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EMERGENCY CONTRACEPTION IN THE EMERGENCY ROOM: “EC IN THE ER” ANALYSIS AND RECOMMENDATIONS

BY JOELLE EMERSON

INTRODUCTION

In 2009, Washington, D.C. passed a law requiring that sexual assault victims in the District’s emergency rooms be given information about and access to emergency contraception (EC). The law became one of a number of “EC in the ER” (emergency contraception in the emergency room) laws—state laws mandating that emergency rooms dispense emergency contraception to sexual assault victims who request it. Though the passage of the law signaled a victory for advocates, a recent analysis suggests that, despite its promise, D.C.’s law has fallen short in its implementation. Unfortunately, D.C.’s failure to enforce its law is a common theme in EC in the ER laws around the country.

Twelve states and Washington, D.C. have enacted EC in the ER laws. EC in the ER laws communicate an understanding

3 See Guttmacher Inst., Emergency Contraception (Oct. 1, 2011) available at www.guttmacher.org/pubs/spib_EC.pdf (listing state EC in the ER laws). Note that I do not include Ohio in my count; though Ohio has a formal policy of providing EC in emergency rooms, but the policy is not legislatively mandated.
4 Emerson, supra note 1; see also infra notes 113-24 and accompanying text.
that the basic standard of care for sexual assault victims should include emergency contraception. These laws are in many ways a positive first step towards ensuring that sexual assault victims are given comprehensive care in emergency rooms. Unfortunately, though, EC in the ER laws face major hurdles to their enforcement, which in many cases severely curb their utility. This paper evaluates existing EC in the ER laws, considering the barriers to their implementation and ultimately making recommendations about what can be done to guarantee that the laws are as effective as possible.

Part I provides background on emergency contraception and the importance of providing EC to sexual assault victims. It then introduces EC in the ER laws as an important tool in ensuring EC provision in emergency rooms. Part II evaluates EC in the ER laws and their statutory enforcement schemes, discussing implementation successes and failures in each state, and ultimately considering why states have had varying levels of success in compliance with their EC in the ER laws. Part II is divided into three sections: the first discusses laws that have no statutory enforcement mechanisms; the second discusses laws that have reactive, or complaint-based enforcement only; and the third discusses laws that have proactive (or a combination of proactive and reactive) enforcement mechanisms.6

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6 Note that advocates in some of the states that have passed EC in the ER laws have conducted research to determine the effectiveness of the laws. In other states, no such data exists. The analysis provided in this paper reflects the differing levels of data available for various states; for those states where no data was available, the analysis is likewise more limited. The unavailability of data does not necessarily mean that a state’s law is not functioning well;

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Ultimately, the paper concludes that the presence or absence of a statutory enforcement scheme is not outcome-determinative: some states with no statutory enforcement have successfully implemented their laws, and some states with strong statutory schemes have fallen short. The laws that have been most successful have included a combination of factors, most notably strong enforcement (though not necessarily statutorily-mandated), and stakeholder involvement in ensuring the success of the law.

I. BACKGROUND ON EMERGENCY CONTRACEPTION AND EC IN THE ER LAWS

A. Importance of Emergency Contraception for Sexual Assault Victims

In order to understand EC in the ER laws, it is important to understand what emergency contraception is, what it is not, and what it can do for sexual assault victims in hospital emergency rooms. Emergency contraception, commonly referred to as the “morning after pill” or “the pill,” is an FDA-approved method of preventing pregnancy after sexual assault, unprotected intercourse or failure of another birth control method. EC is effective if taken within seventy-two hours, but has the highest rate of success if taken within the first twenty-four hours of unprotected sex. EC is sold under the brand names Plan B, Plan B

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it simply means that advocates in that state have not yet collected data about EC in the ER.

7 See supra note 1.
9 Research indicates that, when taken within 72 hours, EC can reduce the risk of getting pregnant by 75%. James Trussell et al., The Role of Emergency Contraception, 190 A.M. J. OBSTETRICS & GYNECOLOGY S31-33 (Apr. 2004).
One-Step and Next Choice. In general, the sooner EC is taken, the better it works.

Emergency contraception is often confused with pills such as RU-486, the so-called "abortion pill," which is used to end pregnancies after conception. Opponents of EC suggest that because it inhibits ovulation, fertilization or implantation, it interferes with potential human life and is thus akin to abortion. Notwithstanding these charges by opponents, EC has little in common with RU-486 mifepristone, and medical evidence makes clear that EC does not induce abortion or interfere with an existing pregnancy. In fact, when taken after conception, EC does not have any adverse affects on a fetus. Emergency

11 Id.
12 Charlotte Ellerton et al., Extending the Time Limit for Starting the Yuzpe Regimen of Emergency Contraception to 120 Hours, 101 OBSTETRICS AND GYNECOLOGY 1168, 1168-71 (2003).
15 EC pills available in the United States contain the hormone progestin; RU-486 contains mifepristone. See Trussel, supra note 9.
17 See supra note 8.
contraception actually works much like other types of birth control pills, which are used to prevent pregnancy by about eleven million American women each year. Proponents of EC as a method of preventing pregnancy suggest that, if used correctly and consistently, EC has great potential to reduce the need for abortion.

