically necessary for that individual. Rape is a crime that is a violent, traumatic and intimate violation, in which all sense of personal control and decision-making is ripped apart. If I had been one of the 12,594 new cases seen by Rape Crisis Centers in 2000 (latest DOH figures available) that had been the victim of a rape, then I would have wanted information to give me back my decision-making capacity every step of the way from service providers. If I were one of the 4604 people in 2000 who did in fact receive medical services for sexual assault with the assistance of Rape Crisis Centers, I would have wanted those services provided by a hospital that cared for me in a compassionate manner, following a "first do no harm" model of health care. That model would inform me about each procedure being followed and provide information critical to my decisions regarding any injuries I may have, potential exposure to Sexually Transmitted Infections, evidence that I may have been given substances without my knowledge prior to the assault, or the risks of possible pregnancy. Just as for any other health care procedure, no providers of any kind of care have the right to make decisions for me about healthcare treatment related to the rape, or withhold information that would allow me to make an informed decision.

The Coalition's support for legislation to ensure the availability of Emergency Contraception for all sexual assault survivors seeking treatment for rape in New York State hospital emergency departments is based on two points: existing state law that commits New York to quality care for victims of crime; and sound public health practice - the proven efficacy of thorough, quality emergency health services for healing from the trauma of sexual violence.

Article 23 of the New York State Executive Law is titled *Fair Treatment Standards for Crime Victims.* It sets forth basic standards for all agencies in the State that comprise "the criminal justice system" when it comes to the provision of services to victims of crime. The Department of Health is deemed a "crime victim-related agency" under this law and is expected to see that its agents

"ensure that crime victims routinely receive emergency social and medical services as soon as possible." The law places particular emphasis on the importance of "adequate and appropriate" services for "crime victims with special needs," including victims of "sex-related offenses." For the most part, this law is a showpiece that few institutions charged with victim care pay attention to understanding and implementing. And, the state uses no teeth to ensure that they do.

For a victim of rape, assessment of the extent of injuries and risk of further injury and determination of risk and provision of pregnancy prophylaxis and prophylaxis for Sexually Transmitted Infections including HIV are essential pieces of the needed health care following an assault. Each of these are "adequate and appropriate" components of the forensic exam and should be fully offered and provided "as soon as possible" to all sexual assault victims who present at any emergency department for services. Acquiring a STI as a result of a rape, adds a layer of stigma, made doubly harsh when the condition goes untreated due to failure to assess and inform about risk and treatment at the time of emergency care. Becoming pregnant as a result of a rape also adds a layer of stigma to what should be a joyous celebration of life. Emergency contraception has been scientifically proven to be safe and effective in preventing such a pregnancy. A study published in the American Journal of Preventative Medicine estimated that of the more than 25,000 rape related pregnancies nationwide each year, 22,000 could be prevented through timely use of Emergency Contraception.

As you know, Emergency Contraception is an FDA approved medication that can prevent pregnancy if taken within 72 hours of unprotected intercourse. The sooner it is taken, the more effective it is. A sexual assault survivor presenting to an emergency department anywhere in New York State should not be told the medication is not available or to have to go elsewhere to obtain it. Many survivors do not present to hospitals for services until twenty-four hours or more after the assault. Any additional delay in obtaining Emergency Contraception increases her chance of becoming pregnant. Professional medical organizations such as the American College of Obstetricians and Gynecologists and the American Medical Association endorse emergency contraception for rape victims.

Accurate and thorough assessment information to make informed choices about medical treatment options is one of the most important steps in stabilizing the physical and mental well being of sexual assault survivors. Studies have shown that Post-traumatic Stress Disorder (PTSD) and many related chronic health and mental health symptoms are minimized by prompt, quality health care responses. The likelihood of long-term poor health status, poor quality of life, substance abuse and other risky behaviors and high, continued use of health services can also be reduced.

A recent US Bureau of Justice Statistics report pointed to the strong correlation between sexual assault survivors who receive effective medical attention and reporting to the police, one of the important mechanisms for community accountability for preventing additional incidents of sexual violence.

Currently, many hospitals across the state are inconsistent in the delivery of "adequate and appropriate" forensic health care to sexual assault survivors. Survivors should not face a different standard of care depending on which hospital they present to for services. Joanne Smith of the Family Planning Advocates will present preliminary data from a Fall 2002 survey of New York hospitals conducted after the NYS Department of Health's release of the revised *Protocol for the Care of the Acute Adult Sexual Assault Patient*. With over a 90% response rate, the majority of hospitals are stating Emergency Contraception is discussed and offered. Yet, that data is inconsistent with what sexual assault survivors and Rape Crisis advocates report about routine encounters at these same hospitals. Some are given partial care, incorrect information, or referred elsewhere for treatment without the crucial information that the medication must be ingested within 72 hours to be effective. Technical assistance calls received by Coalition staff from advocates accompanying sexual assault victims document observations and complaints from victims and family members after receiving

services. Many indicate hospital emergency department staff are unfamiliar with or lack basic knowledge about the fundamentals of the standards of care set forth in the Department of Health document. They also fail to understand the importance of routine, consistent application of these practices. Emergency contraception not offered is not effective. Nor is emergency contraception effective when discussed but not offered or a prescription is written without corresponding information on where it can be filled.

While multi-disciplinary forensic trainings currently being planned by the Coalition will review a basic knowledge of sexual assault care for health, law enforcement and advocacy professionals statewide, these trainings are only a small step in ensuring complete and consistent care. Setting regulations via legislation as well as recommending standards of practice sends a clear message and sets an appropriately high bar about the expected level of care for survivors of sexual violence in New York communities.

If legislation to promulgate a regulation is what it takes to let all hospitals know that "adequate and appropriate," comprehensive emergency care for rape victims regardless of setting or affiliation is their right under the Fair Treatment Standards for Crime Victims, then that is the necessary next step.

The New York State Coalition Against Sexual Assault supports passage of this bill, appearing for the third year in the Assembly, and urges the Senate and Governor to concur that sexual assault survivors deserve the full medical services promised them as victims of crime, regardless of from which hospital they seek assistance.

TESTIMONY
JOANN M. SMITH
PRESIDENT & CEO, FAMILY PLANNING ADVOCATES OF NYS

PUBLIC HEARING ON ACCESS TO EMERGENCY CONTRACEPTION
THE NEW YORK STATE ASSEMBLY COMMITTEE ON HEALTH

Roosevelt Hearing Room C
Legislative Office Building, Albany

January 14, 2003

I. Introduction

Good morning, Chairman Gottfried and members of the Assembly Health Committee. We deeply appreciate the opportunity to present to you today some new information about an extremely important health issue in New York State.

We are here to strongly advocate for public policies which will ensure that women and girls who have suffered the trauma of sexual assault are offered the means to avoid becoming pregnant from the rape. Emergency contraception (EC) is a safe and extremely effective FDA-approved method of preventing pregnancy following unprotected intercourse.

It should be standard policy for hospitals to offer EC to rape victims when they seek treatment at emergency rooms. Yet, sadly, as many as 1,000 women a year are still being sent away from hospitals in New York State without receiving emergency contraception, according to preliminary results of a statewide survey that we and the New York State Coalition Against Sexual Assault (NYSCASA) will be releasing later this month.

My colleague, Anne Liske from NYSCASA, has just given you a compelling account of why sexual assault survivors must be ensured a consistent, high quality standard of medical care when they seek treatment at hospital emergency departments.

We at Family Planning Advocates of NYS strongly support NYSCASA's efforts to improve medical care for sexual assault survivors. Given our expertise in reproductive health care and pregnancy prevention, we are especially pleased to be working closely with NYSCASA to assess current hospital emergency room practices with regard to pregnancy prevention for rape victims.

Women who have been sexually assaulted are both crime victims in need of justice and patients in need of comprehensive medical care, including reproductive services.

II. NYS DOH Protocols

Where do we stand in New York State when it comes to public policies that would ensure compassionate, comprehensive hospital care for sexual assault survivors?

Last June, the New York State Department of Health issued its new "Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault." As you may be aware, this protocol includes a section on pregnancy prevention that covers the subject of emergency contraception.

We at Family Planning Advocates strongly and repeatedly encouraged the DOH to mandate that all hospital emergency departments inform all rape victims about emergency contraception and dispense it on site to those women who, having received the information, then decide they want the medication.

The protocol the Department eventually issued does include an expectation that information about emergency contraception would be provided in the hospital emergency room. Such information is supposed to include the statements that EC "should be taken as soon as possible after unprotected intercourse" and that "optimally, the treatment should be initiated within 12 hours after the assault." That policy represents a step forward for which we are grateful.

However, the DOH protocol still allows hospitals to refuse to actually dispense emergency contraception to sexual assault victims. So, having informed a traumatized woman that she could have an excellent chance of preventing pregnancy if she takes EC as soon as possible, the hospital then can send her away without providing her with this time-sensitive medication.

In fact, that is exactly what is happening to as many as 1,000 rape victims a year in this state, based on results of a statewide hospital survey we and NYSCASA are just completing.

III. Results of the survey

In September of last year, three months after DOH issued its new protocol, FPA and NYSCASA set out to discover whether hospitals had improved their policies. You may recall that the last statewide survey, done by NARAL/NY in 1999, found that less than half of the state's hospitals had a clear policy of providing emergency contraception to rape survivors.

Using the preliminary findings of our survey, which we will formally release later this month, I'd like to give you a picture of what is actually happening when rape victims seek treatment at hospital emergency rooms across New York State.

We sent surveys in September to 201 hospitals, and as of last Friday, had received responses from 185, or 92 percent. We deliberately chose not to replicate some of the previous hospital surveys that have been done around the country, in which surveyors call the emergency room in the role of a rape victim asking whether she could get emergency contraception. Instead, our survey was mailed directly to the hospital CEO and administrators responsible for emergency room care. The survey asked specifically whether the hospital has a standard policy of dispensing emergency contraception.

So, the findings I'm about to give you represent hospitals' own statements about their official policy on emergency contraception for rape survivors.

First, the good news.

Eighty-three (83) percent of the hospitals that responded to our survey (154 out of 185 respondents) reported that it is now their standard policy to dispense emergency contraception on site to sexual assault survivors. That is a significant improvement from the situation in 1999, when the less than half of New York's hospitals were found to have such policies.
The hospitals that reported having instituted official policies to dispense EC on site include a wide variety of facilities: upstate and downstate; urban, rural and suburban and, interestingly, sectarian and non-sectarian.

A total of 21 of these hospitals that are dispensing EC are affiliated with Roman Catholic entities, demonstrating that there is no absolute prohibition against the provision of EC under Catholic health directives In fact, as my colleague Lois Uttley will explain, the Catholic Health Association of the United States has been moving more and more toward a policy of encouraging its provision.

We applaud these hospitals for doing the right thing for rape victims. In the months ahead, we intend to find out if these policies are actually being followed on a day-to-day basis.

Now, the bad news:

A total of 29 hospitals (16 percent of those responding to the survey) stated it is not their standard policy to dispense emergency contraception on site to rape victims. They report this, even after having received the DOH protocol and two mailings from us stressing the importance of EC as a standard part of medical care for rape survivors.

Another two hospitals stated that they do dispense EC, but our follow-up questioning revealed that they do this inconsistently, sometimes allowing the physician on duty to refuse to provide EC, even when there is no alternative provider available. Lastly, 16 hospitals have not responded to the survey at all, despite repeated mailings, faxes and phone calls, leading us to suspect that they may not wish to answer our questions because they do not provide EC.

Later this month, we will be publicly releasing the list of New York hospitals that do not have an official policy of dispensing emergency contraception on site. We will share this list with your committee in advance of its release.

Today, I can tell you the general characteristics of these non-provider hospitals. First, they are spread out all across the state, in a total of 19 counties. In some of the more rural counties, there are no other hospitals located nearby, leaving a rape victim with no convenient alternative.

Seven of the non-provider hospitals are Catholic-sponsored, but the remaining 22 are non-sectarian. This means that while religiously-based objections to emergency contraception may be part of the problem at some of the hospitals, it is not the overriding reason why this many hospitals are refusing to provide EC.

Some of the hospitals are small or in rural areas, and see fewer than 10 rape victims each year. But 10 of these hospitals treat 10 to 50 rape victims a year, two treat 50 to 100 rape victims a year and one reported that it treats more than 200 rape victims a year!

In total, these 29 hospitals collectively send away as many as 1,000 rape victims a year without providing them with emergency contraception to prevent pregnancy. Think of it! One thousand New York women sent away without a time-sensitive emergency medication that could and should be provided immediately in the emergency room.

According to the Department of Health protocol, when a hospital decides not to provide emergency contraception, emergency room staff are supposed to "ensure that such services are provided or made available to the patient without delay." One of the options allowed under the protocol is giving the patient a prescription for EC "when it can be confirmed that there is a pharmacy open and able to meet this need on a timely basis." Another is to refer the patient to a clinic "where arrangements have been made for the patient to receive EC."

Yet, our findings to date indicate that hospitals are not ensuring there are pharmacies open nearby 24 hours a day. In fact, one form reported that a patient had been unable to find an open pharmacy. Another suggested that the rape victim could get to a pharmacy through "a short bus ride."

