Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms

This survey was conducted by Ibis Reproductive Health for Catholics for a Free Choice.

Ibis Reproductive Health

Ibis Reproductive Health, headquartered in Cambridge, Massachusetts, conducts original research including clinical and social science studies, disseminates relevant new and existing information to women and groups that serve them, and mentors others through internships and fellowships.

Ibis Reproductive Health
2 Brattle Square
Cambridge, MA 02138
617-349-0040 (Phone)
617-349-0029 (Fax)
Email: admin@ibisreproductivehealth.org
Web: www.ibisreproductivehealth.org

CFFC
CATHOLICS FOR A FREE CHOICE

Catholics for a Free Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well being, and respect and affirm the moral capacity of women and men to make sound decisions about their lives. Through discourse, education and advocacy, CFFC works in the United States and internationally to infuse these values into public policy, community life, feminist analysis, and Catholic social thinking and teaching.

Catholics for a Free Choice
1436 U Street, NW
Suite 301
Washington, DC 20009
202-986-6093 (Phone)
202-332-7995 (Fax)
Email: cffc@catholicsforchoice.org
Web: www.catholicsforchoice.org

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Executive Summary

At least 5 million times this year,[1] American women will need emergency contraception (EC), a hormonal contraceptive that reduces the chance of pregnancy if taken up to 72 hours after unprotected intercourse. If taken within 72 hours of unprotected intercourse, EC is 75 percent effective in preventing pregnancy. The latest research indicates that EC is most effective if taken early in the menstrual cycle, before ovulation. Whether because of a broken condom, a moment of passion, a calendar miscalculation or the tragedy of rape, women frequently find themselves needing a second chance to prevent a pregnancy. EC gives women that second chance.

Ten years ago, knowledge about EC was limited. Not only women, but doctors seemed unaware of its existence. Now, after widespread public education efforts, EC is much better known and more widely available. It is even the subject of state law and health regulation. Mandates that EC be provided to women who have been raped are increasing. While some gaps in service provision still exist, physicians, pharmacies and hospital emergency rooms are the most frequent sources of EC.

A potential obstacle to the provision of EC in hospital emergency rooms are ethical guidelines developed by the Catholic bishops that seek to ensure that the nation's 600 Catholic hospitals do not violate Catholic teaching—and Catholic teaching prohibits all contraception. Moreover, in spite of ample medical evidence to the contrary, the dominant view among the US bishops is that EC can work to cause an abortion and, therefore, must be forbidden in all circumstances.

A single exception has been developed in Catholic health care ethics. Directive 36 of the US bishops' *Ethical and Religious Directives for Catholic Health Care Services* (Directives)—a code of conduct for Catholic health care providers—addresses the possibility of using EC after rape as a way of permitting "A female who has been raped [to] defend herself against a potential conception from the sexual assault." Thus, the directive permits the use of EC when a woman "is the victim of sexual assault" **and**, "if, after appropriate testing there is no indication that she is pregnant." This guideline, while well intentioned, is complex and requires significant judgment calls on the part of Catholic hospital personnel, judgment calls that may be affected by the local bishop's political views as well as those of the hospital administration.

To find out about the availability of EC in Catholic hospital emergency rooms, Catholics for a Free Choice commissioned a survey of all US Catholic emergency rooms in late August 2002. Conducted by Ibis Reproductive Health, the survey focused on whether or not the emergency room provided EC at all and under what circumstances it was provided. If it did not provide EC, did it refer women to other providers who could provide it within the 72-hour period in which EC is most likely to be effective? Ibis staff telephoned 597 Catholic hospital emergency rooms (virtually all Catholic hospitals in the US). They asked questions of the triage nurse or whoever else answered the phone about the availability of EC in the emergency room, including whether or not the hospital referred for EC if it was not provided.

Only five percent of the emergency rooms provided EC on request. An additional 23% percent of Catholic emergency rooms provide EC to rape victims only. Thus, only 28% of Catholic ERs will provide women who have been raped with EC. Among those Catholic hospitals that do provide EC to rape victims, the majority set up unnecessary barriers, such as pregnancy tests or police reports. These hospitals also do not volunteer information over the phone, but admit to dispensing EC to rape victims only after repeated questioning, which could deter some victims. Some hospitals (6%) indicated that the decision about providing EC was left to the attending physician. Presumably, with good luck, a woman who had been raped might be seen by an attending physician who would provide EC, but there were no guarantees.

Fifty-five percent of the hospital emergency rooms would not dispense EC under any circumstances and 11% of the respondents were unsure if it is provided at the hospitals where they work or were non-responsive, even after repeated questioning.

Only half of those hospitals that do not provide EC give referrals. More important than whether a referral was given was whether it was effective. In other words, did the referral lead the woman to a place that actually provided EC within the 72–hour timeframe it is most effective (Table 5, page 21) When study staff followed up on the referrals, almost two-thirds (64%) proved to be dead ends, a tragic result not only for women who have been raped, but also for all women looking for that second chance to prevent a pregnancy.

For many, the hallmark of a Catholic hospital is the fact that compassion and kindness are part of the core mission of the hospital and study staff praised some respondents for their kindness, responsiveness and concern. Only eight percent were evasive, hostile or suspicious. Some were uninformed and provide incorrect information about EC, evidencing the extent to which the Catholic directive limiting EC is itself confusing. Comments included:

"Go look in the Yellow Pages under abortion."

"I don't know if EC is legalized yet."

"Any hospital starting with "Saint" won't help you out."

Given the high number of Catholic hospitals that are not providing EC and not giving women meaningful referrals for EC and the trend toward state laws mandating EC provision or referral for women who have been raped, some Catholic hospital emergency rooms are likely on a collision course with the law.