Because EC is time-sensitive and because emergency rooms serve as an entry point into the health care system for victims of sexual assault who may not have the time or ability to get to a primary care doctor, it is essential that emergency rooms provide EC to victims. The National Protocol for Sexual Assault Medical Forensic Examinations has found that “[f]or individuals who experience this horrendous crime [sexual assault], having a positive experience with the criminal justice and health care systems can contribute greatly to their overall healing.” The World Health Organization recommends that emergency contraception should be offered to women who see a doctor within five days of being sexually assaulted. An estimated 25,000 women in the United States become pregnant as a result of sexual assault each year, and statistics suggest that 22,000 of those pregnancies would be prevented if every sexual assault victim

20 Trussell, supra note 18, at 1.
21 Chelsea Polis et al., Accessibility of Emergency Contraception in California’s Catholic Hospitals, 15 Women’s Health Issues 174 (2005).
23 WORLD HEALTH ORGANIZATION, GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE, 64 (2003), whqlibdoc.who.int/publications/2004/924154628X.pdf.
were given EC. That is, nearly 90% of pregnancies resulting from sexual assault could be prevented if sexual assault victims were treated with emergency contraception.

Women who are not provided EC are forced to choose between having an abortion and carrying an unwanted pregnancy to term. Providing EC to sexual assault survivors is therefore a vital component of comprehensive medical treatment; failure to provide EC denies survivors control over their bodies at a critical time and exacerbates the trauma of the sexual assault by forcing them to confront an unwanted pregnancy. The absence of appropriate and comprehensive medical care after an assault may also result in feelings of being victimized again.

The provision of EC is especially important in emergency rooms, as ERs often provide the first or only medical care that victims of sexual assault receive. There are a number of reasons that sexual assault victims might receive their only medical treatment in an emergency room. For example, some may not have health insurance or a primary care doctor. Others might be seeking treatment outside of normal business hours. And many women might not want to see a primary care physician

24 F. Stewart & J. Trussell, Prevention of Pregnancy Resulting from Rape: A Neglected Preventative Health Measure, 19 AM. J. PREVENTIVE MEDICINE 228, 228-29 (2000).
25 Id. These statistics might be somewhat misleading, as all women who are sexually assaulted would not necessarily choose to utilize emergency contraception. However, the numbers still indicate that the uniform availability of EC would likely have a major impact on pregnancy rates for victims of sexual assault.
28 Elizabeth Temin et. al., Availability of Emergency Contraception in Massachusetts Emergency Departments, 12 ACAD. EMERGENCY MED. 987, 990-91 (2005).
29 Boumil & Sussman, supra note 27, at 27.
30 Id.
due to privacy concerns, embarrassment, shame or fear.\textsuperscript{31} Even for victims that have a primary care doctor and are willing to see them, emergency rooms may still provide the most immediate means of accessing treatment.\textsuperscript{32}

The legal consideration of EC provision to rape victims has been sparse.\textsuperscript{33} In one of the few cases addressing the issue, a sexual assault victim sued a hospital for not offering her prophylaxis when she sought medical treatment there.\textsuperscript{34} The defendant, a Catholic hospital, did not give the plaintiff information about emergency contraception and failed to inform her that the pill is most effective in the first seventy-two hours after unprotected sexual contact.\textsuperscript{35} The plaintiff did not see her regular doctor until more than seventy-two hours after the rape, and therefore was unable to access EC when it would have been most effective.\textsuperscript{36} The plaintiff sued for declaratory and injunctive relief, seeking to require the hospital to provide rape victims with information and access to emergency contraception.\textsuperscript{37} The court found that "estrogen pregnancy prophylaxis," or emergency contraception, is "'post-coital contraception,' not abortion."\textsuperscript{38} However, in denying relief to the plaintiff, the court held that because she did not become pregnant as a result of the incomplete medical care, she did not suffer injuries that warranted

\textsuperscript{31} Id.
\textsuperscript{32} Id.
\textsuperscript{35} Id. at 409.
\textsuperscript{36} Id.
\textsuperscript{37} Id. at 408.
\textsuperscript{38} Id. at 412.
compensation. The court left open the possibility that had damages (such as pregnancy) resulted from a failure to provide information about emergency contraception, “a rape victim [could] state a cause of action for damages for medical malpractice.”

B. Issues with EC Provision in Hospitals

While the benefits of EC are widely recognized in the medical community and advocates consider it critical in the treatment of sexual assault victims, victims still face major barriers to accessing EC. Some hospitals have formal policies of not providing EC; in others, individual doctors or nurses choose not to provide it. In ongoing debates about how EC actually functions, the Catholic Church has led the charge that EC is equivalent to abortion. Catholic hospitals, which comprise 12.5% of the nation’s hospitals, operate under the Ethical and

39 Id.
44 Id.
Religious Directives for Catholic Health Care Services (The Directives) developed by the U.S. Conference of Catholic Bishops.\textsuperscript{45} The Directives were designed to ensure that Catholic hospitals do not violate Catholic teachings prohibiting the use of artificial contraception.\textsuperscript{46}

Notwithstanding the Directives' probation on artificial contraception, some advocacy groups (including groups within the Catholic community, such as Catholics for Free Choice) argue that EC is actually in line with Catholic beliefs.\textsuperscript{47} Catholic hospitals' statement of identity, which asserts that Catholic hospitals "foster healing, act with compassion and promote wellness for all persons and communities," seems to be in line with providing comprehensive care to victims of sexual assault.\textsuperscript{48} Further, Directive 36 specifically allows EC provision for "a female who has been raped to defend herself against a potential conception from the sexual assault . . . if, after appropriate testing there is no indication that she is pregnant."\textsuperscript{49} Emergency contraception


\textsuperscript{46} Id. For example, Directive 52 says, "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning. Id. The Directives also explain that "[t]he Church cannot approve contraceptive interventions." Id.