I want you to picture a woman who has just been traumatized by rape – who may have been physically injured, may have had her clothes torn off, may have had her wallet stolen, who may be terrified of being stalked by her attacker when she leaves the hospital. I ask you: Is it reasonable to expect that woman to leave the hospital, find a bus, wait for the bus, pay the bus fare, and then go into a pharmacy where she may have to stand on line and use her own available cash to fill a prescription for emergency contraception?

I think not. In fact, I think it is an extremely insensitive and even cruel way to treat a woman who has just become a crime victim. I doubt that the leaders of New York State, and the people they represent, want to have crime victims treated this way.

IV. Why legislation is still needed

That is why I believe New York must enact legislation requiring that all hospital emergency rooms actually offer and dispense emergency contraception on site to rape victims.

Yes, the Department of Health Policy has been a step forward. But, we still have at least 29 hospitals not dispensing emergency contraception. In other words, we have "Russian roulette" health care for rape victims. If you are lucky, you end up in a hospital with a policy of dispensing EC. If not, then your risk of becoming pregnant from the assault will go up dramatically.

Moreover, the NYS Department of Health protocol has no force of law. It is merely a protocol, not even a regulation. If hospital administrators change, or commitment wanes, the current level of compliance even with the less-than-desirable protocols could decline.

It is time for New York to ensure that rape victims are given the means to prevent one of the most disastrous consequences of sexual assault: unintended pregnancy. Last year, the State Assembly passed Assemblywoman Susan's John's bill requiring all hospital emergency rooms to provide emergency contraception for rape survivors.

The Assembly must pass this important legislation again, and take a leadership role in persuading both the State Senate and the Governor to back this measure. It is time for New York to stop the unnecessary tragedy of pregnancies from rape.

Thank you.

Summary of Anti-Choice Testimony on Emergency Contraception Before the NYS Assembly Committee on Health, January 14, 2003

The New York State Assembly Committee on Health Convened a public hearing on Tuesday, January 14 to hear testimony on two pieces of proposed legislation regarding emergency contraception: 1) a measure that would allow pharmacists to directly dispense EC through prior arrangements with a physician, in a program similar to that already in effect in California and Washington and 2) a bill mandating that all hospital emergency departments in the state offer emergency contraception to rape victims and dispense it on site.

This is a summary of the main points made by anti-choice groups testifying at the hearing and an anti-choice legislator who sits on the committee. We are sharing these with colleagues from other states and at the national organizations in order to help anticipate likely anti-choice arguments against similar state legislation elsewhere.

Representative of three anti-choice groups testified against the legislation. They were Lori Hougens, a spokeswoman for the NYS Right to Life Committee; Mary Dwelley, acting President of Feminists for Life of NY; and Mary Arden Smith of the Long Island Coalition of Life. As expected, these groups made the usual argument that pregnancy begins at fertilization (instead of the medical definition that it begins at implantation) and thus EC is an abortifacient when it interferes with implantation. But those opposed to the proposed legislation also made the following less expected claims:

1 Emergency contraception may cause cancer.

Referring to concerns that use of Hormone Replacement Therapy may increase the risk of breast cancer, and misrepresenting a recent FDA decision, State Right to Life Committee spokeswoman Lori Hougens contended that emergency contraception also could cause cancer, especially in teenage girls who she speculate would use the drug multiple times. “A pregnant teenager is better than a dead teenager,” she said, adding, “none of us wants to see a teenage girl get breast cancer, even if she had had an abortion.”

Hougens based her cancer claim on a misrepresentation of the FDA’s January 8, 2003, announcement about new warning labels on products carrying estrogen and progestin hormones. As is clearly stated in a press release posted on the FDA website, the warning labels are specifically for estrogen and estrogen with progestin therapies for postmenopausal woman and concern the risks of long-term use of these products. The FDA warning has nothing whatsoever to do with emergency one-time use of EC. To read the FDA press release, go to:
www.fda.gov/bbs/topics/NEWS/2003/NEW00863.html

2 Providers do not disclose all information regarding effects of EC, thus denying women the right to informed consent.

Opponents argued that women are not told of EC’s potentially “abortifacient” nature and therefore are not disclosing all necessary information the women need to make an informed decision. Mary Dwelley of Feminists for Life contended that women are “falsely” led to believe that EC is only contraception.

In essence, she is arguing that physicians, nurses, and pharmacists should be required to inform women that, if they believe life begins at fertilization, they should know that by taking EC they could be ending a life.

Of course, we have been arguing that by failing to inform women about the potential to prevent rape-related pregnancy through timely use of EC, hospitals and physicians are violating women's rights to informed consent. Thus, we have the battle of informed consent arguments.

3 Emergency contraception is anti-woman because it puts the burden on women and relieves men of any responsibility.

Mary Dwelley of Feminists for Life argued that EC "sells out women by putting the burden on her to purge her body of fertilized eggs." She added that access to EC "services the sexual needs of men by divorcing them from accountability." Of course, one could say the same thing about all contraception except condoms.

4 EC will increase promiscuity and cause increased rates of sexually transmitted diseases, especially among teenagers.

The opposition also argued that increased availability of emergency contraception would promote irresponsible behavior and promiscuity, especially among teenagers, and lead to increased rates of sexually transmitted diseases. This is the old "abstinence-only" argument with a new hat. EC is, of course, "back-up" birth control. But a study presented at the American Public Health Association annual meeting in November 2003, reported that there is no evidence that access to emergency contraception leads to risk-taking. The study measured incidences of sexually transmitted diseases, number of sex partners and frequency of sex in the study population.[1]

[1] Harper, C, Raine, T., Rocca, C. Klausner, J.D., Darney, P. and Padian, "Sexual risk-taking and emergency contraception," presentation at the APHA conference in San Francisco, November 19, 2003.

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Memo of Opposition from the New York State Catholic Conference
Re: A.15, John/S.202, Spano
Emergency contraception in hospitals

The above-referenced bill would require all hospitals in the state to provide "emergency contraception" to any rape victim who requests it, as well as information about "emergency contraception" prepared by the State Health Department.

The New York State Catholic Conference opposes this legislation.

Catholic hospitals in New York State offer compassionate, holistic care to sexual assault victims, providing psychological, physical and spiritual support, together with accurate medical information. They cooperate with law enforcement officials and assist victims through the often-complicated maze of systems that they must navigate to ensure justice is served.

Catholic-sponsored hospitals are guided by the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* promulgated by the United States Conference of Catholic Bishops. The ERDs state, in part, "A female who has been raped should be able to defend against a potential conception from the sexual assault." Catholic teaching holds that rape as an act of violence and aggression certainly justifies the prevention of ovulation, sperm capacitation or fertilization.

However, "emergency contraception" treatment formulations may act at times not to prevent fertilization, but to alter the lining of the uterus such that implantation of an already-fertilized egg cannot occur. In such a case, the drugs destroy a developing human life at its earliest stages of development.

While Catholic hospitals may offer contraception to victims of sexual assault to prevent conception, the medication may not be offered if there is evidence it would have an abortion-inducing effect. Catholic hospitals do not and will not adopt policies intended to remove, destroy or interfere with the implantation of an embryo. Because this legislation would force Catholic and other religious health care institutions to violate this fundamental principle, it would strike a serious blow to religious freedom in this state.

We would note that the State Health Department issued revised guidelines last year requiring hospitals to establish policies for the administration of pregnancy prophylaxis to rape victims treated in the emergency room. The guidelines also state that no hospital is required to provide or participate in an abortion. Catholic hospitals abide by these state guidelines; no legislation is needed to alter current policies and practices.

We strongly oppose this legislation because it fails to respect the religious beliefs and freedom of conscience of faith-based care providers.

Response to the NYS Catholic Conference Memo of Opposition to A.15/S.202 Provision of Emergency Contraception (EC) in Hospitals

What the Memo of Opposition States: "While Catholic hospitals may offer contraception to victims of sexual assault to prevent conception, the medication may not be offered *if there is evidence it would have an abortion-inducing effect.* Catholic hospitals do not and *will not adopt policies intended to remove, destroy or interfere with the implantation of an embryo."*

Discussion: The memo states that it is acceptable for Catholic hospitals to provide emergency contraception for rape victims under two circumstances – if it works to prevent ovulation or fertilization – but not under a third – if it interferes with the implantation of a fertilized ovum on the uterine wall. The memo characterizes this third potential mechanism of action as having "an abortion-inducing effect." However, medical experts and bioethicists have raised five significant challenges to this argument:

1. **Emergency contraception is contraception, not abortion.** The medical definition of pregnancy is that it begins with successful implantation of a fertilized ovum. EC cannot dislodge a fertilized ovum once it has become implanted or otherwise disrupt an established pregnancy. EC pills are essentially a high dose of birth control pills, and are not the same thing as RU-486, the so-called "abortion pill." When the U.S. Food and Drug Administration (FDA) approved the use of birth control pills as emergency contraception in 1996, an FDA spokeswoman specifically stated: "These birth control pills are used to prevent pregnancy, not to stop it. This is not abortion."[1] In fact, timely use of emergency contraception can *prevent the need for abortion*. A study by the Alan Guttmacher Institute has estimated that use of EC averted 51,000 abortions in the United States in the year 2000.[2]

2. **Interference with implantation of a fertilized ovum is the least likely way for EC to work, according to medical experts and the senior director for ethics of the Catholic Health Association of the United States.** Recent research on emergency contraception "was unable to demonstrate *any* effect which might be associated with inhibition of implantation," according to a 2000 article in the *British Medical Journal.*[3] A 1999 article in the *American Journal of Obstetrics and Gynecology* concluded that "No scientific evidence supports an abortifacient effect" of emergency contraception.[4] Having reviewed numerous scientific studies, the senior director of ethics for the Catholic Health Association, Ronald Hamel, Ph.D., concluded that "The scientific literature indicates that emergency contraceptive medications most likely act by preventing ovulation or fertilization and do not have post-fertilization effects sufficient to prevent implantation." In an article in the association's journal, Health Progress, he wrote that "it is highly improbable that emergency contraception would contribute to the demise of a conceptus."[5]

[1] FDA spokeswoman Mary Pendergast, quoted in "FDA Panel endorses 'morning after' pill," CNN website, posted June 29, 1996 at 12:25 a.m.

[2] *Perspectives on Sexual and Reproductive Health*, The Alan Guttmacher Institute, November/December 2002 and January/February 2003 issues.

[3] Glasier, Ann, "Emergency Contraception," *British Medical Journal*, vol 56, 2000, pp. 126-133.

[4] Rivera, Roberto; Yacobsen, Irene; and Grimes, David. "The Mechanism of Action of Hormonal Contraceptives and Intrauterine Contraceptive Devices," *American Journal of Obstetrics and Gynecology*, vol 181, Nov 1999, p. 1267

3 There is no test that can determine if an ovum has been fertilized prior to the time of implantation, so there will never be "evidence" that the use of EC would destroy a fertilized ovum (blastocyst) or interfere with its implantation. A recent article in *JAMA*, the Journal of the American Medical Association, stated that "there is no practical way to identify conception before implantation of the blastocyst" (fertilized ovum). The *JAMA* article authors and other medical experts explain that the hormone produced by pregnancy (Chorionic gonadotropin or hCG), which is what pregnancy tests measure, cannot be detected until after implantation. [6] The Director of Population Studies at Princeton University, Prof. James Trussell, states simply that "there is no test for fertilization." Because no test can tell if fertilization has taken place, there will never be "evidence" that the use of EC would have what the NYS Catholic Conference refers to as "an abortion-inducing effect."

4 Because of this lack of evidence, the provision of emergency contraception to rape victims would never be carried out with the "intent" to "remove, destroy or interfere with the implantation of an embryo." Dr. Hamel, the Catholic Health Association ethicist, wrote that "the intention in administering emergency contraception is to prevent conception and not to inhibit implantation. If a conceptus is present, but fails to be implanted and ultimately is destroyed, this would be an unintended and even an unforeseen event." [7]

5 Moral concern for a fertilized ovum must be balanced by moral concern for the traumatized rape victim. "A proportionate reason exists for administering emergency contraceptive medications, namely, the prevention of pregnancy resulting from the sexual assault and its subsequent impact on the overall well-being of the woman," wrote Dr. Hamel, the Catholic Health Association ethicist. "The improbability that the woman has conceived as a result of the assault and the unlikely abortifacient effects of emergency contraception provide moral certainty sufficient to justify the administration of the medications…In these tragic situations, Catholic health providers have a unique opportunity to reveal God's healing presence by responding with compassion and sensitivity to the vulnerable woman in need of care." [8]

Talking Points: The memo of opposition from the NYS Catholic Conference is out of step with scientific and medical evidence, as well as with the ethical advice of the director of ethics of the Catholic Health Association of the United States, which represents more than 600 Catholic health facilities nationwide. It is also out of step with the practices of 27 Catholic hospitals in New York State (75 percent of those responding to a recent survey) that reported they have policies to routinely dispense EC to rape victims.[9] At these and other Catholic hospitals, moral concern for a traumatized rape victim outweighs concern over the "highly improbable" possibility that EC might interfere with the implantation of a fertilized ovum, which cannot be detected in any case.