Three states, Washington, Illinois, and California (effective January 2003) require by law that rape survivors be counseled about or offered EC in all emergency rooms; six other states (Florida, Kentucky, Connecticut, Ohio, Maryland and New York) require or encourage the dispensation of EC to rape victims through mechanisms other than a direct mandate through the law.

Follow-up studies will need to be done to determine if Catholic hospitals will be willing to follow medical protocol and state laws and responsibly tend to the health of some of their most vulnerable patients.

Report highlights:

- Only 5 percent will provide it upon request
- 23 percent will dispense only to rape survivors—but with some restrictions
- 6 percent will provide EC at the discretion of the attending physicians
- 11 percent of hospitals either didn't respond or claimed not to know if they dispensed EC
- In at least two states – Washington and Illinois – some Catholic hospitals may be breaking the law by not providing EC or an effective referral to rape victims
- Of those hospitals that refuse to dispense EC, 53 % refused to provide a referral. Of those hospitals that provided a referral, 64 % of the referrals were not effective.

[1] Ellertson, C., J. Koenig, J. Trussell, and J. Bull, "How many US women need emergency contraception?" *Contemporary OB/GYN*, October, 1997, 103-128.

Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms

A National Study by Ibis Reproductive Health For Catholics for a Free Choice

Introduction

Why Emergency Contraception is Important

At least five million times this year,[1] American women will need emergency contraception (EC), a hormonal contraceptive that reduces the chance of pregnancy if taken up to 72 hours after unprotected intercourse. Whether because of a broken condom, an unplanned moment of passion, a calendar miscalculation or the tragedy of rape, women frequently find themselves needing a second chance to prevent pregnancy. When they do, they might well turn to the emergency room of their local hospital, especially during off hours. After all, most women do not have private physicians on call around the clock, and emergency contraception is not yet available over the counter in the United States. Since the therapy prevents pregnancy more effectively the sooner it is taken after unprotected intercourse,[2] women might not be able to wait until the next available appointment at their local family planning clinics.

Americans going to an emergency room expect to be offered the latest options in modern medicine. They expect that medical decisions will not be governed by religious beliefs, such as those of the Christian Science faith prohibiting medical intervention, of the Jehovah's Witnesses prohibiting blood transfusions or those of the Catholic church regarding reproductive health. What happens if the local Catholic hospital emergency room decides to ignore medical guidance from trusted authorities such as the American Medical Association, the American College of Obstetrician/Gynecologists, and the United States Food and Drug Administration,[3] and instead imposes a religious restriction on the provision of emergency contraception?

Hospitals Surveyed on EC Availability

To measure the extent of the problem, we undertook a survey of all Catholic hospital emergency rooms in late August 2002. We wanted to know if emergency contraception was offered and under what circumstances. The survey also assessed the potential experience of the particular subset of women who need EC because they have been raped. Statistics from the Federal Bureau of Investigation show that over 90,000 forcible rapes occurred in 2001, a rate of 62.2 per 100,000 women.[4] Not only do these women have a particularly compelling need for the therapy, but in several states the law actually singles them out, requiring that they be offered prescriptions or referrals for EC in hospitals.

A 1998 study by Catholics for a Free Choice (CFFC) contacted all 589 Catholic hospital emergency rooms in the United States and found that only 10% offered EC to women who have been raped.[5] The 1998 study prompted a media blitz that was broadly critical of Catholic hospitals and their implied attempt to substitute theology for standard medical care. In responding to the study, Catholic health officials sought to assure the public that Catholic hospitals do provide women who have been raped with compassionate care, but never provided counter data on whether and when its hospitals provided EC. The August 2002 study found that 28% of Catholic hospital emergency rooms offer EC to women who have been raped. That is 23% for rape victims only and five percent upon request. The current study also included significant detail on referrals for EC among those hospitals that do not offer it themselves.

Catholic Hospitals—the Big Picture

Catholic hospitals provide a substantial portion of all hospital care in the United States, with one in five people in the US receiving care in a Catholic hospital. Of all hospitals that take emergency patients, 13% are Catholic. Of the roughly 107 million emergency room visits in the United States in 2000, 15% were seen at Catholic hospitals.[6] Figure 1 (page 17) shows the extent of Catholic emergency care in each state. Most states lie above the diagonal line, which means that Catholic hospitals in those states provide more than their share of emergency care, given the fraction of hospitals that are Catholic. Wisconsin has the highest proportion of Catholic care, with fully 41% of emergency patients seen at Catholic hospitals. In ten other states, over a quarter of the emergency caseload is handled at Catholic hospitals (MO, IA, IL, KS, MI, SD, AK, MT, OR, and WA.) So access to EC in Catholic emergency rooms is a substantial issue nationwide, and a particularly critical problem in certain states, given the number of Catholic emergency rooms that do not provide it.

State Laws and Regulations

Because the nation's medical authorities have established EC as a standard and appropriate medical care, all emergency rooms at a minimum should offer EC to rape survivors. Yet several national and state-level studies have shown that rape victims are often denied information or prescriptions for EC, even at secular hospitals.[7]

To remedy this, there is a trend toward state law and regulation mandating the provision of or referral for EC. Three states have passed legislation mandating that rape survivors must be provided with information about EC when they arrive in any hospital emergency room. Table 1 (page 18) gives the relevant excerpts of these laws from Illinois, Washington and California.[8]

Six other states require or encourage emergency rooms to dispense EC to rape victims through mechanisms other than a direct mandate through the law. These arrangements are discussed later in this report.

Three states allow pharmacists to dispense EC to anyone who requests it and for whom it is not contraindicated. Washington, California and Alaska each take advantage of their states' collaborative drug therapy agreements that allow pharmacists to work under an umbrella prescription from a licensed prescriber.