\textsuperscript{47} See Ibis Reproductive Health & Catholics For A Free Choice, Complying with the Law? How Catholic Hospitals Respond to State Laws Mandating the Provision of Emergency Contraception to Sexual Assault Patients (2006); Ibis Reproductive Health & Catholics For A Free Choice, Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms" (2002).


\textsuperscript{49} United States Conference of Catholic Bishops, supra note 45.
is therefore not necessarily out of line with Catholic views on medical care.

In 2005, a nationwide survey tracked whether EC was being dispensed to victims of sexual assault in emergency rooms. The survey found that approximately 55% of Catholic hospitals and 42% of non-Catholic hospitals in the United States would not dispense emergency contraceptives in their emergency departments under any circumstance. In Catholic hospitals where the drug was dispensed, it was often given only following a pregnancy test.51 Because emergency contraception will not affect an existing pregnancy, such a prerequisite only serves to create a barrier between the sexual assault victim and protection from pregnancy.

A 2003 survey of EC provision in New York hospitals found that as many as one thousand rape victims were being sent away from emergency rooms without having been given emergency contraception.52 The Education Fund of Family Planning Advocates asserts that these findings helped make the case for the state legislation that was enacted shortly thereafter requiring that all hospitals offer EC to rape victims.53

The above studies indicate that, without a state law mandating the provision of EC in emergency rooms, there is little hope that the drug will be dispensed uniformly, especially in Catholic hospitals.54 Thus, EC in the ER laws bring states closer to ensuring

50 Harrison, supra note 42, at 11.
51 See Complying with the Law, supra note 47, at 11.
52 FAMILY PLANNING ADVOCATES OF NYS AND NEW YORK STATE COALITION AGAINST SEXUAL ASSAULT, Results of Statewide Survey of Provision of Emergency Contraception to Rape Survivors at Hospital Emergency Departments in NYS (2003).
54 With the exception of Ohio, all states with policies requiring hospitals to dispense EC have enacted said policies through the passage of a state law. Ohio is somewhat of an anomaly. There is currently no state law mandating EC provision in emergency rooms (though there is such a law pending), but
protection of rape victims from unwanted pregnancies. Nevertheless, as the discussion in Part II indicates, these laws alone are not always enough to ensure consistent EC provision.

C. Introduction to EC in the ER Laws & Statutory Enforcement Schemes

In order to ensure that hospitals comply with EC in the ER laws, some states’ statutes indicate the mechanisms by which the laws are to be enforced. In general, statutory enforcement schemes in EC in the ER laws can be defined as either proactive or reactive. Reactive can also be thought of as “complaint-based.” A proactive enforcement scheme tasks the government with investigating compliance issues. Reactive enforcement, on the other hand, typically calls for investigations into compliance only as a response to complaints against a particular hospital. A third type of enforcement scheme—and arguably the strongest—includes both types of enforcement mechanisms; that is, states must independently investigate hospital compliance, but they must also follow up on complaints of noncompliance.

In all but four EC in the ER laws, enforcement mechanisms are actually codified in the statute. In some of these states, the enforcement scheme is mentioned only briefly; in others, en-

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there’s a state policy of provision that goes further than even some state laws. See Ohio Department of Health, Sexual Assault and Domestic Violence Prevention Program, OHIO PROTOCOL FOR SEXUAL ASSAULT FORENSIC AND MEDICAL EXAMINATION, (Revised 2011) http://www.odh.ohio.gov/odhPrograms/hprrt/sadv/sadvprot.aspx (follow “Protocol for the Treatment of Adult and Older Adolescent Sexual Assault Patient” hyperlink).

55 The EC in the ER laws of South Carolina, California, Connecticut and New York all lack statutory enforcement mechanisms. These laws are discussed in Part II.A., infra.

56 For example, the enforcement mechanism in Oregon’s EC in the ER law states only that “[t]he Oregon Health Authority. . . may impose civil penalties against any hospital that does not comply with the rules detailed in these laws.” OR. REV. STAT. § 435.254 (2009).
Enforcement is discussed in detail.\textsuperscript{57} At least seven jurisdictions with EC in the ER laws utilize some form of reactive enforcement.\textsuperscript{58} If, after investigating a complaint, the responsible government agency (typically the department of health) finds that a hospital is violating the law, reactive enforcement mechanisms authorize the agency to take action either by penalizing the hospital or by requiring a revision of hospital policies. For example, a hospital in New Mexico may be fined $1,000 or have its license revoked in the case of numerous unresolved complaints.\textsuperscript{59} In Washington, if a hospital is found to be violating the law, it is issued a "statement of deficiency" and must submit revised policies or a plan to correct the problem.\textsuperscript{60} In New Jersey, the law requires an annual report to the public summarizing both the complaints filed and the actions taken in response.\textsuperscript{61} Reactive enforcement can thus be an effective tool in regulating compli-

\textsuperscript{57} New Jersey's law, for example, describes in detail its requirements that the Department of Health investigate complaints of noncompliance as well as independently investigate hospital compliance and issue reports regarding its findings. N.J. STAT. ANN. § 26:2H-12.6c (West 2008).


\textsuperscript{60} Telephone interview with Linda L. Foss, Executive Director, Inspections and Investigations, Clinical Care Facilities, Washington State Dept. of Health (Jan. 5, 2010).