[5] Hamel, Ronald P., and Panicola, Michael R., "Emergency Contraception and Sexual Assault," Health Progress, Sept-Oct 2002. This article also references an article, "A Moral Analysis of Pregnancy Prevention After Sexual Assault," from the National Catholic Bioethics Center's *Catholic Health Care Ethics: A Manual for Ethics Committees* (Cataldo, Peter, and Moraczewski, Albert, editors, 2001), which states that "the chance of an abortifacient effect in a sexual assault survivor should be 1.2 percent or less."

[6] Wilson, Allen, et al, "Natural Limits of Pregnancy Testing in Relation to the Expected Menstrual Period," *JAMA*, Oct 10, 2001, Vol 286, No 14, p. 1759.

[7] Ibid.

[8] Wilson, Allen, et al, "Natural Limits of Pregnancy Testing in Relation to the Expected Menstrual Period," *JAMA*, Oct 10, 2001, Vol 286, No 14, p. 1759.

[9] Results of a statewide survey by the New York State Coalition Against Sexual Assault and Family Planning Advocates of NYS. Surveys were sent to 210 hospital emergency rooms in NYS, including 38 located in Catholic hospitals. Of those 38, 36 responded and 27 (or 75 percent) it is their standard policy to provide emergency contraception to rape survivors. Some stated they require a pregnancy test before the medication is dispensed to detect any pregnancy from prior to the rape.

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STATE LEGISLATURE PASSES BILL REQUIRING HOSPITALS TO PROVIDE EMERGENCY CONTRACEPTION FOR RAPE VICTIMS

New York will be the First Eastern State to Require the Provision of EC to Sexual Assault Survivors

ALBANY, NY (June 20, 2003) The New York State Legislature today passed "Emergency Contraception for Rape Victims" legislation. This bill (A.15a/S.202a) will require hospitals to counsel survivors of sexual assault about emergency contraception (EC) and offer it on-site.

"New York's legislators have recognized the necessity of providing comprehensive and compassionate care to victims of rape," said JoAnn Smith, president and CEO of Family Planning Advocates of New York State. "At last, rape survivors treated at hospitals can count on having emergency contraception available on-site, without needless delays. We are very grateful for the hard work of Assemblymember Susan John and Senator Nick Spano on this issue."

"This is a tremendous victory for the women of New York State," said Assemblymember Susan John, who sponsored Assembly Bill No. 15a and championed this legislation in the Assembly for three years. "Pregnancy resulting from sexual assault can be safely prevented using emergency contraception. All hospitals will now provide this safe and effective medication on-site."

Early this morning, the New York State Assembly passed EC for Rape Victims legislation by an overwhelming majority. Several hours later, the State Senate passed the bill unanimously, with a vote of 61-0.

"This vital crime victim's legislation is essential for the health of New York's women," said Senator Nick Spano, sponsor of Senate Bill No. 202a. "Rape survivors will no longer be denied access to emergency contraception. This legislation will ensure that EC is available in every hospital emergency room. Emergency contraception is just that – contraception. It prevents pregnancy and will not interfere with an established pregnancy."

Smith credited Assembly Speaker Sheldon Silver and Senate Majority Leader Joseph Bruno with providing essential leadership on this important legislation. Once signed into law by Governor Pataki, the act will make New York the first Eastern state to require the provision of emergency contraception to rape victims. The states of California, Washington and New Mexico have similar laws.

More than 75 organizations in New York joined Family Planning Advocates (FPA) to support legislation to ensure that rape victims have access to EC in hospital emergency departments. Emergency contraception is a safe and effective, FDA-approved method of preventing pregnancy after unprotected sex. An estimated 25,000 American women become pregnant every year as a result of rape. As many as 22,000 of those pregnancies could be prevented through timely use of emergency contraception.

A study completed this year by Family Planning Advocates of New York State and the New York State Coalition Against Sexual Assault found that many hospitals in New York do not offer rape victims treated in their emergency rooms the opportunity to use EC on-site to prevent pregnancy.

As many as 1000 rape victims each year have been sent away from emergency rooms in New York without the option to receive EC on-site. Some 24 hospitals in 16 counties failed to provide emergency contraception to survivors of sexual assault. Results of the study on emergency contraception policies are available at http://www.fpaofnys.org/education/ecsurvey2003.html.

Family Planning Advocates of New York State is a non-profit, statewide organization dedicated to protecting and expanding access to a full range of reproductive health care services. FPA represents New York's Planned Parenthoods, individual family planning clinics, and hundreds of organizations and thousands of individual members.

NEW YORK STATE CATHOLIC CONFERENCE
465 State Street • Albany, NY 12203-1004
Phone (518) 434-6195 • Fax (518) 434-9796
www.nyscatholicconference.org

Statement on 'Emergency Contraception' Legislation
New York State Catholic Conference

Albany, June 19, 2003 —The State Senate and Assembly have reached agreement on legislation mandating that hospital emergency rooms provide "emergency contraception" drugs to survivors of rape, provided the drugs are not contraindicated, the woman is not pregnant, and it is within a medically appropriate amount of time from the attack.

Amendments to this legislation adequately addressed the concerns of Catholic hospitals, which currently administer these drugs to rape survivors under such conditions. Therefore, following consultation with Catholic ethicists, the New York State Catholic Conference withdrew its objection to this legislation when Senate and Assembly sponsors agreed on the amendment language.

"We are pleased with the resolution of this difficult issue, and are particularly grateful for the leadership of Senator Nicholas Spano, Senate Majority Leader Joseph Bruno and their staffs, who listened to our concerns, understood them, and were instrumental in leading to this agreement," said Richard E. Barnes, executive director of the Catholic Conference.

"Catholic hospitals are second to none in providing compassionate, holistic care to survivors of rape. This legislation will not affect how that care is provided. Catholic hospitals in New York will continue to offer these medications to rape survivors, consistent with this law and with Church teaching."

Catholic teaching prohibiting the use of artificial contraception does not and has never applied to women who are raped. The Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops state: "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."

The Catholic Conference represents New York State's Bishops in matters of public policy.

(Sample advertisement promoting "EC in the ER" legislation)

Emergency Contraception For Rape Victims

It's about time…

If legislation requiring hospitals to provide emergency contraception to rape victims does not pass during this legislative session, many sexual assault survivors will face the trauma of unintended pregnancy – in addition to the horror of rape.

No woman who has been raped should be denied the opportunity to prevent pregnancy. Emergency contraception (EC) is a safe and effective, FDA-approved method of preventing pregnancy. Yet as many as 1,000 rape victims annually leave hospitals in 16 New York counties without the best possible chance to prevent a pregnancy from rape.

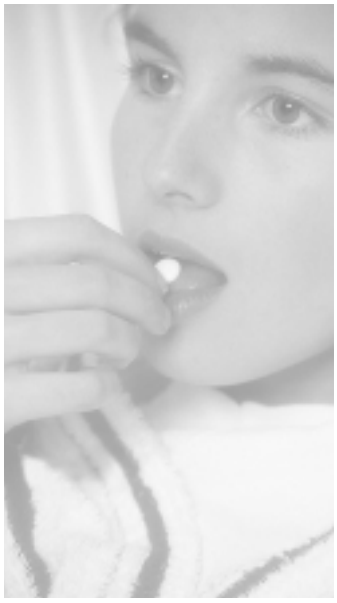
Emergency contraception prevents a pregnancy before it is established. The American College of Obstetricians and Gynecologists states that EC will not interrupt, disrupt or harm an established pregnancy. Emergency contraception is not related to RU-486 (a medical abortion pill) and will not result in pregnancy termination.

The State Assembly has passed the "EC in the ER" bill three years in a row.

It's time for the State Senate to Pass S.202

(insert names of supporting organizations here if desired)

Appendix 2: Sample Legislation



MergerWATCH

Emergency Contraception in the Emergency Room

State-by-State

A Project of the Education Fund of Family Planning Advocates of New York State

State/Bill Number	Date introduced	Bill Status	Required Provision	Referral Option	Information Only	Enforcement	Hospital Training
Arizona* H 2374, S 1087	1/03	Pending	NO	YES	NO	NO	NO
Arkansas HB 2836	3/14/03	Pending	YES	NO	NO	YES	YES
California A 1860	1/31/02	Enacted	YES	NO	NO	NO	NO
Colorado* H 1252	1/30/03	Pending	NO	NA	NA	NA	NA
Hawaii* H 189, S 658	1/17/03	Pending	YES	NO	NO	YES	YES
Illinois* S 114	2/1/01	Enacted	NO	NO	YES	NO	NO
Massachusetts* S 546 H 2438	1/1/03	Pending	YES	NO	NO	NO	YES
Minnesota H 322, S 270	2/6/03	Pending	YES	NO	NO	YES	YES
New Jersey* A 297, S 956	1/8/02, 2/11/02	Pending	YES	NO	NO	NO	NO
New Mexico H 119	1/03	Enacted	YES	NO	NO	YES	YES
New York A 15, S 202	1/8/03	Enacted	YES	NO	NO	NO	NO
Texas H 2629, S 1393	3/13/03, 3/20/03	Pending	YES	NO	NO	NO	NO
Washington S 6537	1/21/02	Enacted	YES	NO	NO	YES	NO
West Virginia H 2899	2/7/03	Pending	YES	NO	NO	YES	YES
Wisconsin A 170	3/18/03	Pending	YES	NO	NO	YES	YES

**Arizona - Passed Senate 3/25/03;Provides information & EC; referral option based on religious tenets*
**Colorado - Passed House 4/3/03;Not a mandate; "encourages" hospitals to provide EC & information*
**Hawaii - Passed House 3/4/03, Passed Senate 4/25/03; vetoed by governor*
**Illinois - Mandates referral of patient to another provider, since bill does not mandate on site provision of EC*
**Massachusetts - Legislation includes pharmacy access to EC as well*
**New Jersey - Dependent upon implementation of protocols, which include the provision of EC*

Note: Oregon SB 752 provides for the funding of emergency contraception for a victim of sexual assault. However, the bill does not require any hospitals to provide EC.

Year Introduced: The date in which the bill was introduced.
Bill Status: The position of the bill within the Legislature.
Required Provision: Mandated hospital provision that includes the following:

A. Provide each sexual assault victim with medically and factually accurate and unbiased written and oral information about emergency contraception.

B. Orally inform each sexual assault victim of her option to receive emergency contraception at the hospital.

C. Provide emergency contraception immediately at the hospital to each sexual assault victim who requests it.

Referral Option: Bill provides hospitals the option to refer a patient to another provider if the hospital does not dispense EC.
Information Only: The hospital must inform patient about EC and present the patient with her options, but is not obligated to provide emergency contraceptives.
Enforcement: The state shall oversee hospitals and impose any fines if victim is denied care.
Hospital Training: Hospitals shall ensure that employees providing care to rape victims have been trained to provide medically and factually accurate and unbiased information about emergency contraception.

Updated October 2003

Due to changes in legislative action, this chart will be updated as needed and posted at www.mergerwatch.org.

NARAL Pro-Choice America Foundation

MODEL LEGISLATION TO GUARANTEE SEXUAL ASSAULT VICTIMS ACCESS TO EMERGENCY CONTRACEPTION IN HOSPITAL EMERGENCY DEPARTMENTS [i]

A BILL

To ensure appropriate emergency health care for sexual assault victims.[ii]

Be it enacted by [state]:

SECTION 1: SHORT TITLE

This Act may be cited as the "Emergency Care for Sexual Assault Victims Act of [year]."

SECTION 2: FINDINGS

The [state] legislature finds that:

A. Each year, over 600,000 women are raped in the U.S.

B. In [most recent year with data], [number] women were [raped] in [state].[iii]

C. After a woman is raped, she may face or anxiously fear the additional trauma of an unwanted pregnancy.

D. Each year, approximately 25,000 women in the United States become pregnant as a result of rape. An estimated 22,000 of these pregnancies — or 88 percent — could be prevented if sexual assault victims had timely access to emergency contraception. [Insert state-specific date if available]

E. Emergency contraception is a safe, responsible, and effective back-up method of birth control that prevents pregnancy after sexual intercourse.

F. Medical research indicates that the sooner emergency contraception is administered, the better the chance of preventing unintended pregnancy.

G. Emergency contraception does not cause abortion and does not work if a woman is already pregnant.

H. Emergency contraception is an integral part of comprehensive and compassionate emergency care for sexual assault victims.

I. The American College of Emergency Physicians (ACEP) and the American College of Obstetricians

and Gynecologists (ACOG) agree that emergency contraception should be offered to all victims of sexual assault if they are at risk of pregnancy.

J. A nationwide study found that fewer than half of all sexual assault victims eligible for emergency contraception actually received the treatment during a visit to a hospital emergency department. [Or insert state specific information about availability of emergency contraception in emergency departments.]

K. Most women do not know about emergency contraception: nearly three-quarters of women surveyed have not heard of emergency contraception pills, the most commonly used form of emergency contraception, and only two percent of women have ever used them. Therefore, women who have been raped are unlikely to ask for emergency contraception.

L. It is essential for all hospitals that provide emergency medical treatment to offer emergency contraception as a treatment option to any woman who seeks medical care as a result of an alleged sexual assault.

SECTION 3: DEFINITIONS

The following words and phrases when used in this Act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

A. "Emergency contraception" means any drug or device approved by the Food and Drug Administration that prevents pregnancy after sexual intercourse.