Catholic Directives

A major obstacle to the provision of EC in Catholic hospitals has been the *Ethical and Religious Directives for Catholic Health Care Services*. The *Directives*, as they are frequently called, were developed by the US bishops in consultation with the Vatican and their implementation is required in all health facilities that are affiliated with the Catholic church. These *Directives* include specific instructions on various medical issues that directly intersect with Catholic teaching, such as abortion and euthanasia. The *Directives* absolutely prohibit the provision of direct abortion and voluntary contraceptive sterilization in Catholic hospitals. Regarding contraception, the *Directives* say that the church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[9]

Over the last decade, as emergency contraception became a standard of treatment for rape victims and public knowledge of its availability increased, Catholic ethicists, health care providers and bishops attempted to reconcile the prohibition on contraception and abortion with a growing demand within the Catholic health and social service community for a compassionate response to women who have been raped. Hardliners within the Catholic community held that since one mode of operation of emergency contraception was the prevention of the implantation of a fertilized ovum, it must be considered an abortifacient and prohibited in all circumstances. For these Catholics, the medical definition of pregnancy, implantation of a fertilized ovum, was irrelevant; as was the medical definition of abortion, the expulsion of an established pregnancy. Pregnancy for these Catholics was fertilization – and anything that expelled a fertilized ovum, which they viewed as a person, was abortion. But Catholic authorities and experts did know that emergency contraception also acted to prevent fertilization, an act that would be contraception not abortion. While even contraception is forbidden by the church, it has been considered acceptable for women who have been raped to "defend" themselves against the rapist by seeking to prevent that part of the rapist's body that has invaded them—his semen, sperm and DNA—from fertilizing her ovum. Thus developed Directive 36:

> "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, offer the person psychological and spiritual support and accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."

Implementing Directive 36

This Directive is, at best, confusing and ambiguous. Catholic ethicists within hospital systems as well as in the academic community are not in agreement regarding the implementation of the Directive. Each Catholic hospital is free to interpret the Directive and implement either a liberal or a conservative policy. That process is subject to theo-political pressure, most often from conservative bishops and lay Catholic groups demanding strict application of Catholic teachings in Catholic hospitals. Since rape is not an acceptable reason for abortion, they say, it should not be an acceptable reason for contraception.

Some aspects of the Directive are meaningless. For example, the Directive suggests a pregnancy test for each rape victim. This approach is useless at best. EC must be given within 72 hours of intercourse, far too early for a pregnancy to establish itself fully or for any test to identify a pregnancy. A pregnancy test can only tell if a woman was already pregnant before the assault. EC does not affect existing pregnancies,[10] so even if a woman was unknowingly pregnant, the EC would not cause an abortion. Either way, the pregnancy test satisfies neither medical need nor Catholic teaching.[11] It only erects a barrier between the rape victim and protection from pregnancy. For this reason, this study details whether Catholic emergency rooms require pregnancy tests of rape survivors.

Very conservative Catholic ethicists suggest that the Directives require more than a pregnancy test. Rev. Kevin O'Rourke, director of the Center for Health Care Ethics at St. Louis University, has interpreted the Directive to mean that Catholic hospitals should administer *ovulation* tests to rape victims before giving EC. In his view, if the ovulation test and the date of the woman's last period suggest that she has not yet ovulated, then the EC may delay ovulation and avert a pregnancy, a process consistent with Catholic doctrine. If the woman is currently ovulating, he recommends that EC not be given.[12] This is unworkable for two reasons. First, ovulation tests cannot pinpoint the moment of ovulation as accurately

as O'Rourke requires. Second, an ovulating woman is *most* at risk of pregnancy and in need of EC. To deny a woman EC because she is ovulating is to defeat the reason for giving EC to begin with. Again, the ovulation test would constitute a useless exercise for rape survivors.

Only a small percentage of Catholic hospitals have managed to jump the hurdles presented by the Directive on emergency contraception and actually offer EC in a meaningful way to women who have been raped. Of the 23% of Catholic hospital emergency rooms that offer EC to rape survivors, only three percent offer it without restriction. The others require pregnancy tests (13%) or that the rape be reported to the police (.5%). Seven percent of those responding that they do provide EC to rape survivors did not know what the requirements were in their emergency rooms. Most significantly, the study shows that 66% of Catholic hospital emergency rooms do not provide EC to rape survivors at all or have policies that are sufficiently unclear as to make provision of EC unlikely.

Directive 36 addresses EC only in the context of rape victims. The implication is that EC is never acceptable under any other circumstances, which cuts off the much larger population of women who need EC in cases of failed or forgotten contraception. This approach is contradictory and self-defeating even by Catholic standards. As more scientific information about how EC works becomes available, it appears that even by Catholic definitions of pregnancy (fertilization, not implantation), EC is a contraceptive. The latest research examines whether emergency contraception works better depending on when in the cycle the woman takes it. Research shows that it is most effective when women use it early in the cycle, before they have ovulated. The treatment seems to be far less effective when women take it later in the cycle, close to or after the day of ovulation. This timing suggests that the pills might work mainly by suppressing or delaying ovulation.

This would be good news for all Catholic health care institutions and for all women who need EC. It should lead to a revision of the *Directives* that would permit the use of EC not only for rape survivors, but for all women at risk of pregnancy. For women who have been raped, it would mean that Catholic hospitals would be a true place of compassionate and understanding care; for all others it would provide an opportunity to prevent abortion. If EC were generally available and used by women who had not used contraception or whose contraceptive had failed, it would reduce the demand for abortion by 60%[13] simply by averting conceptions to begin with, an outcome that would surely be attractive to Catholic health care providers. The present policy in Catholic emergency rooms which severely restricts EC even for women who have been raped actually increases abortion rates.

Methodology

During August 23-25, 2002, study staff telephoned each of the nation's 597 Catholic hospital emergency rooms. The list of hospitals was compiled from two diocesan hospital lists provided by Catholics for a Free Choice. Due to numerous hospital mergers between 1998 and 2002, the list included some duplicates and non-Catholic hospitals, which were removed. No hospitals were listed in Vermont, Utah, or Wyoming. Because this is as close as possible to a census of Catholic hospitals, no tests of statistical significance are required on the results.