\textsuperscript{61} See N.J. Stat. Ann. § 26:2H-12.6f. The statute says, "The commissioner shall prepare an annual report, which shall be available to the public, summarizing the substantiated complaints, the actions taken by an emergency health care facility or the commissioner to address the complaints, and the commissioner's findings concerning any pattern of failure to provide services under, or noncompliance with, the provisions of this act." Id.
ance with EC in the ER laws, as it provides a means by which sexual assault victims who have not been given appropriate treatment can report the violation, and it helps the state monitor hospital compliance on the ground.

Despite the potential efficacy of reactive enforcement, disillusionment with such a limited enforcement scheme recently led advocates in New Mexico to introduce a second EC in the ER bill that, had it passed, would have required the Department of Health to establish a tracking system to determine the success of the law.\(^6\) Although New Mexico has a strong reactive enforcement mechanism, supporters of the proposed bill clearly felt that the law needed proactive enforcement. Reactive enforcement assigns full responsibility for the law's enforcement to sexual assault victims, who, for a variety of reasons, may not file complaints. Such a scheme assumes that victims will be aware of the law, know that they can complain, know how to file a complaint, and, in the wake of a traumatic sexual assault, seek to pursue a formal complaint process against the hospital. Unsurprisingly, then, reactive enforcement mechanisms operating alone can sometimes result in little enforcement whatsoever.

Five EC in the ER laws include proactive enforcement mechanisms.\(^6\) With a proactive enforcement scheme, the onus is on the state to investigate potential violations, rather than solely on victims to file complaints. Some advocates argue that this sort of enforcement scheme is much more likely to be effective as it leaves government agencies—which should have knowledge and expertise about the law—responsible for making sure the law is followed.\(^6\)


II. Compliance Issues and Recommendations

The passage of an EC in the ER law—while promising in theory—does not necessarily ensure the provision of EC in practice. A 2005 study of Catholic hospitals in California, New York, South Carolina, and Washington (four of the first states to pass EC in the ER laws) found that 35% of responding hospitals would not provide EC under any circumstance, despite the existence of a law mandating its provision.65 Among those respondents, only 53% gave the name and telephone number of another facility where EC might be available, and only 53% of those referrals actually lead to a facility that provides EC.66 Thus, the existence of EC in the ER laws did not guarantee that patients visiting Catholic hospitals would have access to EC, or even that they would be referred to a hospital that would provide them with the drug.

This Section analyzes the successes and failures of EC in the ER laws. The Section is organized into three Parts, based on the three types of enforcement mechanisms in EC in the ER laws. Part A analyzes compliance issues in states with no enforcement mechanism; Part B analyzes compliance issues in states with reactive enforcement only; Part C analyzes compliance issues in states with proactive enforcement mechanisms (or combined proactive and reactive enforcement mechanisms). Ultimately, the findings in this Section demonstrate that, while enforcement mechanisms may help ensure compliance with EC in the ER laws, they are not sufficient to guarantee a law’s effectiveness. The states that have experienced the most success with their EC in the ER laws are those in which advocates and stakeholders have been deeply involved, and strategies for compliance have extended beyond the scope of what is statutorily required.

65 See Complying with the Law, supra note 47.
66 Id.
A. No Statutory Enforcement Mechanism

South Carolina, California, Connecticut, and New York's EC in the ER laws each lack statutory enforcement mechanisms.\textsuperscript{67} The experiences in these states indicate that, while the absence of a statutory enforcement scheme can make enforcement difficult, there are non-statutory strategies that can be pursued to improve compliance and enforcement.

South Carolina was the first state to mandate EC provision by statute—the state's EC in the ER law was enacted in 1997.\textsuperscript{68} The law says that exams of sexual assault victims "must include medication for pregnancy prevention if indicated and if desired."\textsuperscript{69} A study ten years after the passage of the law demonstrated that of the hospitals that treat sexual assault victims in South Carolina, 90\% have a protocol for providing emergency contraception.\textsuperscript{70} This statistic seems to suggest that in South Carolina, hospitals are at least aware of the law and for the most part are in compliance. Because the law has been in existence for thirteen years, and advocacy groups have been working for several years to educate health care providers about the requirement,\textsuperscript{71} the general statistics regarding compliance seem promising.

\textsuperscript{67} S.C. CODE. ANN. § 16 3-1350 (2003); CAL. PENAL CODE § 13823.11 (2009); CONN. GEN. STAT. § 19a-1le (2011); N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2008).
\textsuperscript{68} S.C. CODE. ANN. § 16 3-1350 (2003).
\textsuperscript{69} Id.
\textsuperscript{70} TERESE N. HARRISON, Ibis Reproductive Health for the South Carolina Emergency Contraception Initiative, Accessibility of Emergency Contraceptive Pill-Related Services for Sexual Assault Survivors in South Carolina 4 (2007).
\textsuperscript{71} For example, South Carolina Emergency Contraception Initiative has worked to educate health care providers as well as the general public about the law as well as how providers can be sure to provide appropriate care to victims of sexual assault. See generally The South Carolina Emergency Contraception Initiative, About Us, http://www.morningafterinfo.org/about.php (last visited Feb. 17, 2010).
The 90% statistic is misleading, however, because hospitals in South Carolina have erected major barriers to the actual provision of the drug, allowing them to technically comply with the law and claim that they have a protocol for providing EC, but avoid actually providing it in a number of circumstances. For example, all of the hospitals in South Carolina that treat sexual assault victims require a pregnancy test before administering EC.\textsuperscript{72} Sixty percent of hospitals require sexual assault patients to file a police report before accessing EC, and forty percent require them to undergo a rape kit examination in order to receive emergency contraception.\textsuperscript{73} Some hospitals have multiple requirements (i.e., requiring a rape kit exam and the filing of a police report), and 40% of the hospitals treating sexual assault victims reported that EC provision is contingent upon all three criteria being met.\textsuperscript{74}