B. "Emergency care to sexual assault victims" means medical examinations, procedures, or services provided at a hospital [health care facility] to a sexual assault victim following an alleged rape.

C. "Sexual assault" ["Rape"] iv means [as defined by state statute].

D. "Sexual assault victim" means a female who alleges or is alleged to have been raped and presents as a patient.

E. "Medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and:
(1) published in peer-reviewed journals where applicable; or (2) comprising information that leading professional organizations and agencies with relevant expertise in the field, such as the American College of Obstetricians and Gynecologists (ACOG), recognize as accurate and objective.

SECTION 4: EMERGENCY CARE TO SEXUAL ASSAULT [RAPE] VICTIMS

It shall be the standard of care for hospitals [health care facilities] [v] that provide emergency care to sexual assault victims to:

A. Provide each sexual assault victim with medically and factually accurate and objective written and oral information about emergency contraception, prepared pursuant to Section 6 of this section;
B. Orally inform each sexual assault victim of her option to be provided emergency contraception at the hospital [health care facility]; and

C. Provide the complete regimen of emergency contraception immediately [promptly] at the hospital [health care facility] to each sexual assault victim who requests it.

SECTION 5: TRAINING OF PROVIDERS

Each hospital [health care facility] shall ensure that each person who provides care to sexual assault victims is provided with medically and factually accurate and objective information about emergency contraception.

SECTION 6: PATIENT INFORMATION MATERIALS

The [state department of health] or contracted designee shall develop, prepare, and produce informational materials relating to emergency contraception for the prevention of pregnancy for distribution to and use in all emergency departments in the state, in quantities sufficient to comply with the requirements of this section. The [Secretary], in collaboration with community sexual assault programs and other relevant stakeholders, may also approve informational materials from other sources for the purposes of this section.

The informational materials must:
1. Be medically and factually accurate and objective;
2. Be clearly written and readily comprehensible in a culturally competent manner, as the [state department of health], in collaboration with community sexual assault programs and other relevant stakeholders, deems necessary to inform victims of sexual assault;
3. Explain the nature of emergency contraception, including its use, safety, efficacy, and avail ability, and that it does not cause abortion.

SECTION 7: ENFORCEMENT[vi]

In addition to any remedies at common law, the [state department of health] shall respond to complaints and shall periodically determine whether hospitals [health care facilities] are complying with this Act. The [state department of health] may use all investigative tools available to it to verify compliance with this Act. If the [state department of health] determines that a hospital is not in compliance with this Act, the [department] shall:

A. Impose a fine of [$5,000] per woman who is denied medically and factually accurate and objective information about emergency contraception or who is not offered or provided emergency contraception;

B. Impose a fine of [$5,000] for failure to comply with Section 5 of this Act. For every 30 days that a hospital [health care facility] is not in compliance with Section 5, an additional fine of [$5,000] shall be imposed; and

C. After two violations, suspend or revoke the certificate of authority or deny the hospital's [health care facility's] application for certificate of authority.

SECTION 8: SEVERABILITY

If any provision, word, phrase or clause of this Act, or the application thereof, to any person,

entity or circumstance should be held invalid, such invalidity shall not affect the remaining provisions, words, phrases or clauses of this Act which can be given effect without the invalid provision, word, phrase, clause or application, and to this end, the provisions, words, phrases or clauses of this Act are declared severable.

SECTION 9: CONFLICT

All laws and parts of laws in conflict with this Act are repealed.

SECTION 10: EFFECTIVE DATE

This Act shall be effective [date].

[i] *Before moving forward with a proactive legislative campaign to guarantee sexual assault victims' access to emergency contraception in hospital emergency departments, consult with the sexual assault community in your state to ensure that such a requirement is consistent with existing sexual assault treatment protocols.*

[ii] *The term "victim" is used to underscore the fact that sexual assault survivors are victims of violent crime and to highlight this legislation as an important victims' rights initiative. Sexual assault advocates in your state may use of the term "survivor" as well as "victim" to underscore the resiliency of women who survive the violent crime of rape.*

[iii] *State-level data may be limited to the number of reported rather than actual rapes. Consult with the sexual assault coalition in your state to determine whether data exists on the number of actual rapes in your state. If not, consider including in the bill the number of rape victims in your state that are discharged from emergency departments without having received emergency contraception.*

[iv] *Because the legal definitions of sexual assault and rape may vary from state to state, check with the sexual assault coalition in your state to identify the appropriate term for your legislation.*

[v] *In some states, sexual assault victims who present at hospitals may be referred to specialized health care facilities for treatment. Consult with the sexual assault community in your state to determine whether the term "hospital" is broad enough to encompass all facilities where sexual assault victims receive emergency medical care.*

[vi] *Because the issue of enforcement may be a source of conflict with your state hospital association, choosing an appropriate enforcement mechanism is important to the success of the bill. To avoid unnecessary opposition, consult with your legislative sponsor to identify an enforcement provision that is consistent with applicable state laws and regulations.*

August 2003

State of Washington

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 6537

Chapter 116, Laws of 2002
57th Legislature
2002 Regular Session

SEXUAL ASSAULT VICTIMS—EMERGENCY CARE
EFFECTIVE DATE: 6/13/02
Passed by the Senate February 16, 2002
YEAS 36 NAYS 13

BRAD OWEN
President of the Senate

Passed by the House March 6, 2002
YEAS 75 NAYS 19

CERTIFICATE

I, Tony M. Cook, Secretary of the Senate of the State of Washington, do hereby certify that the attached is
SUBSTITUTE SENATE BILL 6537 as passed by the Senate and the House of Representatives on the dates hereon set forth.

FRANK CHOPP, **Speaker of the House of Representatives**
TONY M. COOK **Secretary**

Approved March 26, 2002 FILED
March 26, 2002 - 8:50 a.m.
GARY LOCKE
Governor of the State of Washington
Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 6537

Passed Legislature - 2002 Regular Session
State of Washington 57th Legislature 2002 Regular Session
By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Costa, Winsley, Kohl-Welles, Thibaudeau, Fairley, Kline, Jacobsen, Prentice, B. Sheldon and Keiser)
READ FIRST TIME 02/08/2002.

AN ACT Relating to emergency care for victims of sexual assault; 1) amending RCW 70.41.020; adding new sections to chapter 70.41 RCW; and 2) creating a new section. 3)
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON: 4
NEW SECTION. **Sec. 1**. (1) The legislature finds that:
(a) Each year, over three hundred thousand women are sexually assaulted in the United States;
(b) Nationally, over thirty-two thousand women become pregnant each year as a result of sexual assault. Approximately fifty percent of these pregnancies end in abortion; (c) Approximately thirty-eight percent of women in Washington are sexually assaulted over the course of their

lifetime. This is twenty percent more than the national average; (d) Only fifteen percent of sexual assaults in Washington are reported; however, even the numbers of reported attacks are staggering. For example, last year, two thousand six hundred fifty-nine rapes were reported in Washington, this is more than seven rapes per day.

(2) The legislature deems it essential that all hospital emergency rooms provide emergency contraception as a treatment option to any woman who seeks treatment as a result of a sexual assault.

Sec. 2. RCW 70.41.020 and 1991 c 3 s 334 are each amended to read as follows:
Unless the context clearly indicates otherwise, the following terms, whenever used in this chapter, shall be deemed to have the following meanings:

(1) "Department" means the Washington state department of health.

(2) "Emergency care to victims of sexual assault" means medical examinations, procedures, and services provided by a hospital emergency room to a victim of sexual assault following an alleged sexual assault.

(3) "Emergency contraception" means any health care treatment approved by the food and drug administration that prevents pregnancy, including but not limited to administering two increased doses of certain oral contraceptive pills within seventy-two hours of sexual contact.

(4) "Hospital" means any institution, place, building, or agency which provides accommodations, facilities and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care, of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis. "Hospital" as used in this chapter does not include hotels, or similar places furnishing only food and lodging, or simply domiciliary care; nor does it include clinics, or physician's offices where patients are not regularly kept as bed patients for twenty-four hours or more; nor does it include nursing homes, as defined and which come within the scope of chapter 18.51 RCW; nor does it include ((maternity homes)) birthing centers, which come within the scope of chapter 18.46 RCW; nor does it include psychiatric hospitals, which come within the scope of chapter 71.12 RCW; nor any other hospital, or institution specifically intended for use in the diagnosis and care of those suffering from mental illness, mental retardation, convulsive disorders, or other abnormal mental condition. Furthermore, nothing in this chapter or the rules adopted pursuant thereto shall be construed as authorizing the supervision, regulation, or control of the remedial care or treatment of residents or patients in any hospital conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any well recognized church or religious denominations.

(5) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(6) "Secretary" means the secretary of health.

(7) "Sexual assault" has the same meaning as in RCW 70.125.030.

(8) "Victim of sexual assault" means a person who alleges or is alleged to have been sexually assaulted and who presents as a patient.

Sec. 3. A new section is added to chapter 70.41 RCW 13 to read as follows:

(1) Every hospital providing emergency care to a victim of sexual assault shall:

(a) Provide the victim with medically and factually accurate and unbiased written and oral information about emergency contraception;

(b) Orally inform each victim of sexual assault of her option to be provided emergency contraception at the hospital; and

(c) If not medically contraindicated, provide emergency contraception immediately at the hospital to each victim of sexual assault who requests it.

(2) The secretary, in collaboration with community sexual assault programs and other relevant

stakeholders, shall develop, prepare, and produce informational materials relating to emergency contraception for the prevention of pregnancy in rape victims for distribution to and use in all emergency rooms in the state, in quantities sufficient to comply with the requirements of this section. The secretary, in collaboration with community sexual assault programs and other relevant stakeholders, may also approve informational materials from other sources for the purposes of this section. The informational materials must be clearly written and readily comprehensible in a culturally competent manner, as the secretary, in collaboration with community sexual assault programs and other relevant stakeholders, deems necessary to inform victims of sexual assault. The materials must explain the nature of emergency contraception, including that it is effective in preventing pregnancy, treatment options, and where they can be obtained.

(3) The secretary shall adopt rules necessary to implement this section. 2

Sec. 4. A new section is added to chapter 70.41 RCW 3 to read as follows:
The department must respond to complaints of violations of section 3 of this act. The department shall convene a task force, composed of representatives from community sexual assault programs and other relevant stakeholders including advocacy agencies, medical agencies, and hospital associations, to provide input into the development and evaluation of the education materials and rule development. The task force shall expire on January 1, 2004.

Passed the Senate February 16, 2002.
Passed the House March 6, 2002.
Approved by the Governor March 26, 2002.

State of California

Filed in Office of Secretary of State March 26, 2002.
BILL NUMBER: AB 1860 CHAPTERED
BILL TEXT

CHAPTER 382
FILED WITH SECRETARY OF STATE SEPTEMBER 6, 2002
APPROVED BY GOVERNOR SEPTEMBER 5, 2002
PASSED THE ASSEMBLY AUGUST 12, 2002
PASSED THE SENATE AUGUST 8, 2002
AMENDED IN SENATE JUNE 17, 2002
AMENDED IN SENATE MAY 28, 2002
AMENDED IN ASSEMBLY APRIL 11, 2002

INTRODUCED BY Assembly Member Migden
(Coauthors: Assembly Members Alquist, Frommer, Jackson, and Koretz)

JANUARY 31, 2002

An act to amend Section 13823.11 of the Penal Code, relating to sexual assault victims.

LEGISLATIVE COUNSEL'S DIGEST

AB 1860, Migden. Sexual assault victim: pregnancy counseling: emergency contraception.

Existing law sets forth minimum standards for the examination and treatment of victims of sexual assault, including the taking of a baseline gonorrhea culture, a syphilis serology, and specimens for a pregnancy test, if indicated by the history of contact.

This bill would provide, in addition, that where indicated by the history of contact, a female victim of sexual assault shall be provided with the option of postcoital contraception by a physician or other health care provider, and postcoital contraception shall be dispensed by a physician or other health care provider upon the request of the victim.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 13823.11 of the Penal Code is amended to read:

13823.11. The minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault, including child molestation and the collection and preservation of evidence therefrom include all of the following:

(a) Law enforcement authorities shall be notified.

(b) In conducting the physical examination, the outline indicated in the form adopted pursuant to subdivision (c) of Section 13823.5 shall be followed.

(c) Consent for a physical examination, treatment, and collection of evidence shall be obtained.