Trained interviewers followed a script (available upon request) and strict recording on pre-coded forms. The questionnaires were tested in pre-pilot (n=5) and pilot (n=20) studies of non-Catholic hospitals. All interviewers were trained female staff, aged in their mid-twenties to mid-thirties. At least three attempts were made to reach every hospital.

By conducting the survey over a weekend, we approximated the experience of a woman who has had unprotected intercourse on a Thursday evening. Because most health clinics close on weekends, weekend hours might best represent the time women would most likely seek EC in the emergency room.

Interviewers asked questions of the triage nurse or whoever else answered the telephone, just as would be the case for a woman actually seeking EC. For this reason, these results reflect the true availability of EC in emergency rooms, which may be quite different from official hospital policy regarding EC.

This study used a "mystery client" format in which callers inquired about EC, as any woman would, not as part of an official study. They never directly claimed to require EC themselves or to have been raped, but asked general questions such as "Do you give out emergency contraception?" and "So even for women who have been raped you don't give it out?" If respondents directly asked whether the caller had been raped, callers responded with "I would rather not talk about it." No calls were taped, no names were taken, and no individuals are identified in this report.

The survey required interviewers to repeat or rephrase questions in cases of ambiguous responses regarding EC dispersal. After several non-committal responses, interviewers tallied their answers as "no response." Cases in which the respondent said specifically that (s)he could not answer the information over the phone were also tallied in the "no response" category.

Researchers entered and analyzed data using standard statistical software, and all data entry was checked twice for accuracy.

Results

Provision of EC

Table 1 (page 18) shows that 55% of respondents would not dispense EC under any circumstances, which many justified in terms of Catholic teaching. These direct quotes from respondents include some of the more forceful or colorful denials of EC:

"Any hospital starting with 'Saint' won't help you out."

"No Catholic hospital will ever do that. They don't take rape cases."

"Honey, this is a Catholic hospital, you couldn't even come close here."

"Any doctor here absolutely won't because it's a Catholic hospital."

"We're pro-life and all that."

In some cases, however, the respondent expressed regret or apology over the restrictive Catholic policy.

Fully 11% of others, did not know, were unclear or nonresponsive, perhaps reflecting the confusion over Directive 36. Only five percent of respondents would provide EC on request, and another six percent leave it to the discretion of the emergency room doctor who would treat the patient.

Twenty-three percent of respondents report that they dispense EC to rape survivors, but most of those impose unnecessary restrictions. The woman must often prove that she is not pregnant—a useless exercise as discussed above—or must report her situation to the police—an administrative and criminal issue that should not affect provision of EC. In many cases, emergency room staff do not know whether a pregnancy test is necessary, again reflecting general confusion on policy.

Table 5 (page 21) breaks down these results by region of the country.[14] The southern states have the highest proportion of emergency rooms refusing to give out EC at all (66%), and the midwestern states have the highest proportion of unclear answers (16%). Although the numbers are small, the western region has the highest proportion of emergency rooms willing to dispense EC on request (eight percent).

Catholic Hospital Compliance with State EC Regulation

At the time of our fieldwork, eight states regulated EC in the emergency room in some way. Washington state law specifically requires emergency rooms to dispense EC to rape victims, yet only three Catholic emergency rooms out of 18 in the state are clearly abiding the law. Two dispense EC on request, and one dispenses for rape survivors without any other restrictions. Seven more do dispense to rape survivors, but they require pregnancy tests or are unclear about this requirement. Six do not dispense at all, in apparent violation of state law.

Illinois requires emergency rooms to inform rape victims about EC and give referrals on request. The California law requires both information and provision, but was passed two weeks after this study was conducted. It goes into effect January 2003. If practice does not change in the case of Catholic hospitals we surveyed, California will be out of compliance with the law. Out of the 50 Catholic emergency rooms in that state, 22 never dispense it, and 23 only in cases of rape. These hospitals are not strictly breaking the law, which only requires information, not provision of EC.

The results are similar for the six states with less strict regulations than in Washington and Illinois. In Florida, state law strongly implies that EC must be given to rape victims in emergency rooms. Five of the eight respondents at Catholic hospitals in Florida refuse to dispense EC under any circumstances. In Kentucky and Connecticut, emergency rooms are required to follow state medical protocols that encourage the provision of EC to rape victims, but three-quarters of respondents in Kentucky and half in Connecticut never dispense EC. In Ohio, hospitals that do not provide EC to rape victims are not reimbursed for the cost of treating those women. Yet 10 out of 26 respondents in Ohio would never dispense EC. This study did not investigate costs and payments, but these 10 hospitals should not be reimbursed from the state victim compensation fund. The Maryland provision is less strict, suggesting rather than requiring that EC be offered in order to be reimbursed from the state fund. This suggestion appears to be ignored by five of the seven Catholic hospital emergency rooms in the state, which do not provide EC under any circumstances. In New York, where Department of Health guidelines require a discussion of EC with rape victims, fully 18 out of 39 respondents would never dispense EC. Eight hospitals provide referrals. Thus, the remaining 10 hospitals who are not providing or referring are in violation of DOH guidelines.

Referrals

Are referrals available at the 328 Catholic emergency rooms that do not provide EC at all? Table 4 (page 20) shows that fewer than half of respondents at these hospitals named a place where EC could be obtained. The proportion is highest in the Midwest and Northeast and lower in the West and South. A few respondents misunderstood the legal status of EC, as shown by these responses to requests for referrals:

"As far as I know, no ER gives them out."

"I don't know if EC is legalized yet."