These barriers—especially the requirement that victims file a police report—may have a major impact on the number of women who are ultimately able to receive EC. Requiring a victim to report a sexual assault is a huge burden,\textsuperscript{75} which explains

\textsuperscript{72} While emergency contraception does not affect an existing pregnancy, requirements related to pregnancy are not unique to South Carolina. Harrison, supra note 42, at 4; see also Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610 (Feb. 25, 1997). Laws in Massachusetts and Connecticut also allow providers to test for pregnancy before administering EC. See Telephone interview with Lenore Tsikitas, Education and Clinical Operations Specialist, Family Planning Program, Massachusetts Dept. of Public Health (Dec. 18, 2009); see also infra note 96 and accompanying text. In New York, providers do not have to dispense EC to women who are pregnant. N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2008).

\textsuperscript{73} Harrison, supra note 42, at 4.

\textsuperscript{74} Id.

\textsuperscript{75} Typically, victims are required to undergo a rape kit examination, a lengthy process which includes “an internal examination (either vaginally, anally or both) taking swabs of any secretions left by the perpetrator. . . . In addition, samples of the victim’s hair and pubic hair will be plucked from the root, and . . . some discomfort will be felt. . . . The clothes the victim was wearing will be held as evidence. . . . A series of photographs will also be taken of the victim, including anywhere there are bruises, scrapes or cuts.”
why underreporting of sexual assault is so common. Factors contributing to underreporting of sexual assault include “shame and embarrassment, self-blame, fear of media exposure, fear of further injury or retaliation and fear of a legal system that often puts the victim’s behavior and history on trial.” Thus, this barrier could serve to severely limit the number of sexual assault victims in South Carolina who receive EC.

Although South Carolina’s EC in the ER law has been in existence since 1997, the state has not developed any mechanisms for ensuring that hospitals are in compliance, leaving the law essentially powerless. Lottie McClorin, Program Manager of the South Carolina Contraceptive Access Campaign, has found that hospital noncompliance is common; she says that hospitals are governed by their own individual policies, and that staff are not well-trained about the EC provision requirement. McClorin’s organization attempts to address this problem, a major component of which includes educating health care professionals so that they know that there is a state EC in the ER law, and explaining what sorts of policies would count as following the law and what policies would violate the law. Thus, though emergency contraception is technically and facially available for sexual assault victims, and though it seems like hospitals in

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76 In 2005, under 39% of all rapes and sexual assaults were reported to law enforcement. Id.
77 Id.
78 Telephone Interview with Lottie McClorin, Program Manager for the South Carolina Emergency Contraception Initiative (Dec. 21, 2009).
79 Id.
80 Id.
South Carolina know that the law exists, its availability is being severely limited by a myriad of restrictions.

Premising the availability of emergency contraception on a victim’s willingness to file a police report, or even to undergo a rape kit examination, is an unreasonable barrier and will likely lead to many victims who might need the drug—and whom South Carolina’s law was intended to serve—to ultimately not receive EC.

California’s law is much newer than South Carolina’s, but, like South Carolina, California may face barriers to EC provision in its emergency rooms. California’s law does not include an enforcement mechanism, and only specifies that victims “shall be provided with the option of postcoital contraception” and that it “shall be dispensed by a physician or other health care provider upon the request of the victim.” In a survey conducted about a year after California passed its EC in the ER law, researchers found that among California’s Catholic hospitals, 66% would not provide EC under any circumstances, including rape. Of those that would not dispense EC, less than half of the respondents provided a referral. Of the fourteen referrals given, only about one third led to a facility that provides EC. Though the survey does not shed light on the compliance rates for non-Catholic hospitals, it does highlight major compliance issues among the forty-four Catholic hospitals in California. One of the likely reasons for this non-compliance is

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81 In conducting interviews for this Paper, it was difficult to gather much on-the-ground information from advocates in California. Sexual assault and reproductive rights advocacy groups in the state do not appear to be focusing on EC in the ER at this time.
82 CAL. PENAL CODE § 13823.11 (West 2002).
84 Id.
85 Id.
86 One advocate interviewed about the EC in the ER provision in California explained that the EC provision in California “depends on the hospital. . .some faith-based hospitals can’t give it out” but will give a prescription
the lack of an enforcement mechanism in California’s law, as well as potential barriers to enforcement.

The law in California requires that law enforcement authorities be notified when a woman reports having been sexually assaulted. In practice, this could mean that if a woman chooses not to report the assault to law enforcement, she may not have routine access to EC. Further, as in South Carolina, hospitals in California are not subject to penalties for failure to comply with the EC in the ER law, which serves to further limit the law’s effectiveness.

Connecticut’s law, though it does not have a statutory enforcement mechanism, attempts to curb a hospital’s ability to burden victims’ access to EC. For example, emergency rooms are not allowed to develop policies for limiting EC provision other than requiring a pregnancy test. This requirement prevents hospitals from imposing some of the barriers that exist in other states, such as requiring a rape kit exam or the filing of a police report (South Carolina), or requiring the notification and involvement of law enforcement authorities (California). Further, the bill attempts to prevent hospitals from getting out of providing EC because of religious or moral objections to the drug by allowing health care facilities to contract with independent providers to ensure compliance with the law (so that religiously-affiliated hospitals would not have to require their own

for victims to fill elsewhere. Telephone interview with Kavin Black, Organizational Services Coordinator, CALCASA (Feb. 7, 2011).