(1) Consent to an examination for evidence of sexual assault shall be obtained prior to the examination of a victim of sexual assault and shall include separate written documentation of consent to each of the following:

(A) Examination for the presence of injuries sustained as a result of the assault.
(B) Examination for evidence of sexual assault and collection of physical evidence.
(C) Photographs of injuries.
(2) Consent to treatment shall be obtained in accordance with usual hospital policy.
(3) A victim of sexual assault shall be informed that he or she may refuse to consent to an examination for evidence of sexual assault, including the collection of physical evidence, but that a refusal is not a ground for denial of treatment of injuries and for possible pregnancy and sexually transmitted diseases, if the person wishes to obtain treatment and consents thereto.
(4) Pursuant to Chapter 3 (commencing with Section 6920) of Part 4 of Division 11 of the Family Code, a minor may consent to hospital, medical, and surgical care related to a sexual assault without the consent of a parent or guardian.
(5) In cases of known or suspected child abuse, the consent of the parents or legal guardian is not required. In the case of suspected child abuse and nonconsenting parents, the consent of the local agency providing child protective services or the local law enforcement agency shall be obtained. Local procedures regarding obtaining consent for the examination and treatment of, and the collection of evidence from, children from child protective authorities shall be followed.
(d) A history of sexual assault shall be taken.
The history obtained in conjunction with the examination for evidence of sexual assault shall follow the outline of the form established pursuant to subdivision (c) of Section 13823.5 and shall include all of the following:
(1) A history of the circumstances of the assault.
(2) For a child, any previous history of child sexual abuse and an explanation of injuries, if different from that given by parent or person accompanying the child.
(3) Physical injuries reported.
(4) Sexual acts reported, whether or not ejaculation is suspected, and whether or not a condom or lubricant was used.
(5) Record of relevant medical history.
(e) (1) If indicated by the history of contact, a female victim of sexual assault shall be provided with the option of postcoital contraception by a physician or other health care provider.
(2) Postcoital contraception shall be dispensed by a physician or other health care provider upon the request of the victim.
(f) Each adult and minor victim of sexual assault who consents to a medical examination for collection of evidentiary material shall have a physical examination which includes, but is not limited to, all of the following:
(1) Inspection of the clothing, body, and external genitalia for injuries and foreign materials.
(2) Examination of the mouth, vagina, cervix, penis, anus, and rectum, as indicated.
(3) Documentation of injuries and evidence collected.
Prepubertal children shall not have internal vaginal or anal examinations unless absolutely necessary (this does not preclude careful collection of evidence using a swab).
(g) The collection of physical evidence shall conform to the following procedures:
(1) Each victim of sexual assault who consents to an examination for collection of evidence shall have the following items of evidence collected, except where he or she specifically objects:
(A) Clothing worn during assault.
(B) Foreign materials revealed by an examination of the clothing, body, external genitalia, and pubic hair combings.
(C) Swabs and slides from the mouth, vagina, rectum, and penis, as indicated, to determine the presence or absence of sperm and sperm motility, and for genetic marker typing.
(2) Each victim of sexual assault who consents to an examination for the collection of evidence shall have reference specimens taken, except when he or she specifically objects thereto. A reference specimen is a standard from which to obtain baseline information (for example: pubic and head

hair, blood, and saliva for genetic marker typing). These specimens shall be taken in accordance with the standards of the local criminalistics laboratory.

(3) A baseline gonorrhea culture, and syphilis serology, shall be taken, if indicated by the history of contact. Specimens for a pregnancy test shall be taken, if indicated by the history of contact.

(4) (A) If indicated by the history of contact, a female victim of sexual assault shall be provided with the option of postcoital contraception by a physician or other health care provider.

(B) Postcoital contraception shall be dispensed by a physician or other health care provider upon the request of the victim.

(h) Preservation and disposition of physical evidence shall conform to the following procedures:

(1) All swabs and slides shall be air-dried prior to packaging.

(2) All items of evidence including laboratory specimens shall be clearly labeled as to the identity of the source and the identity of the person collecting them.

(3) The evidence shall have a form attached which documents its chain of custody and shall be properly sealed.

(4) The evidence shall be turned over to the proper law enforcement agency.

AN ACT RELATING TO HEALTH CARE; ENACTING THE SEXUAL ASSAULT SURVIVORS EMERGENCY CARE ACT; PROVIDING PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE.—This act may be cited as the "Sexual Assault Survivors Emergency Care Act".

Section 2. DEFINITIONS.—As used in the Sexual Assault Survivors Emergency Care Act:

A. "department" means the department of health;

B. "emergency care for sexual assault survivors" means medical examinations, procedures and services provided by a hospital to a sexual assault survivor following an alleged sexual assault;

C. "emergency contraception" means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse;

D. "hospital" means a facility providing emergency or urgent health care;

E. "medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards; published in peer-reviewed journals; and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology, such as the American college of obstetricians and gynecologists;

F. "sexual assault" means the crime of criminal sexual penetration; and

G. "sexual assault survivor" means a female who alleges or is alleged to have been sexually assaulted and who presents as a patient to a hospital.

Section 3. EMERGENCY CARE FOR SEXUAL ASSAULT SURVIVORS—STANDARD OF CARE.—

A. A hospital that provides emergency care for sexual assault survivors shall:

(1) provide each sexual assault survivor with medically and factually accurate and objective written and oral information about emergency contraception;

(2) orally and in writing inform each sexual assault survivor of her option to be provided emergency contraception at the hospital; and

(3) provide emergency contraception at the hospital to each sexual assault survivor who requests it.

B. The provision of emergency contraception pills shall include the initial dose that the sexual assault survivor can take at the hospital as well as the subsequent dose that the sexual assault survivor may self-administer twelve hours following the initial dose.

Section 4. TRAINING.—No later than September 30, 2003:

A. a hospital shall ensure that all personnel who provide care to sexual assault survivors are trained to provide medically and factually accurate and objective information about emergency contraception; and

B. the department shall adopt rules regulating the training to be provided by hospitals pursuant to the Sexual Assault Survivors Emergency Care Act to personnel who provide emergency care for sexual assault survivors.

Section 5. ENFORCEMENT—ADMINISTRATIVE FINES.—

A. Complaints of failure to provide services required by the Sexual Assault Survivors Emergency Care Act may be filed with the department.

B. The department shall immediately investigate every complaint it receives regarding failure of a hospital to provide services required by the Sexual Assault Survivors Emergency Care Act to determine the action to be taken to satisfy the complaint.

C. The department shall compile all complaints it receives regarding failure to provide services required by the Sexual Assault Survivors Emergency Care Act and shall retain the complaints for at least ten years so that they can be analyzed for patterns of failure to provide services pursuant to that act.

D. If the department determines that a hospital has failed to provide the services required in the Sexual Assault Survivors Emergency Care Act, the department shall:

(1) issue a written warning to the hospital upon receipt of a complaint that the hospital is not providing the services required by the Sexual Assault Survivors Emergency Care Act; and

(2) based on the department's investigation of the first complaint, require the hospital to correct the deficiency leading to the complaint.

E. If after the issuance of a written warning to the hospital pursuant to Subsection D of this section, the department finds that the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall, for a second through fifth complaint, impose on the hospital a fine of one thousand dollars ($1,000):

(1) per sexual assault survivor who is found by the department to have been denied medically and factually accurate and objective information about emergency contraception or who is not offered or provided emergency contraception; or

(2) per month from the date of the complaint alleging noncompliance until the hospital provides training pursuant to the rules of the department.

F. For the sixth and subsequent complaint against the same hospital if the department finds the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall impose an intermediate sanction pursuant to Section 24-1-5.2 NMSA 1978 or suspend or revoke the license of the hospital issued pursuant to the Public Health Act.

Section 6. SEVERABILITY.—If any part or application of the Sexual Assault Survivors Emergency Care Act is held invalid, the remainder of its application to other situations or persons shall not be afffected.

HJC/HB 119

HR 2527 IH
108th CONGRESS
1st Session

H. R. 2527

To provide for the provision by hospitals of emergency contraceptives to women who are survivors of sexual assault.

IN THE HOUSE OF REPRESENTATIVES
June 19, 2003

Mr. GREENWOOD (for himself, Mr. ROTHMAN, Mrs. JOHNSON of Connecticut, Ms. DEGETTE, Ms. SLAUGHTER, Mr. PALLONE, Mr. OLVER, Mrs. DAVIS of California, Mr. ABERCROMBIE, Mr. EVANS, Mr. GEORGE MILLER of California, Ms. CORRINE BROWN of Florida, Ms. LEE, Mr. INSLEE, Mr. CASE, Mr. WAXMAN, Mr. TIERNEY, Mr. BACA, Mrs. JONES of Ohio, Mr. BLUMENAUER, Mr. LARSON of Connecticut, Mr. NADLER, Mr. DINGELL, Mr. MCDERMOTT, Mr. BROWN of Ohio, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. HARMAN, Ms. LOFGREN, Mr. MATSUI, Mr. BRADY of Pennsylvania, Ms. DELAURO, Mr. STARK, Mr. FALEOMAVAEGA, Mr. GRIJALVA, Ms. BERKLEY, Ms. CARSON of Indiana, Mr. FARR, Mr. JACKSON of Illinois, Mr. OWENS, Mrs. MALONEY, Mr. SANDERS, Mr. WU, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for the provision by hospitals of emergency contraceptives to women who are survivors of sexual assault.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Compassionate Assistance for Rape Emergencies Act'.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) It is estimated that 25,000 to 32,000 women become pregnant each year as a result of rape or incest. An estimated 22,000 of these pregnancies could be prevented if rape survivors had timely access to emergency contraception.
(2) A 1996 study of rape-related pregnancies (published in the American Journal of Obstetrics and Gynecology) found that 50 percent of the pregnancies described in paragraph (1) ended in abortion.
(3) Surveys have shown that many hospitals do not routinely provide emergency contraception to women seeking treatment after being sexually assaulted.
(4) The risk of pregnancy after sexual assault has been estimated to be 4.7 percent in survivors who were not protected by some form of contraception at the time of the attack.
(5) The Food and Drug Administration has declared emergency contraception to be safe and effective in preventing unintended pregnancy, reducing the risk by as much as 89 percent.
(6) Medical research strongly indicates that the sooner emergency contraception is administered, the greater the likelihood of preventing unintended pregnancy.
(7) In light of the safety and effectiveness of emergency contraceptive pills, both the American Medical Association and the American College of Obstetricians and Gynecologists have endorsed more widespread availability of such pills.

(8) The American College of Emergency Physicians and the American College of Obstetricians and Gynecologists agree that offering emergency contraception to female patients after a sexual assault should be considered the standard of care.
(9) Nine out of ten women of reproductive age remain unaware of emergency contraception. Therefore, women who have been sexually assaulted are unlikely to ask for emergency contraception.
(10) New data from a survey of women having abortions estimates that 51,000 abortions were prevented by use of emergency contraception in 2000 and that increased use of emergency contraception accounted for 43 percent of the decrease in total abortions between 1994 and 2000.
(11) It is essential that all hospitals that provide emergency medical treatment provide emergency contraception as a treatment option to any woman who has been sexually assaulted, so that she may prevent an unintended pregnancy.

SEC. 3. SURVIVORS OF SEXUAL ASSAULT; PROVISION BY HOSPITALS OF EMERGENCY CONTRACEPTIVES WITHOUT CHARGE.

(a) IN GENERAL- Federal funds may not be provided to a hospital under any health-related program, unless the hospital meets the conditions specified in subsection (b) in the case of--
(1) any woman who presents at the hospital and states that she is a victim of sexual assault, or is accompanied by someone who states she is a victim of sexual assault; and
(2) any woman who presents at the hospital whom hospital personnel have reason to believe is a victim of sexual assault.

(b) ASSISTANCE FOR VICTIMS- The conditions specified in this subsection regarding a hospital and a woman described in subsection (a) are as follows:

(1) The hospital promptly provides the woman with medically and factually accurate and unbiased written and oral information about emergency contraception, including information explaining that--
(A) emergency contraception does not cause an abortion; and
(B) emergency contraception is effective in most cases in preventing pregnancy after unprotected sex.

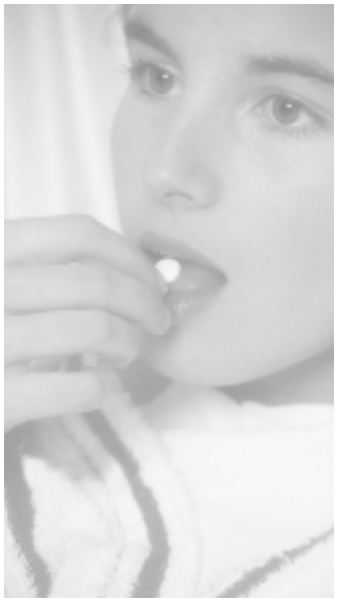
(2) The hospital promptly offers emergency contraception to the woman, and promptly provides such contraception to her on her request.
(3) The information provided pursuant to paragraph (1) is in clear and concise language, is readily comprehensible, and meets such conditions regarding the provision of the information in languages other than English as the Secretary may establish.
(4) The services described in paragraphs (1) through (3) are not denied because of the inability of the woman or her family to pay for the services.

(c) DEFINITIONS- For purposes of this section:
(1) The term 'emergency contraception' means a drug, drug regimen, or device that is--
(A) used postcoitally;
(B) prevents pregnancy by delaying ovulation, preventing fertilization of an egg, or preventing implantation of an egg in a uterus; and
(C) is approved by the Food and Drug Administration.

(2) The term `hospital' has the meanings given such term in title XVIII of the Social Security Act, including the meaning applicable in such title for purposes of making payments for emergency services to hospitals that do not have agreements in effect under such title.
(3) The term `Secretary' means the Secretary of Health and Human Services.
(4) The term `sexual assault' means coitus in which the woman involved does not consent or lacks the legal capacity to consent.

(d) EFFECTIVE DATE; AGENCY CRITERIA - This section takes effect upon the expiration of the 180-day period beginning on the date of the enactment of this Act. Not later than 30 days prior to the expiration of such period, the Secretary shall publish in the Federal Register criteria for carrying out this section.