In Illinois, emergency rooms are required by law to refer rape victims to a source of EC. Of the 22 Illinois respondents that said their hospitals would not provide EC in cases of rape, only six made referrals. This leaves 16 Illinois Catholic hospitals in apparent violation of state law.

Respondents most commonly referred callers to other hospitals (Table 5, page 21). In the Northeast, over 90% of referrals were to other hospitals. In the southern states only about half were to other hospitals and almost a third were to rape hotlines. Fifteen respondents directed callers to other places such as pregnancy hotlines, public health departments, or in one case, the personal phone number of an on-call physician.

The results for Washington, California, and Alaska are of interest because some pharmacists in those states can dispense EC without a prescription, so callers could be referred to any nearby participating pharmacy with a minimum of inconvenience. Of the four referrals in Washington, two were to hospitals and the two classified as "other" were in fact to pharmacies. In one of these pharmacy referrals, the respondent said, "Those are actually sold over the counter at any pharmacy." This reflects a rare awareness of the pharmacy program, at least in this dataset, but it is not entirely correct because not all pharmacies dispense EC. The other pharmacy referral in Washington was to a specific pharmacy near the hospital. In California, 31 respondents would never dispense EC, and only 10 of those gave referrals, none of which were to pharmacies. The single Alaskan respondent who would not dispense EC under any circumstances also would not give a referral. This suggests that the pharmacy program is better understood by Catholic emergency room personnel in Washington than in California and Alaska, perhaps reflecting the age of the pharmacy program in each state.

Respondents in the six states with other regulations regarding EC for rape victims also did not often provide referrals. In Florida, only one of the five respondents who would not dispense EC under any circumstances was willing to give a referral. In Kentucky, half gave referrals, and in Connecticut none. Four out of 10 gave referrals in Ohio, 3 out of 5 in Maryland, and 8 out of 18 in New York. Again, the various types of regulations in these states have not compelled Catholic hospitals to fully provide or refer for EC.

The Effectiveness of Referrals

More important than whether a referral was given is whether it worked. Did it lead to a place that actually provides EC (Table 6, page 21)? When referrals were followed up, fully 64% proved to be dead ends, leading to wrong numbers, clinics closed on weekends, or places that did not offer EC or referrals for it. These would not have resulted in the caller obtaining EC by the end of the 72-hour period. About a third of referrals led to EC directly, and six percent resulted in access to EC after another referral or two. Referrals in the southern states were the least effective, with almost 80% proving to be dead ends. The western region had the highest proportion of directly effective referrals (42%). In Illinois, two of the six referrals were dead ends, in violation of state law. In Washington, the two referrals to hospitals were dead ends, and the referral to a specific drug store was directly effective. The one remaining referral to "any pharmacy" was not followed up because it is impossible to know which pharmacy a caller would turn to. This general referral would work best for women living in areas of the state with a high proportion of pharmacists participating in the EC program.

Finally, Table 7 (page 22) shows that referrals to rape hotlines, clinics, or other places were much less likely to work than referrals to other hospitals.

Treatment of Callers

Several respondents were praised by project staff for their kindness, responsiveness, and concern. On the whole, 65% of respondents had efficient and helpful attitudes (Table 8, page 22). An additional 12% were helpful but brusque. Only eight percent were evasive, suspicious, or hostile.

Some of the unsupportive and judgmental comments include:

"Go look in the Yellow Pages under abortion."

"Who are you? This is a Catholic hospital." (repeated twice in a harsh tone)

"This is a Catholic hospital." (in answer to every question)

"We frown upon that."

"You can try some of the other ERs, but this hour of the night I can honestly tell you, you won't find any place." (regarding rape)

A handful of respondents displayed misconceptions about EC:

"You can't be pregnant and take it because it's dangerous. It's a strong medicine."

"We don't give out any information on abortion."

"Oh, is *that* what the morning after pill is for?"

"There's a 24-hour time frame for that."

"Emergency *what*?" (repeated twice)

Yet several others told callers to take birth control pills in the correct higher dosage, indicating a good knowledge of the method and willingness to inform women about it.

Staff at emergency rooms that offer EC only in cases of rape were generally reluctant to discuss this option with callers. In response to an initial inquiry about EC, fully 76% of respondents said they do not provide EC. Only after up to four additional specific questions about rape and other conditions did they revise their answers. Of the 23% that provide EC in cases of rape, virtually all first told callers that EC was not available at all.

Over half of callers were placed on hold at least once, 18% twice or more. Thirty-one percent of callers were transferred once, and five percent were transferred twice. Occasionally, initial respondents gave different responses than a doctor or supervisor who later joined the conversation.

Summary

Among those Catholic hospitals that do provide EC to rape victims, the majority require unnecessary hurdles such as pregnancy tests or police reports. These hospitals also do not volunteer information over the phone, but admit to dispensing EC to rape victims only after repeated questioning. Only half give referrals for EC, and only one third of those referrals actually work. This problem will worsen as Catholic hospitals continue to merge with non-Catholic hospitals, restricting reproductive health care at secular health networks.

This study also finds that Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services*, revised as recently as 2001, has not clarified the confusion about EC among emergency room personnel at Catholic hospitals. Fully 11% did not know, refused to answer, or were unclear

whether to provide EC, and many openly expressed ignorance or confusion. Some Catholic thinkers interpret Directive 36 to mean that EC is acceptable for rape victims without a pregnancy test. If these voices can clarify the confusion among Catholic hospitals, the situation may improve.

The new laws in three states—Washington, Illinois, and California—that require rape survivors to be counseled about or offered EC in all emergency rooms constitute a good start. The Washington and Illinois laws went into effect before our fieldwork, but it is not possible to show with this data whether they actually improved access to EC. Nevertheless it can be shown that in both states several hospitals maybe in violation of state law. Six other states (Florida, Kentucky, Connecticut, Ohio, Maryland and New York) require or encourage the dispensation of EC to rape victims through mechanisms other than a direct mandate through the law.