87 Cal. Penal Code § 13823.11(a) (West 2009).
88 See Complying with the Law, supra note 47.
89 Id.
90 Conn. Gen. Stat. § 19e-112e(b)(3) (2011) (mandating that health care facilities must provide “emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a licensed health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test.”)
92 Cal. Penal Code § 13823.11(a) (West 2009).
employees provide the medication). Advocates in Connecticut estimate that hospitals follow guidelines about 90% of the time that advocates are actually present. Because there is no outside enforcement mechanism, however, advocates’ reports are the only source for compliance-related information and may not reflect the overall rates of hospital compliance.

Though advocates should not be the only source of information gathering, their information can be key in the development and implementation of EC in the ER laws. New York’s law was passed in part due to a survey demonstrating that as many as 1,000 rape victims each year were not being provided EC in emergency rooms. The survey found that 15% of responding hospitals either had no standard policy on dispensing EC, or had inconsistent policies on dispensing.

While it does not have a specific enforcement mechanism built into the statute, New York’s law includes language that seems to reflect legislative intent that the law be enforced. The compliance language says that “[t]he commissioner shall promulgate all such rules and regulations as may be necessary and proper to implement [the law].” However, it is unclear to what part of the law this language relates, and, without more, it is not enough to be considered a statutory enforcement scheme. However, New York also has administrative protocol for treating sexual assault victims. The Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault establishes a standard of

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93 Id.
94 E-mail from Anna Doroghazi, Dir. of Pub. Policy and Commc’n, Conn. Sexual Assault Crisis Services, to Joelle Emerson (Feb. 18, 2010).
95 Id.
97 Id.
care for providers throughout the state, and requires all hospitals to establish and implement policies for the treatment of rape victims. The protocol also advises hospitals to counsel rape victims about EC and to either provide it on-site or arrange for the rape victim to receive it from an alternate provider in a timely manner.

While the language does not clearly mandate provision of EC, it does require acting consistently with the EC in the ER law (which mandates provision), and it says that hospitals should “[p]rovide female patients with appropriate information to make an informed choice regarding emergency contraception to prevent pregnancy resulting from sexual assault, and ensure that such services are provided upon request to the patient without delay, unless medically contraindicated.” Though somewhat unclear, this statement seems to be essentially requiring EC provision.

The protocol also mandates that providers “adhere to and fully document services provided” under the EC in the ER law, and says that “[a]ny undue delay in making this service available to a patient...would not be consistent with the current standards of care for female victims of rape and sexual assault. As such, hospitals not complying in a timely fashion would not be considered in compliance with department requirements.” This language regarding compliance seems to suggest that there is some sort of evaluation of hospital compliance, but does not discuss whether there are any penalties for noncompliance.

In an audit conducted immediately after the passage of New York’s law, Family Planning Advocates found staff confusion

100 Id.
101 Id.
102 Id.
103 Id.
and several instances of providers not complying with the law (although many of the noncompliance issues were related to the HIV prophylaxis requirement, and not to EC in the ER specifically).104

In a 2009 interview, Ronnie Powelko, a staff attorney with Family Planning Advocates explained that, in the years since the law was passed, hospitals have been complying.105 This may be due in part to the fact that New York’s law specifies that “[n]o hospital shall be required to provide emergency contraception to a rape victim who is pregnant.”106 In fact, it was the addition of this language that led the New York state Catholic Conference to drop its objections to the proposed EC in the ER bill.107 Perhaps this language in the statute, coupled with the administrative protocol advising hospitals that they can arrange for victims to receive EC from another provider (as long as it is done in a timely manner), has led to better compliance among Catholic hospitals.

Another factor that may have contributed to New York’s success was the fact that advocates actively engaged stakeholders in lobbying for the passage of the law and constructing the issue as a victim’s rights (rather than a reproductive rights) issue. According to Carol Blowers of Family Planning Advocates, the conversation in New York was “different from the beginning.”108 Family Planning Advocates worked with sexual assault groups and victim’s rights groups, ultimately securing bipartisan support for its EC in the ER law.

104 Telephone interview with Ronnie Powelko, Staff Attorney, The Education Fund of Family Planning Advocates (Nov. 24, 2009).
105 Id.
106 N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2011).
107 See PREVENTING PREGNANCY FROM SEXUAL ASSAULT, supra note 96, at 36.
108 Telephone interview with Carol Blowers, Vice President of Gov’t Relations, The Educ. Fund of Family Planning Advocates (Feb. 4, 2011).
Blowers also credits the law’s success to the major role that New York’s Department of Health has played in enforcement. At the time the EC in the ER law was passed, rape crisis centers in New York were funded out of the Department of Health. The DOH therefore had a point-person who focused solely on sexual assault issues, and the Department was a partner in passing the EC in the ER legislation. Because it played a role in getting the law passed, Blowers explains, the DOH was “on top of compliance issues” as soon as the law was in place. Blowers’ account indicates that the involvement of stakeholders and the active role of New York’s Department of Health were critical in securing uniform provision of EC in New York hospitals.