Appendix 3: Voluntary Change



Letter 1: To a hospital that indicated a standard policy of providing EC to sexual assault survivors

Dear [Appropriate Hospital CEO],

Your emergency department participated in a survey about services for sexual assault survivors in Pennsylvania emergency rooms between January and May 2000. Rebecca Simons, M.D. conducted the survey under the auspices of the Johns Hopkins School of Public Health and the Clara Bell Duvall Project of the ACLU of Pennsylvania.

While the overall results were extremely disappointing, **we are pleased that your hospital was among the 28% that routinely provides emergency contraception (also known as the "morning-after pill") in an appropriate manner.** Your hospital follows an appropriate standard of care for emergency contraception — it is offered and provided on site to rape victims regardless of the physician on duty or the time of day.

Soon you will be receiving comprehensive guidelines for the treatment of sexual assault victims from the Pennsylvania Coalition Against Rape (PCAR). PCAR is a state network of centers serving victims of sexual violence. Professionals in the fields of nursing, medicine, advocacy, law enforcement and prosecution developed these guidelines called Sexual Assault Response Team (SART) Standards. Because a pregnancy resulting from rape can be devastating to victims, offering emergency contraception to victims of sexual assault is stipulated in the SART Standards.

We commend your hospital's efforts and hope that you will continue to provide emergency contraception as part of comprehensive medical services to victims of sexual assault. Should you have any questions, please contact the Director of the Duvall Project, Carol Petraitis (cpetraitis@aclupa.org), or call (215) 629-0111. The complete study is available online at www.aclupa.org/duvall/pubs/ecinpa.

Letter 2: To a hospital that indicated no standard policy of providing EC to sexual assault survivors

Dear [No EC Hospital CEO],

Your emergency department participated in a survey about services for sexual assault survivors in Pennsylvania emergency rooms between January and May 2000. Rebecca Simons, M.D. conducted the survey under the auspices of the Johns Hopkins School of Public Health and the Clara Bell Duvall Project of the ACLU of Pennsylvania.

As the enclosed fact sheet shows, the results were extremely disappointing. Only 28 % of Pennsylvania emergency rooms routinely provide emergency contraception (the "morning-after pill") to victims of sexual assault in a timely, appropriate manner. **Unfortunately [hospital name] was among the 12% whose responses to the survey indicate that the hospital emergency department does not provide emergency contraceptive services.** Rape victims are not given emergency contraceptive pills, provided with a prescription, nor are they referred elsewhere for emergency contraceptive services. This is especially problematic because emergency contraception is an appropriate standard of care for rape victims, and other hospitals in Pennsylvania have adopted written protocols.

Soon you will receive comprehensive guidelines for the treatment of sexual assault victims from the Pennsylvania Coalition Against Rape (PCAR). PCAR is a state network of centers serving victims of sexual violence. Professionals in the fields of nursing, medicine, advocacy, law enforcement and prosecution developed these guidelines called Sexual Assault Response Team (SART) Standards. Because a pregnancy resulting from rape can be devastating to victims, offering emergency contraception to victims of sexual assault is stipulated in the SART Standards.

In light of this information we hope that you will work with your emergency department to raise the standards of care for victims of sexual assault. If your hospital's standards have changed since the survey was conducted, please let us know. Should you have any questions or if you need assistance with this matter, please contact the Director of the Duvall Project, Carol Petraitis (cpetraitis@aclupa.org), or call (215) 629-0111. The complete study along with a model set of guidelines for emergency contraceptive services can be found on line at www.aclupa.org/duvall/pubs/ecinpa.

Letter 3: To a hospital that indicated a policy which depends upon the physician on duty

Dear [Physician Dependent Hospital CEO],

Your emergency department participated in a survey about services for sexual assault survivors in Pennsylvania emergency rooms between January and May 2000. Rebecca Simons, M.D. conducted the survey under the auspices of the Johns Hopkins School of Public Health and the Clara Bell Duvall Project of the ACLU of Pennsylvania.

Overall, the results were extremely disappointing. Only 28% of Pennsylvania hospitals routinely provide emergency contraception (the "morning-after pill") to rape victims in a timely, appropriate manner. **Unfortunately, (Name of Hospital) was among the 51% in which the provision of emergency contraception depends upon the physician on duty.**

This is especially problematic because each doctor has a distinct perspective on emergency contraception. Since emergency contraception is an appropriate standard of care for rape victims, it is important to adopt a written policy, as other hospitals in Pennsylvania have done.

Soon you will receive comprehensive guidelines for the treatment of sexual assault victims from the Pennsylvania Coalition Against Rape (PCAR). PCAR is a state network of centers serving victims of sexual violence. Professionals in the fields of nursing, medicine, advocacy, lawenforcement and prosecution developed these guidelines called Sexual Assault Response Team (SART) Standards. Because a pregnancy resulting from rape can be devastating to victims, offering emergency contraception to victims of sexual assault is stipulated in the SART Standards.

In light of this information we hope that you will work with your emergency department to raise the standards of care for victims of sexual assault. If your hospital's standards have changed since the survey was conducted, please let us know. Should you have any questions or if you need assistance with this matter, please contact the Director of the Duvall Project, Carol Petraitis (cpetraitis@aclupa.org), or call (215) 629-0111. The complete study along with a model set of guidelines for emergency contraceptive services can be found on line at www.aclupa.org/duvall/forhospitals.html.

Letter 4: To Catholic hospitals that are found through EC in the ER surveys to have poor or nonexistent policies on EC in the ER.

Dear Catholic Hospital President/CEO, Emergency Department Doctors and Emergency Department Nurse Manager:

We are writing to call to your attention what appears to be a serious gap in your facility's treatment of sexual assault victims. We would like to explain the problem, as we see it, and request an opportunity to meet with you to discuss this matter further and offer any assistance you may need in improving your treatment protocol.

Recently, our organizations, (*insert names of pro-choice group and coalition against sexual assault that conducted the joint survey*) conducted a survey of hospital emergency departments in the state of _____. Overall, we were pleased to find that _____ percent of hospital emergency departments are offering emergency contraception pills (ECPs) to rape victims as part of emergency treatment. The results for your facility, however, indicate that (*choose the appropriate one from the following list)* 1) your facility does not include counseling about and the offering of ECPs in your standard treatment protocol for sexual assault victims; 2) your facility has an inconsistent policy about the offering of ECPs that depends on the time of day or the staff on duty; or 3) your facility writes prescriptions for ECPs for rape victims, but those prescriptions cannot be easily filled in a timely manner because there is no pharmacy nearby that is open 24 hours a day and/or the nearby pharmacies do not stock emergency contraception pills.

Emergency contraception pills are a safe and effective, FDA-approved method of preventing pregnancy following unprotected intercourse. ECPs are essentially a high dose of ordinary birth control pills, and should not be confused with RU-486, the "abortion pill." When taken within 120 hours following unprotected intercourse, ECPs are highly effective in *preventing* pregnancy. Routine use of emergency contraception can help ensure that thousands of women each year are not re-victimized by having to deal with a pregnancy resulting from rape. Consider the fact that 12 percent of women experience a sexual assault in their lifetimes and 4.7 percent of these result in pregnancy.[1] Each year in the United States, an estimated 25,000 women become pregnant as a result of sexual assault. EC could be used to prevent 22,000 of these pregnancies.[2]

We recognize that the *Ethical and Religious Directives for Catholic Health Care Services*, which govern Catholic facilities such as yours, prohibit the routine provision of contraception. However, as we are sure you are aware, Directive 36 makes a specific exception for emergency treatment of victims of sexual assault, offering the following guidance:

> *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*

[1]Holmes M., Resnick H., Kilpatrick D. and Best C. "Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women." *American Journal of Obstetrics and Gynecologists.* 1996. 175:320-5.
[2]Stewart, F. and Trussell J., "Prevention of Pregnancy Resulting From Rape." *American Journal of Preventive Medicine.* 2000; 19:228-229.
[3]Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition, United States Conference of Catholic Bishops, http://www.nccbuscc.org/bishops/directives.htm

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.[3]

Over the years, some Catholic hospitals had decided that prohibiting the provision of emergency contraception was the only way to be in compliance with this somewhat confusing guidance, given the medical impossibility of determining what is spelled out in the last sentence of Directive 36. Other facilities had developed various inexact ways to trying to approximate the requirements of that sentence through such efforts as giving the patient an ovulation test.

Recently, however, there has been helpful new guidance for hospitals on this subject from the Catholic Health Association. As a result, many Catholic hospitals are now adopting policies of offering ECPs to rape victims. In New York, for example, a statewide survey found that 75 percent of Catholic hospitals reported they had adopted a policy of consistently offering EC to rape victims. You may wish to refer to two articles in recent issues of *Health Progress*, the journal of the Catholic Health Association (which is available at www.chausa.org):

- ❑ "Emergency Contraception and Sexual Assault," an article appearing in the September-October 2002 issue, concludes that the "appropriate testing" requirement mentioned in Directive 36 can be fulfilled by giving a standard pregnancy test to the rape victim before offering her ECPs. (If the patient is already pregnant, she does not need emergency contraception.) In this article, Dr. Ronald Hamel, PhD, senior director, ethics, for the Catholic Health Association, and Micheal Panicola, PhD, corporate vice president, ethics for SSM Health Care, argue against the ovulation method, saying "the pregnancy approach is responsive to the needs of the woman who has suffered untold trauma from being sexually assaulted and is consistent with the Catholic moral tradition generally and Catholic teaching on this matter particularly."[4]

- ❑ In the July-August 2003 issue, "A Venue for Theological/Ethical Issues" CHA President Father Michael Place reported that the United States Conference of Catholic Bishops' Committee on Doctrine "concluded that testing only for pregnancy unrelated to sexual assault is not inconsistent with Directive 36."[5]

We urge you to institute a hospital policy to ensure that all victims of sexual assault are informed about the potential use of ECPs to prevent pregnancy from the rape, and are offered such medication in a manner consistent with the new guidance from the Catholic Health Association. We have enclosed some materials (such as fact sheets) further explaining the importance of EC in the ER.

We will be contacting you within the coming weeks to follow up on this letter. We look forward to discussing this important aspect of emergency care for victims of sexual assault.

Sincerely,

cc: The rape crisis group serving the region in which the hospital is located

[4]Hamel, Ronald and Micheal Panicola. "Emergency Contraception and Sexual Assault." *Health Progress.* September-October 2002, http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0209&ARTICLE=I

[5]Place, Michael. "A Venue for Theological/Ethical Issues." *Health Progress.* July-August 2003, http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0307&ARTICLE=B

PINNACLE HEALTH HOSPITALS

Women's and Children's Services
Children's Resource Center

GUIDELINE NUMBER: I-7

SUBJECT: Emergency Contraception (EC)

OBJECTIVE: To develop a consistent method of protecting against pregnancy.

GENERAL GUIDELINES:

These are general guidelines and may not be applicable in all situations. Decisions must be made in the context of the situation and of judgmental parameters existent at the time of decision-making.

Emergency contraception will be offered to all nonpregnant patients whose breast or pubic hair development is Tanner Stage II or beyond, even if they have not begun to menstruate, unless they are reliable users of a hormonal contraceptive.

1. Obtain a gynecologic history.

    a. If the patient is a reliable user of hormonal contraception, EC is not indicated.

    b. If the patient was menstruating normally at the time of sexual intercourse, EC is not indicated.

    c. If the patient may be pregnant, be sure that her pregnancy test is negative before prescribing EC. Pregnancy is a contraindication to EC, not because it can injure the fetus, but because it is not indicated

2. Obtain verbal consent by informing the patient of the availability of EC and its complications and side effects:

    a. Women rarely experience nausea using Plan B as an EC.

    b. The failure rate for EC is not known, but it is thought to be low if used within 72 hours of sexual contact.

        1) The pregnancy rate will increase with increased time between sexual intercourse and the use of EC.

        2) Although EC is generally used up to 72 hours after intercourse, it may be used later after intercourse (up to 120 hours) but its effectiveness is not known.

3. There is no need to split the doses of Plan B by 12 hours. Prescribe both to be taken immediately.

4. Counsel the patient that a pregnancy test should be performed if she misses her period after using EC.

APPROVAL:

Approved by:

Director, Community Health Services

Signature _____ Date _____

Medical Director, CRC

Signature _____ Date _____

Reviewed by: **Date:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PENNSYLVANIA COALITION AGAINST RAPE

The Center for Reproductive Law and Policy sells an eleven minute video on emergency contraception. The video, *Speak EC: What Every Woman Needs to Know About Emergency Contraception*, is available for the low cost of $10. The content covers myths about EC, what it really is and how it works. Sexual assault is mentioned briefly in the video. Karla Vierthaler, while interning at PCAR, created a brochure to supplement the information in the video. The brochure puts the nausea resulting from EC into perspective (the video seems to emphasize this side effect) and provides for a stronger link between sexual assault and EC.

PCAR purchased videos for each rape crisis center and satellite office in Pennsylvania. A packet including the video, the supplemental brochure and an additional brochure titled "Emergency Contraception" was provided to each center and satellite office in the state. Mass quantities of brochures on EC were also included and are provided at no charge to centers upon request.

The video can be purchased through the Center for Reproductive Law and Policy. Log on to www.crlp.org/pub_videos.html, or call 917-637-3600.