Only with future follow-up studies can we determine if Catholic hospitals in these states are willing to follow medical protocol and state law, and responsibly tend to the health of some of their most vulnerable patients.

Conclusion

The provision of emergency contraception, especially to women who have been raped has become a standard of medical care. It is endorsed by the country's leading medical associations, such as the American Medical Association, the American College of Obstetricians and Gynecologists and by the US Centers for Disease Control. All health care institutions that counsel or treat women who have been raped should inform, provide or meaningfully refer women for emergency contraception. State legislatures and health authorities are beginning to require that emergency contraception be offered to women who have been raped; an effort to make the provision of EC a federal standard has been introduced in the US Congress. This is encouraging as these laws are an important advance in ensuring women's health and well being.

The Ibis Reproductive Health survey demonstrates that Catholic hospital emergency rooms are, for the most part, not informing women about, providing, or referring women who have been raped for EC. Moreover, many of these hospitals as well as their trade association, the Catholic Health Association, claim that they either cannot provide EC to women who have been raped or can only do so under very limited and restricted circumstances. They seek exemptions from laws that require the provision of or referral for EC, claiming their conscience or religious freedom would be violated if they were required to follow the law.

Hospitals, we believe, are community assets, health care a public trust, and moral decision-making the right of individuals, including women. A Catholic hospital that does not put the conscience and religious freedom of individuals first is not living up to its claim that it provides "compassionate and understanding care…to a person who has is the victim of sexual assault." If this is not understood by Catholic health care providers, then it is essential that 'the laws' serve to protect the religious freedom, conscience and health of women.

Endnotes

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2 Ellertson C., K. Blanchard, A. Webb, A. Bigrigg, and S. Haskell, "Emergency contraception," *Lancet*, Oct 31, 1998, 352(9138): 1477.

3 American Medical Association, Access to emergency contraception, "Policy of the House of Delegates, H-75, 985; American College of Obstetricians and Gynecologists, 1996, "ACOG practice pattern number 3; Emergency oral contraception," Washington, DC, ACOG; and Food and Drug Administration, 1997, "Prescription drug products: Certain combined oral contraceptives for use as postcoital emergency contraception," *Federal Register*, 62 (37): 8610-8612.

4 Federal Bureau of Investigation, "Crime in the United States 2001: Uniform Crime reports," US Department of Justice, US Government Printing Office, Washington, DC, online: http://www.fbi.gov/ucr/01cius.htm

5 Catholics for a Free Choice, "Caution: Catholic Health Restrictions May be Hazardous to Your Health," Washington, DC, 1999.

6 American Hospital Association, Annual Survey of Hospitals, 2002, American Hospital Association and Health Forum, data supplied to authors.

7 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*, 2002, 39(6), 631-638; Clara Bell Duvall Education Fund; "Study Update: Emergency Contraception services for rape victims in Pennsylvania hospitals," online, http://www.aclupa.org/duvall/ecupdate.html; 2002, NARAL/NY Foundation; "Preventing pregnancy after rape: Does your hospital provide EC to rape survivors?" New York, NARAL, 1999; Smugar, S., B. Spina, and J. Merz, "Informed consent for emergency contraception: Variability in hospital care of rape victims," *American Journal of Public Health*, 2002 90 (9): 1372-6.

8 A similar bill, the "Compassionate Care for Female Sexual Assualt Survivors Act," was introduced in the US House of Representatives in April 2002 by Rep. Constance Morella (MD). It would have required all hospitals that receive federal funds to describe and provide EC to all rape vicitms at that hospital. Rep. Morella lost her re-election bid in November 2002, and the fate of the bill is uncertain.

9 Pope Paul VI, Encyclical Letter, On the Regulation of Birth (Humanae Vitae); (Washington, DC: United States Catholic Conference, 1968), no. 14.

10 Grimes, D., and E. Raymond, "Emergency contraception," *Annals of Internal Medicine*, 2002, 137(3): 180-9.

11 Bucar, L, and D. Nolan, "Emergency contraception and Catholic hospitals," *Conscience*, 1999, 20(1): 20-2.

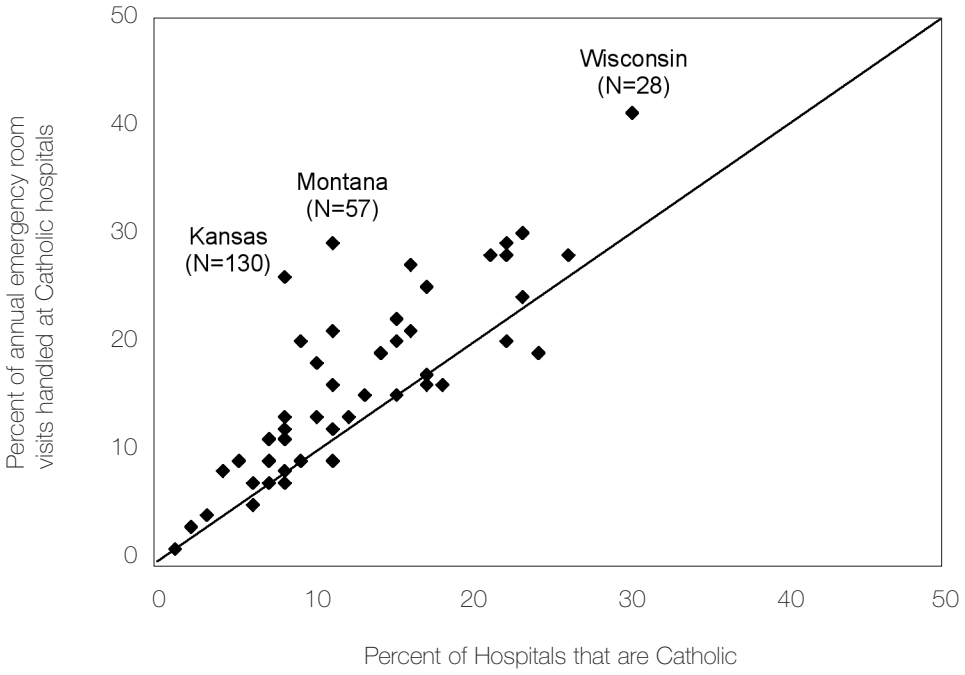
12 O'Rourke, K., "Applying the Directives: The Ethical and Religious Directives concerning three medical situations require some elucidation," *Health Progress*, 1998, 79(4): 64-69.