The stories of states without specific enforcement mechanisms provide important lessons both for each other and for other states that might pass laws with weak or non-existent statutory enforcement schemes. New York’s experience indicates that, especially where statutory enforcement is weak, the involvement of stakeholders is key in ensuring a law’s success.

Some policy of regulating compliance—even while such a policy is not statutorily-mandated—is also important. In New York, though the statute does not require Department of Health enforcement, the DOH took initiative in ensuring compliance. A policy of at least reviewing complaints, or ideally conducting independent investigations into hospital compliance, would be especially helpful in states like South Carolina where hospitals are in many cases following a set of internal policies that may on their face violate the state’s EC in the ER law.

It is also apparent that some of the problems in these states are related to a lack of knowledge and information about the law. It would therefore be beneficial for advocacy groups and

109 Id.
110 Id.
111 Id.
112 Id.
113 See Telephone Interview with Lottie McClorin, supra note 78.
other stakeholders to get involved in the education of both hospital staff and the general public about EC in the ER and what the state law requires.114

B. Reactive Enforcement

Several states have tried to address the enforcement problem by mandating that the Department of Health investigate or respond to complaints that hospitals have violated the EC in the ER law. New Mexico, Pennsylvania, Utah and Oregon all have exclusively complaint-based laws.115

New Mexico’s law requires emergency rooms to “provide emergency contraception at the hospital to each sexual assault survivor who requests it.”116 The law also has a comprehensive system for implementing its complaint-based enforcement. It requires the department to “immediately investigate every complaint it receives” as well as “compile all complaints it receives . . . [and] retain the complaints for at least ten years so that they can be analyzed for patterns of failure to provide services.”117

The statute also lays out a specific plan for what the department must do once it has received a complaint. The Department of Health is required to “issue a written warning to the hospital,” and, “based on the department’s investigation of the first complaint, require the hospital to correct the deficiency leading to the complaint.”118 Then, “[i]f after the issuance of a written

114 Pennsylvania, Oregon, Washington, and Wisconsin also have unique methods of involving advocates and other stakeholders. See discussion on Pennsylvania infra notes 125-32 and accompanying text; discussion on Oregon, infra notes 149-60 and accompanying text; discussion on Washington, infra notes 161-63 and accompanying text; discussion on Wisconsin, infra notes 212-15 and accompanying text.
117 Id.
118 Id.
warning to the hospital. . .the department finds that the hospital has failed to provide services," the department will fine hospitals $1,000 per victim alleging a complaint or per month of the alleged complaint until the hospital comes into compliance. Finally, after five complaints, the department must impose a sanction or suspend or revoke the hospital’s license. While it is only reactive and complaint-based, New Mexico’s statute does have a comprehensive and detailed plan for enforcement. And its penalty provisions—the ability to fine hospitals and suspend hospital licenses—could likely be a major deterrent to noncompliance if actually carried out.

A 2009 survey conducted in New Mexico, six years after the passage of the EC in the ER law, found substantial flaws in hospitals’ knowledge of the law. Of the 87% of New Mexico hospitals that responded to the survey, only 12% of emergency room responders reported awareness of any requirements to offer EC to sexual assault victims. And although New Mexico has no parental consent requirements, 33% of respondents indicated a belief that parental consent was necessary for minor victims of sexual assault.

Thus, while the law has been operating in New Mexico for six years, hospitals and staff are still overwhelmingly uninformed about its existence and requirements. This might be in part due to a lack of enforcement. Staff in charge of the complaint review process explain that there have been no complaints related to EC provision since the law was passed. So, either the system for filing complaints is not working properly (that is,

119 Id.
120 N.M. STAT. ANN. § 24-10D-5(F) (2011).
121 Eve Epsey et al., Compliance with Mandated Emergency Contraception in New Mexico Emergency Departments, 18 J. WOMEN’S HEALTH 619, 619 (2009).
122 Id.
123 Id.
124 Telephone interview with Gary Purvines, Facility Licensing & Certification Bureau, N.M. Dep’t of Health (Dec. 22, 2010).
complaints are being filed but they are not being investigated), or no complaints have been filed. Based on the statistics regarding a lack of awareness about or misunderstanding of the law, however, it seems as though violations are likely occurring. The fact that complaints are not being filed (or are not being investigated) highlights the flaws inherent in an entirely complaint-based system. That is, there is a good chance that violations of the law are occurring, but because the system is complaint-based only, the Department of Health is completely unaware of them. Thus, while passing a law with a specific enforcement scheme is helpful, the lack of proactive enforcement is still a major barrier to the law’s success.

In Pennsylvania, the law has a different barrier inhibiting its efficacy. As the only EC in the ER state with an “opt out” clause written into the statute, Pennsylvania law exempts providers who have religious or moral objections. To mitigate the potential harmfulness of this clause, the Pennsylvania Department of Health requires exempted hospitals to follow certain protocol to attempt to ensure that victims of sexual assault are able to get EC elsewhere. The protocol require that the hospitals (1) provide oral and written notice to sexual assault victims that EC is not provided at the hospital, (2) provide oral and written notice of the hospital’s obligation to arrange for transportation for the sexual assault victim, and (3) upon request of the sexual assault victim, arrange for immediate and free transportation to the closest hospital where EC is provided.

125 The law says that a “hospital may choose not to provide emergency contraception onsite if doing so may be contrary to the stated religious or moral beliefs of the hospital.” 28 PA. CODE § 117.53, § 117.55, § 117.57 (2008).
127 Id.
While the policies attempt to curb the negative impact of the opt out clause, they still present problems for victims. The protocols are only successful where hospitals comply, and where victims actually go to a providing facility after the initial denial. Because the exempt hospital is not required to provide information about EC, victims may not realize that the drug is time-sensitive, or how important and effective it can be following a sexual assault. Thus, after being denied EC at one hospital, many victims may not go to another facility until it is too late, if they go at all.