If you would like more information on PCAR's EC trainings or the brochure, please contact PCAR at 800-692-7445.

PCCD Pennsylvania Pathways for Victim Services
Workshop Proposal

Workshop Title: **Ensuring Optimum Care: Emergency Contraception as an Option**

Presenters: Barbara Sheaffer – Pennsylvania Coalition Against Rape
Carol Petraitis – Clara Bell Reproductive Freedom Project

Workshop Description:
Only half of the emergency departments in Pennsylvania give rape victims the option of preventing pregnancy! This workshop explains how emergency contraception (EC) works and why victims should be offered EC as an option. Forms of EC and strategies to access it will be discussed. Updated information will be provided.

Objectives:
At the completion of this workshop, participants should be able to

1. explain the three mechanisms of how emergency contraception works;
2. list the forms of emergency contraception; and
3. identify ways to access emergency contraception for victims.

Workshop content:
The two main goals of this workshop are to fully inform counselor/advocates about emergency contraception and to prepare them to assist victims in accessing emergency contraception. This workshop was presented last year at Pathways, but since victims still have difficulty accessing EC, and at times are not even informed about it, the workshop is still quite relevant. Through forums such as these, access to EC is improving.

Outline:

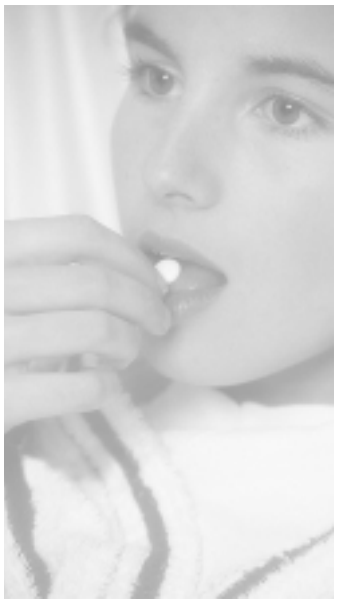
I. Icebreaker
II. EC quiz
III. PowerPoint presentation on EC
IV. Review quiz
V. Small group discussion with EC scenarios
VI. Wrap-up/resources

For the small group discussion, participants will be split into groups to discuss scenarios in which access to EC is thwarted. The groups will brainstorm solutions to the presented problems. Scenarios and solutions will be shared with the large group. (Sample scenarios included).

Throughout the workshop, participants will be encouraged to ask questions and talk about their experiences in helping victims with EC access. Informational brochures and other materials will be provided to the participants.

For more information, please contact PCAR at 800-692-7445.

Appendix 4: Resource Guide



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Organizations and Internet Resources

ACLU Reproductive Freedom Project
www.aclu.org/reproductiverights

American College of Obstetricians and Gynecologists
www.acog.org

Back Up Your Birth Control Campaign
www.backupyourbirthcontrol.org

Catholics for a Free Choice
www.catholicsforchoice.org

Center for Reproductive Rights
917-637-3600
www.crlp.org

Clara Bell Duvall Reproductive Freedom Project of the ALCU of Pennsylvania
215-629-0111
www.aclupa.org/duvall

Emergency Contraception Provider list
Hotline: 888-NOT-2-LATE
http://not-2-late.com

Family Violence Prevention Fund
http://endabuse.org

MergerWatch Project
518-436-8408
www.mergerwatch.org

NARAL ProChoice America
www.naral.org

National Alliance of Sexual Assault Coalitions, Library of Information
http://connsacs.org/learn/library.html

National Center for Victims of Crime
www.ncvc.org

National Sexual Violence Resource Center
877-739-3895
www.nsvrc.org

National Violence Against Women Prevention Research Center
www.vawprevention.org

National Women's Law Center
202-588-5180
www.nwlc.org

Not-2-Late: The Emergency Contraception Website
(provides EC information in Spanish, English, French and Arabic)
http://ec.princeton.edu/

Pennsylvania Coalition Against Rape
800-692-7445
www.pcar.org

Physicians for Reproductive Choice and Health
www.prch.org

Planned Parenthood
Hotline: 800-230-PLAN
www.plannedparenthood.org

Plan B®, Women's Capital Corporation
800-330-1271
www.go2planB.com

Preven®, Gynetics
800-311-7378
www.preven.com

Rape, Abuse & Incest National Network
www.rainn.org

Reproductive Health Technologies Project
www.rhtp.org

State and Territory Coalitions Against Sexual Assault

Alabama Coalition Against Rape
PO Box 4091,
Montgomery, AL 36102
phone: 334-264-0123
toll-free: 888-725-7273
fax: 334-264-0128
company email: acar@acar.org
website: www.acar.org

Alaska Network on Domestic Violence and Sexual Assault
130 Seward Street, Suite 209
Juneau, AK 99801
phone: 907-586-3650
toll-free: 800-520-2666
fax: 904-463-4493
company email: info@andvsa.org
website: http://www.andvsa.org

Arizona Sexual Assault Network
77 East Thomas Road, Suite 110
Phoenix, AZ 85012
phone: 602-258-1195
fax: 602-258-1179
company email: info@azsan.org
website: www.azsan.org

Arkansas Coalition Against Sexual Assault
215 North East Avenue,
Fayetteville, AR 72701
phone: 479-527-0900
toll-free: 866-632-2272
fax: 479-527-0902
company email: acasa@sbcglobal.net
website: http://www.acasa.ws/

California Coalition Against Sexual Assault
1215 K Street, Suite 1100
Sacramento, CA 95814
phone: 916-446-2520
fax: 916-446-8166
company email: info@calcasa.org
website: www.calcasa.org

Colorado Coalition Against Sexual Assault
PO Box 300398,
Denver, CO 80203
phone: 303-861-7033
toll-free: 877-372-2272
fax: 303-832-7067
company email: info@ccasa:

Connecticut Sexual Assault Crisis Services, Inc.
96 Pitkin Street,
East Hartford, CT 06108
phone: 860-282-9881
toll-free: 888-999-5545
fax: 860-291-9335
company email: info@connsacs.org

D.C. Rape Crisis Center
PO Box 34125,
Washington, DC 20043
phone: 202-232-0789
fax: 202-387-3812
company email: dcrcc@dcrcc.org

Delaware - CONTACT Delaware, Inc.
PO Box 9525,
Wilmington, DE 19809
phone: 302-761-9800
fax: 302-761-4280

Florida Council Against Sexual Violence
1311-A Paul Russell Road, Suite 204
Tallahassee, FL 32301
phone: 850-297-2000
toll-free: 888-956-7273
fax: 850-297-2002
company email: fcasv@nettally.com
website: www.fcasv.org

Georgia Network to End Sexual Assault
619 Edgewood Avenue SE, Suite 104
Atlanta, GA 30312
phone: 678-701-2700
fax: 678-701-2709
company email: gnesa@mindspring.com
website: www.gnesa.org

Guam Healing Hearts Crisis Center
790 Gov. Carlos G. Camacho Road,
Tamuning, GU 96911
phone: 671-647-5351
toll-free: 800-711-4826
fax: 671-649-6948
company email: csmau@mail.gov.gu

Hawaii Coalition Against Sexual Assault
741 A Sunset Avenue, Room 105
Honolulu, HI 96816
phone: 808-733-9038
fax: 808-733-9032
company email: msshari@aloha.net

Idaho Coalition Against Sexual and Domestic Violence
815 Park Boulevard, Suite 140
Boise, ID 83712
phone: 208-384-0419
toll-free: 888-293-6118
fax: 208-331-0687
company email: domvio@mindspring.com

Illinois Coalition Against Sexual Assault
100 North 16th Street,
Springfield, IL 62703
phone: 217-753-4117
fax: 217-753-8229
company email: sblack@icasa.org

Indiana Coaltion Against Sexual Assault
55 Monument Circle, Suite 1224
Indianapolis, IN 46204
phone: 317-423-0233
toll-free: 800-691-2272
fax: 317-423-0237
company email: incasa@incasa.org

Iowa Coalition Against Sexual Assault
2603 Bell Avenue, Suite 102
Des Moines, IA 50321
phone: 515-244-7424
fax: 515-244-7417

Kansas Coalition Against Sexual and Domestic Violence
220 SW 33rd Street, Suite 100
Topeka, KS 66611
phone: 785-232-9784
fax: 785-266-1874
company email: coalition@kcsdv.org

Kentucky Association of Sexual Assault Programs, Inc.
106A St. James Court,
Frankfort, KY 40601
phone: 502-226-2704
fax: 502-226-2725
website: www.kasap.org

Louisiana Foundation Against Sexual Assault
PO Box 40,
Independence, LA 70443
phone: 985-345-5995
toll-free: 888-995-7273
fax: 985-345-5592
company email: lafasa@I-55.com

Maine Coalition Against Sexual Assault
83 Western Avenue, Suite 2
Augusta, ME 04330
phone: 207-626-0034
toll-free: 800-871-7741
fax: 207-626-5503
website: www.mecasa.org

Maryland Coalition Against Sexual Assault
1517 Governor Ritchie Highway, Suite 207
Arnold, MD 21012
phone: 410-974-4507
toll-free: 800-983-7273
fax: 410-757-4770
company email: info@mcasa.org
website: www.mcasa.org

Massachusetts Coalition Against Sexual Assault and Domestic Violence
14 Beacon Street, Suite 507
Boston, MA 02108
phone: 617-248-0922
fax: 617-248-0902
company email: info@janedoe.org

Michigan Coalition Against Domestic and Sexual Violence
3893 Okemos Road, Suite B2
Okemos, MI 48864
phone: 517-347-7000
fax: 517-347-1377
company email: general@mcadsv.or
website: www.mcadsv.org

Minnesota Coalition Against Sexual Assault
420 North 5th Street, Suite 690
Minneapolis, MN 55401
phone: 612-313-2797
toll-free: 800-964-8847
fax: 612-313-2799company email:
website: www.mncasa.org

Mississippi Coalition Against Sexual Assault
PO Box 4172,
Jackson, MS 39296
phone: 601-948-0555
toll-free: 888-987-9011
fax: 601-948-0525
website: www.mcasa.net

Missouri Coalition Against Sexual Assault
PO Box 104866,
Jefferson City, MO 65110
phone: 573-636-8776
fax: 573-636-6613
company email: mocasajc@earthlink.net
website: http://mocasa.missouri.org

Montana Coalition Against Domestic and Sexual Violence
PO Box 633,
Helena, MT 59624
phone: 406-443-7794
fax: 406-443-7818
company email: mcadsv@mt.net
website: www.mcadsv.com

Nebraska Domestic Violence Sexual Assault Coalition
825 M Street, Suite 404
Lincoln, NE 68508
phone: 402-476-6256
fax: 402-476-6806
company email: info@ndvsac.org
website: www.ndvsac.org

Nevada Coalition Against Sexual Assault
PO Box 530103,
Henderson, NV 89053
phone: 702-940-2033
fax: 702-940-2032
website: www.ncasv.org

New Hampshire Coalition Against Domestic & Sexual Violence
PO Box 353,
Concord, NH 03302
phone: 603-224-8893
fax: 603-228-6096
company email: health@nhcadsv.org
website: www.nhcadsv.org

New Jersey Coalition Against Sexual Assault
2333 Whitehorse-Mercerville Road, Suite B
Trenton, NJ 08619
phone: 609-631-4450
toll-free: 800-601-7200
fax: 609-631-4453
company email: mail@njcasa.org
website: www.njcasa.org

New Mexico Coalition of Sexual Assault Programs, Inc.
3909 Juan Tabo, NE # 6,
Alburquerque, NM 87111
phone: 505-883-8020
toll-free: 888-883-8020
fax: 505-883-7530
company email: nmcaas@swcp.com
website: www.swcp.com/nmcsaas/

New York City Alliance Against Sexual Assault
411 West 114 Street, Suite 6D
New York, NY 10025
phone: 212-523-4344
fax: 212-523-4429
company email: contact_us@nycagainstrape.org
website: www.nycagainstrape.org

New York State Coalition Against Sexual Assault
63 Colvin Avenue,
Albany, NY 12206
phone: 518-482-4222
fax: 518-482-4248
company email: info@nyscasa.org

North Carolina Coalition Against Sexual Assault
4426 Louisburg Road, Suite 100
Raleigh, NC 27616
phone: 919-431-0995
toll-free: 888-737-2272
fax: 919-431-0996
company email: nccasa@nccasa.org

North Dakota Coalition Against Sexual Assault
418 East Rousser, #320
Bismarck, ND 58501-
phone: 701-255-6240
toll-free: 888-255-6240
fax: 701-255-1904
company email: ndcaws@ndcaws.org

Ohio Coalition On Sexual Assault
933 High Street, Suite 120-B
Worthington, OH 43085
phone: 614-781-1902
fax: 614-781-1922
company email: Ohiocoalition@aol.com

Oklahoma Coalition Against Domestic Violence & Sexual Assault
2525 NW Express Way, Suite 101
Oklahoma City, OK 73112
phone: 405-848-1815
fax: 405-848-3469
company email: ocdvsa@swbell.net

Oregon Coalition Against Domestic and Sexual Violence
115 Mission Street, SE, Suite 100
Salem, OR 97302
phone: 503-365-9644
toll-free: 800-622-3782
fax: 503-566-7870
company email: info@ocadsv.com