13 Grossman, R., "Emergency contraceptive pills can prevent abortion," *American Journal of Public Health*, 91(7): 1137.

14 The regions are defined as:

Northeast	Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, and Pennsylvania.
South	Alabama, Arizona, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.
West	Alaska, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington.

Figure 1:
Percent of Hospitals that are Catholic and Percent of Annual Emergency Room Visits Handled at Catholic Hospitals, by State



Source: American Hospital Association (note 9). See appendix for individual state results.

Table 1:
State Laws on Providing EC to Rape Survivors in Emergency Rooms

Illinois
§ 410 ILCS 70/2.2.
"Every hospital providing services to alleged sexual assault survivors . . . must develop a protocol that ensures that each survivor of sexual assault will receive medically and factually accurate and written and oral information about emergency contraception; the indications and counter-indications and risks associated with the use of emergency contraception; and a description of how and when victims may be provided emergency contraception upon the written order of a physician licensed to practice medicine in all its branches."

Washington
§ RCW 70.41.350
"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."

California
§ Section 13823.11 of the Penal Code
"The minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault . . . include all of the following . . . (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."

Florida
Statute § 395.1021 states that "any licensed facility which provides emergency room services shall arrange for the rendering of appropriate medical attention and treatment of victims of sexual assault through … such gynecological, psychological, and medical services as are needed by the victim." Every medical authority in the United States agrees that describing and offering EC is necessary after sexual assault, so EC should certainly be provided in Florida emergency rooms.

Kentucky & Connecticut
The Departments of Health in these two states require that all victims of sexual assault be treated according to specific guidelines that are drawn up by another state agency. In Kentucky, the protocol states that all sexual assault victims must be provided with: information regarding follow-up procedures and appointments concerning … pregnancy."
In Connecticut, the protocol states, "the medical care and treatment of sexual assault victims should be consistent with current professional guidelines and accepted medical standards." Again, EC is standard and appropriate follow-up for the risk of pregnancy after sexual assault so emergency rooms should provide it in these two states.

Ohio & Maryland
This mechanism works indirectly through financial arrangements. Most states have crime victim compensation funds that reimburse hospitals for the cost of treating and collecting forensic evidence from sexual assault victims. In Ohio, statute § 2907.28 mandates that hospitals follow a standard protocol in order to be reimbursed from the state fund. The "Protocol for Sexual Assault and Medical Examination" requires unambiguously that sexual assault victims must be provided with or referred for EC within 72 hours of the assault. So hospitals are financially compelled to provide EC in Ohio. Maryland has a similar arrangement through the victims' compensation fund, but the protocols state that EC "may" be discussed with sexual assault victims. The Maryland Department of Health is currently reviewing this language and may change the verb to "shall." When the fieldwork for this study was carried out, hospitals in Maryland were not required to offer EC but were recommended to do so.

New York
In May 2002, the New York State Department of Health issued its "Protocols for the Acute Care of the Adult Patient Reporting Sexual Assault." It requires that rape victims are informed about EC and referred for it if the provider is unable to dispense it: "Examiners are expected to adhere to and fully document services provided,consistent with the following standards of professional practice:

- Counsel female patients about options for prophylaxis against pregnancy … (also known as emergency contraception or "morning after" pill) and the importance of timely action.
- Ensure that female patients are properly informed of the effectiveness rates, risks, and benefits associated with interventions to prevent pregnancy resulting from sexual assault.
- Provide female patients with appropriate information to make an informed choice regarding prophylaxis against pregnancy resulting from sexual assault, and ensure that such services are provided or made available to the patient without delay."

Thus all rape victims in New York should be provided with or referred for EC.

Table 2:
Number and Percent of Respondents Willing to Provide EC, by Circumstances

	Total
N	597
Never	328 55%
No response / don't know / unclear	67 11%
On request	30 5%
Doctor's discretion	33 6%
Only if not pregnant	3 .5%
Only for rape, total	136 23%
Rape alone	16 3%
Rape and not pregnant	77 13%
Rape, don't know about pregnancy requirement	40 7%
Rape and report to police	3 .5%

Table 3:
Number and Percent of Respondents Willing to Provide EC, by Circumstances and Region of the Country

		Region			
	Total	Northeast	South	Midwest	West
N	597	109	91	241	156
Never	328 55%	63 58%	60 66%	117 49%	88 56%
No response / don't know / unclear	67 11%	14 13%	3 3%	38 16%	12 8%
On request	30 5%	1 1%	4 4%	12 5%	13 8%
Doctor's discretion	33 6%	7 6%	5 5%	16 6%	5 3%
Only if not pregnant	3 .5%	2 2%		1 .4%	
Only for rape, total	136 23%	22 20%	19 21%	57 24%	38 24%
Rape alone	16 3%	2 2%	3 3%	7 3%	4 3%
Rape and not pregnant	77 13%	16 15%	7 8%	31 13%	23 15%
Rape, don't know about pregnancy requirement	40 7%	4 4%	8 9%	18 7%	10 6%
Rape and report to police	3 .5%		1 1%	1 .4%	1 1%

Table 4:
Among Hospitals that Never Dispense EC, Number and Percent of Respondents Giving a Referral

		Region			
	Total	Northeast	South	Midwest	West
N	328	63	60	117	88
Referral given	154 47%	32 51%	25 42%	61 52%	36 41%

Table 5:
Among Hospitals that Never Dispense EC and Respondents that gave a Referral, Number and Percent of Referrals by Type

		Region			
	Total	Northeast	South	Midwest	West
N	154	32	25	61	36
Hospital	119 77%	30 94%	14 56%	47 77%	28 78%
Rape hotline	10 6%	1 3%	7 28%	2 3%	
Clinic	10 6%	1 3%	2 8%	4 7%	3 8%
Other	15 10%		2 8%	8 13%	5 14%

Note: Some respondents made more than one referral. These results are for the first referral named.