Pennsylvania Coalition Against Rape
125 North Enola Drive,
Enola, PA 17025
phone: 717-728-9740
toll-free: 800-692-7445
fax: 717-728-9781
company email: stop@pcar.org

Puerto Rico Rape Crisis Center
Call Box 70184,
San Juan, PR 00936
phone: 787-756-0910
fax: 787-765-7840

Rhode Island Sexual Assault Coalition
300 Richmond Street, Suite 205
Providence, RI 02903
phone: 401-421-4100
fax: 401-454-5565
company email: info@satrc.org

South Carolina Coalition Against Domestic Violence and Sexual Assault
PO Box 7776,
Columbia, SC 29202
phone: 803-256-2900
toll-free: 800-260-9293
fax: 803-256-1030

South Dakota Coalition Against Domestic Violence & Sexual Assault
PO Box 306,
Eagle Butte, SD 57625
phone: 605-964-7103
toll-free: 888-728-3275
fax: 605-964-7104

South Dakota Network Against Family Violence and Sexual Assault
300 N. Dakota Avenue, Suite 112
Sioux Falls, SD 57104
phone: 605-731-0041
company email: sdnafvsa@mcleodusa.org

Tennessee Coalition Against Domestic and Sexual Violence
PO Box 120972,
Nashville, TN 37212
phone: 615-386-9406
fax: 615-383-2967
company email: tcadsv@tcadsv.org

Texas Association Against Sexual Assault
7701 North Lamar, Suite 200
Austin, TX 78752
phone: 512-474-7190
toll-free: 888-918-2272
fax: 512-474-6490
company email: taasa@taasa.org

Utah Coalition Against Sexual Assault
284 West 400 North,
Salt Lake City, UT 84103
phone: 801-746-0404
fax: 801-746-2929
company email: info@ucasa.org

Vermont Network Against Domestic Violence and Sexual Assault
PO Box 405,
Montpelier, VT 05601
phone: 802-223 - 1302
fax: 802-223-6943
company email: vnetwork@vnetwork.org

Virginians Aligned Against Sexual Assault
508 Dale Avenue, Suite B
Charlottesville, VA 22903
phone: 434-979-9002
toll-free: 800-838-8238
fax: 434-979-9003
company email: edvaasa@ntelos.net
website: www.vaasa.org

Washington Coalition of Sexual Assault Programs
2415 Pacific Avenue, SE, # 10-C
Olympia, WA 98501
phone: 360-754-7583
fax: 360-786-8707
company email: wcsap@wcsap.org

West Virginia Foundation for Rape Information and Services, Inc.
112 Braddock Street,
Fairmont, WV 26554
phone: 304-366-9500
fax: 304-366-9501
company email: fris@labs.net
website: www.fris.org

Wisconsin Coalition Against Sexual Assault
600 Williamson Street, Suite N-2
Madison, WI 53703
phone: 608-257-1516
fax: 608-257-2150
company email: wcasa@wcasa.org
website: www.wcasa.org

Women's Coalition of St. Croix
PO Box 222734,
Christiansted-St. Croix, VI 00822
phone: 340-773-9272
fax: 340-773-9062
company email: wcscstx@attglobal.net

Wyoming Coalition Against Domestic Violence and Sexual Assault
PO Box 236, 409 South 4th Street
Laramie, WY 82073
phone: 307-755-0992
toll-free: 800-990-3877
fax: 307-755-5482
company email: wyomingcoalition@quest.net

Glossary of Terms

Conception- Conception occurs when an egg is fertilized by sperm. Medically speaking, conception is not synonymous with pregnancy. Pregnancy begins after conception, when a fertilized egg successfully implants on the wall of the uterus.

Forensic Examination- An examination provided to a sexual assault victim by health care personnel trained to gather evidence of sexual violence in a manner suitable for use in a court of law generally using a standardized forensic evidence collection kit. The examination includes a patient interview, examination for physical trauma and collection of evidence at a minimum.

"Morning-after pill"- Another name for emergency contraception. Reproductive health professionals are using this term less often because it gives the false impression that the medication can only be taken the morning after unprotected sex, when in actuality, it can be taken up to five days later.

Pregnancy- The medical definition of pregnancy is that it begins when a fertilized egg is successfully implanted on the wall of the uterus.

RU-486- This is the so-called "abortion pill" that can be used to end an established pregnancy up to seven weeks into gestation. It is not the same thing as emergency contraception, or the "morning-after pill."

Sexual Assault Counselor/Advocate- A staff member or volunteer at a rape crisis center who represents and supports a victim of sexual violence with the victim's permission. The counselor/advocate provides the victim with counseling, advocacy and options available to the victim through the medical, legal and counseling process.

Sexual Assault Forensic Exam Kit- A designated box or bag containing envelopes and other items for holding possible evidence from a sexual assault forensic exam. Examples are envelopes of debris (e.g. leaves, grass, sand), hair combings and small boxes or envelopes for vaginal, anal and oral swabs. Clothing and other relevant items are also collected and placed in the kit. The kit is sealed and signed by everyone who handles it (e.g. the examiner, police, lab staff); this list of names is known as the chain of evidence or chain of custody. Many states have specifically designed, dedicated kits. Another term for sexual assault forensic exam kit is physical evidence recovery kit (PERK).

Sexual Assault Nurse Examiner (SANE)/Sexual Assault Forensic Examiner (SAFE)- A registered nurse or physician trained to provide comprehensive care, timely collection of forensic evidence and testimony in sexual assault cases.

Sexual Assault/Rape Crisis Center- Facilities that provide crisis counseling and intervention to victims/survivors of sexual violence and their significant others (most 24 hours a day) as well as information and referrals.

Sexual Assault Response Team (SART)- A multidisciplinary team working collaboratively to provide specialized services for victims of sexual violence in the community. The team includes at a minimum, a medical director, a sexual assault forensic examiner, a sexual assault counselor/advocate, a law enforcement representative and a prosecutor. Other members of the community can be a part of the team.

Sexual Violence/Sexual Assault- Any time a person is forced, coerced and/or manipulated into unwanted sexual activity. Sexual assault is legally defined by states.

State/Territory Sexual Violence Coalition- State/territory-wide network of sexual assault crisis programs which work to end sexual violence through victim assistance, community education and public policy advocacy.

Victim vs. Survivor- When a person presents at the emergency department after a sexual assault, the person has been victimized. The person is eligible for crime victims' compensation and the police, generally speaking, view the person as a victim of a crime. Focusing on EC as a victim's rights issue builds sympathy for the people who are violated by their attacker and then possibly violated again when they are not informed about or provided EC if they want it.

In the anti-sexual violence field, the term "survivor" is also used to describe a victim of sexual assault, because they have lived through this terrible experience. "Survivor" is often a personal term which victims/survivors may use once they have reached a certain stage of healing. It is a very subjective term, which is most appropriately used by that person herself/himself. Survivor is an empowering term, but one could argue it does not provoke as much sympathy as the term victim. For the cause of EC in the ER, we want sympathy.

Ensuring Access to Emergency Contraception for Survivors of Rape

Official Position Paper
American Public Health Association
Adopted November 18, 2003

Each year, an estimated 600,000 or more American women are raped,[1] with approximately 25,000 of those rapes resulting in pregnancy. As many as 22,000 of these pregnancies could be prevented by timely administration of emergency contraception.[2]

Hospital emergency departments do not consistently offer emergency contraception pills to sexual assault survivors, according to a study published in the June 2002 issue of the *Annals of Emergency Medicine*. The study, which analyzed seven years of data from the National Hospital Ambulatory Medical Care Survey, found that between 1992 and 1998, only 20 percent of sexual assault survivors received emergency contraception at the time of treatment at a hospital emergency department.[3] This percentage represents less than half of the 45 percent of patients who would have been eligible to use emergency contraception because they were not infertile, using contraception or already pregnant.

The failure of many hospitals to routinely counsel sexual assault survivors about pregnancy prevention and offer emergency contraception has also been documented in studies conducted in several states and in national studies focusing on policies at subgroups of hospitals.[4]

Emergency contraception is a safe and extremely effective FDA-approved method of preventing pregnancy following unprotected intercourse when administered in a timely manner.[5] The FDA has approved two products to be prescribed solely for emergency contraceptive purposes as well as approving the use of ordinary birth control pills, which are taken in high concentrations.[6]

Emergency contraception is most effective when taken within 12 hours of unprotected intercourse, with effectiveness decreasing as time passes[7] and an outside limit of effectiveness now calculated at five days following intercourse.[8] The sooner the medication is administered to a sexual assault survivor, the greater the odds that pregnancy can be prevented. Timely provision of emergency contraception to sexual assault survivors by emergency departments is especially important because rape victims sometimes do not reach a hospital until hours or even days after an assault.

Instead of needing to take emergency contraception in two separate doses twelve hours apart, new research has demonstrated that both doses of one type of emergency contraception (levonorgestrel) can be provided at once.[9] As a result, hospital emergency room personnel can accomplish the complete administration of emergency contraception while treating a rape survivor.

Emergency contraception has no effect on an established pregnancy, and cannot dislodge an implanted embryo.[10] When the use of emergency contraception was approved by the FDA, the agency stated, "The scientific and medical definition of abortion is after implantation. These birth control pills are used to prevent pregnancy, not stop it. This is not abortion." [11]

Timely access to emergency contraception would decrease the number of pregnancies experienced by survivors of sexual assault and the need for these patients to confront decisions about abortion. A study conducted by the Alan Guttmacher Institute concluded that increased access to emergency contraception prevented an estimated 51,000 pregnancies that would have ended in abortion in 2000.[12]

Offering emergency contraception to sexual assault survivors at risk of pregnancy is the accepted standard of care.[13] [14] Many, but not all, medical organizations have policies that explicitly recognize this standard of care. An editorial in the June 2002 *Annals of Emergency Medicine* concluded that emergency contraception options should be offered to all female patients following sexual assault as a routine standard of care.[15]

Efforts to ensure the offering of emergency contraception to at-risk rape victims by hospital emergency departments are separate and distinct from national efforts (including that supported by the APHA) to make emergency contraception available over the counter[16] and from the initiatives in several states to make the medication more available "behind the counter," through direct pharmacist dispensing under an arrangement with a physician.[17] While some rape victims who do not go to emergency departments will benefit from improved access to emergency contraception at neighborhood pharmacies, those victims who are receiving hospital treatment should not be expected to leave the hospital and, in an injured and traumatized state, fill a prescription at a pharmacy.[18] Many communities do not have 24-hour pharmacies and some pharmacies do not stock the medication.[19]

Despite emergency contraception's proven effectiveness in preventing pregnancy after unprotected intercourse, few states have taken action to adopt laws or administrative policies that ensure sexual assault survivors are offered emergency contraception at the time of treatment in a hospital emergency department. As of June of 2003, only three states (Washington, California and New Mexico) had enacted laws that require all emergency departments to offer EC to survivors of sexual assault. In Illinois, state law requires hospitals to tell sexual assault survivors about emergency contraception, but there is no requirement that it be provided.[20]

In New York, the state Department of Health issued protocols in June 2002 requiring hospitals to counsel sexual assault survivors about pregnancy prophylaxis, but stopping short of absolutely mandating on-site provision of emergency contraception.[21]

Although the New York protocols have improved care for sexual assault survivors, the failure to require the immediate provision of emergency contraception has meant that 24 hospitals in 16 counties across the state still do not have policies of providing emergency contraception on site, according to a survey conducted by the New York State Coalition Against Sexual Assault and Family Planning Advocates of New York State. Some of these hospitals send patients to other hospitals or to family planning clinics and doctors offices that are not open 24 hours a day. Other emergency departments give patients a prescription that must be filled at an outside pharmacy, even though such pharmacies are not located nearby the hospital and may not be open 24 hours a day. These hospitals treat a combined total of up to 1,000 sexual assault survivors annually, sending vulnerable crime victims away without offering them the immediate means to prevent pregnancy.[22]

On the federal level, legislation was introduced in Congress in 2002 to require hospitals, as a condition of receiving federal funds, to offer emergency contraception to sexual assault survivors.[23] The legislation's sponsor was not re-elected and the bill has not been re-introduced in 2003.

The American Public Health Association reaffirms its longstanding position that access to the full range of reproductive health services is a fundamental right,[24] and its policy favoring the protection of consumer choice in health care and patients' right to give informed consent;[25] and therefore recommends that:

1. Congress and state legislatures should pass legislation requiring all hospitals that have emergency departments, without exception, to provide all sexual assault survivors who are at risk of pregnancy with accurate, unbiased information about emergency contraception and immediately dispense the medication to those who request it.

2. Professional medical associations and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) should strengthen or adopt policies that will uphold as the standard of care the provision of information about emergency contraception and on-site emergency department dispensing of such medication to all sexual assault survivors who are at risk of pregnancy and desire emergency contraception.

3. Hospitals and hospital associations should adopt policies to ensure that all sexual assault survivors treated in hospital emergency departments receive accurate, unbiased information about emergency contraception and are offered it on-site.

4. State hospital regulatory agencies should adopt standards requiring hospitals with emergency departments, without exception, to provide sexual assault survivors with accurate, unbiased information on emergency contraception and immediately provide the medication to those who are at risk of pregnancy and request emergency contraception.

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