Table 6:
Number and Percent of Referrals by Final Outcome

		Region			
	Total	Northeast	South	Midwest	West
N	149	32	24	60	33
Dead end	96 64%	21 66%	19 79%	38 63%	18 55%
Led directly to EC	44 30%	11 34%	4 17%	15 25%	14 42%
Led eventually to EC	9 6%		1 4%	7 12%	1 3%

Note: 5 cases are missing on these variables.

Table 7:
Number and Percent of Referrals by Final Outcome and Place of Referral

	Hospital	Rape hotline	Clinic	Other
N	117	10	10	12
Dead end	66 56%	10	9	11
Led directly to EC	42 36%		1	1
Led eventually to EC	9 8%			

Table 8:
Number and Percent of Respondents with Certain Attitudes Towards Callers

		Region			
	Total	Northeast	South	Midwest	West
N	595	109	91	239	156
Efficient, helpful	387 65%	65 60%	54 59%	161 67%	107 69%
Kind but ineffective	48 8%	13 12%	10 11%	17 7%	8 5%
Concerned but not helpful	19 3%	1 1%	4 4%	10 4%	4 3%
Evasive	21 4%	3 3%	4 4%	10 4%	4 3%
Suspicious	4 1%		2 2%	2 1%	
Hostile	19 3%	10 9%	2 2%	5 2%	2 1%
Helpful but brusque	73 12%	14 13%	12 13%	24 10%	23 15%
Other	24 4%	3 3%	3 3%	10 4%	8 5%

Note: Two cases are missing on this variable.

Appendix: State-level Results

	Number of hospitals providing EC										Number of hospitals referring, among those never providing		Catholic coverage	
					Only for rape									
	N	On request	On doctor's discretion	Only if not pregnant	Rape alone	Rape and not pregnant	Rape, don't know about pregnancy requirement	Rape and report to police	No response. Don't know. Unclear	Never	Referral given	Referral led directly or eventually to EC	% of hospitals that are Catholic	% of annual ER visits seen at Catholic hospitals
Northeast														
CT	4	1					1			2			14	19
DC	1					1							9	9
DE	1									1			17	16
MA	10				1	3			1	5	3	3	11	12
MD	7					1	1			5	3	1	12	13
ME	3								2	1	1	1	8	13
NH	2		1							1	1		7	11
NJ	15								3	12	9	2	18	16
NY	39		5		1	10	1		4	18	8	2	17	17
PA	26		1	2		1	1		4	17	6	1	12	13
RI	1									1	1	1	8	8
South														
AL	3								1	2	1		2	3
AR	12	1			1	1	3			6	2	2	16	21
FL	8	1				1	1			5	1		6	7
GA	5						1			4			3	4
KY	14		2		1		1			10	5		11	16
LA	9				1	2				6	2	1	8	11
MO	19	2	2			1	2		1	11	5	1	11	29
MS	1									1	1		1	1
NC	1									1	1		*	*
SC	5									5	2		6	5
TN	3					1			1	1			4	8
VA	8							1		7	4	1	8	7
WV	3	1				1				1	1		5	9

Appendix:
State-level Results (continued)

	Number of hospitals providing EC										Number of hospitals referring, among those never providing		Catholic coverage	
					Only for rape									
	N	On request	On doctor's discretion	Only if not pregnant	Rape alone	Rape and not pregnant	Rape, don't know about pregnancy requirement	Rape and report to police	No response. Don't know. Unclear	Never	Referral given	Referral led directly or eventually to EC	% of hospitals that are Catholic	% of annual ER visits seen at Catholic hospitals
Midwest														
IA	17	1	1			4	1	1	6	3	3	1	22	29
IL	50	2	2			13	10		1	22	6	4	26	28
IN	28	1	3			2	1		3	18	9	3	23	24
KS	13					2	1		1	9	7	2	8	26
MI	26		1	1	2	2	1		3	16	8	2	21	28
MN	17	2	2		2	1	1		2	7	5	2	11	9
ND	11	1			1	1			1	7	1	1	24	19
NE	9	1	2						3	3	1		11	21
OH	26		3		1	2	3		7	10	4	1	15	20
SD	9		2						2	5	3		16	27
WI	35	4			1	4			9	17	14	6	30	41
West														
AK	4		1			2				1			17	25
AZ	4				1	1	1		1				7	9
CA	45	4	1		2	2	5			31	10	7	15	15
CO	10	2	1				1			6	3	1	10	18
HI	1									1	1	1	9	9
ID	5	1				3				1			22	20
MT	6	2				1			1	2	2		11	29
NM**	3									3	3	1	7	7
NV	3									3	2		8	12
OK	9					2	2			5	1	1	9	20
OR	13	2	1			1		1	3	5			23	30
TX	35		1			5			5	24	10	3	10	13
WA	18	2			1	6	1		2	6	4	1	22	28

* Our list of Catholic hospitals includes one in North Carolina but the American Health Association lists none in that state.

** The three Catholic hospitals in New Mexico were sold to a non-Catholic entity in September 2002, soon after our fieldwork. The state Attorney General was involved in the transaction and specifically ensured that the hospitals would no longer be governed by Catholic guidelines.