The ACLU’s Clara Bell Duvall Reproductive Freedom Project in Pennsylvania has conducted a series of surveys analyzing changes in emergency room provision of EC. In a survey conducted before the passage of the law, only 28% of hospitals routinely provided EC to victims of sexual assault. The remaining 72% of hospitals did not have established protocol. Many had informal procedures where EC provision was dependent upon a physician’s willingness to offer it; in others, EC was only offered by prescription; and in yet others, neither EC nor any information about EC were offered to the patient at all.

In 2010, several years after the passage of the law, researchers found that 78% of hospitals always offered EC to rape victims. Thirteen percent indicated that EC is sometimes offered, and 8% indicated that they do not offer EC. Since Pennsylvania’s EC in the ER law was passed, uniform EC provision in hospitals has gone from 28% to 78%.

129 Id.
130 Id.
131 Id.
132 Id.
Much of this improvement is due in part to the efforts of advocates in Pennsylvania. Before conducting the survey in 2000, Carol Petraitis, Director of the Duvall Project, began working with the Pennsylvania Coalition Against Rape (PCAR) to determine how to best combine efforts and encourage a change in hospital policies.133 After receiving the results of the first survey, Petraitis sent letters to hospitals informing them of how they had fared in the survey; she also sent information provided by PCAR aimed at encouraging better compliance.134 In the years since the original survey, the two groups have continued their strategic partnership, with the ACLU's Duvall Project utilizing its resources to conduct surveys and write hospital letters, and PCAR providing information about sexual assault treatment.135 Petraitis explains that strategic partnerships between advocates are essential, especially in states where the government is less active in working on EC in the ER issues or enforcing the law.136 She believes that relationships between advocates, state agencies, and hospitals are key to encouraging better compliance, and that teaming up advocacy groups increases resources and strength.137

The Duvall Project and PCAR has also worked with Education Fund of Family Planning Advocates of New York State to create a toolkit that instructs advocates around the country about how to improve EC provision in their own states. The toolkit, “Preventing Pregnancy from Sexual Assault: Four Action Strategies to Improve Hospital Policies on Provision of Emergency Contraception,” details how to conduct EC in the ER surveys to determine hospital provision, how to build coalitions, and which action strategies to use to increase access to EC.

133 See Preventing Pregnancy from Sexual Assault, supra note 96, at 18.
134 Id.
135 Id.
136 Telephone interview with Carol Petraitis, Clara Bell Duvall Reproductive Freedom Project Director, ACLU of Pennsylvania (Dec. 1, 2009).
137 Id.
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(legislation, administrative action, litigation/liability, and encouraging voluntary change).138 This toolkit would be a useful resource for advocates working to improve EC provision in other states.

While Pennsylvania has experienced major improvements in EC provision, the Duvall Project finds that the inconsistency still plaguing many of the state’s hospitals remains a barrier to victims.139 The Duvall Project has therefore been working to restructure Pennsylvania’s enforcement scheme to include proactive enforcement.140 Advocates are also encouraging hospitals to develop signage and transportation policies.141 That is, hospitals should have signs indicating whether or not they dispense EC on-site, and hospitals that do not dispense should have a transportation system set up for getting victims to a providing hospital.142

Utah’s EC in the ER law, which also has a complaint-based enforcement mechanism, has statutory language unlike many of the other EC in the ER laws. Like other laws, Utah’s law requires hospitals to provide sexual assault victims with written and oral information about EC, inform the victim that she may receive EC at the facility, and actually dispense EC.143 However, Utah’s law also mandates that facility “develop and implement a written policy to ensure that a person is present at the designated facility, or on-call,” who can dispense EC and is trained to comply with the EC in the ER law.144 This require-

138 See National Sexual Violence Resource Center et al., supra note 96.
140 See Telephone interview with Carol Petraitis, supra note 136.
141 Id.
142 Id.
143 Utah Health Code, § 26-21b-201 (West 2011).
144 Utah Health Code, § 26-21b-201(1)(f).
ment aims to ensure that a health care provider's personal religious beliefs will not prevent a victim from accessing the drug.

According to advocates, this piece of the law seems to be working. Susan Chasson, a twenty-year veteran of Utah's SANE (Sexual Assault Nurse Examiners) program and the program's current director, explains that religious and moral objections are not a major barrier to EC provision in Utah. However, this success seems to be due only in part to the statutory scheme. In rural areas, where religious or moral objections would be most problematic (because of limited options for seeking other care), Chasson explains that the Utah Hospital Association has worked to ensure that rural hospitals have the necessary information about the law and how to comply. It is unclear whether this same information has been dispensed to urban hospitals.

According to Chasson, the law in Utah seems to be working to some extent. That is, in hospitals that know about the law and understand their duties, EC provision does not appear to be an issue. The biggest issue in Utah seems to be that some hospitals and doctors simply do not know about the law and their duty to provide EC. This failure seems to be due in large part to a failure on the part of the Department of Health to dispense any information on the law. Although the Utah Hospital Association was active in getting information to rural hospitals, urban hospitals have not received the same attention. Chasson suggested that a statute mandating a specific timeframe—for example, ninety days—in which the Department of Health was required to distribute information about the law might be a more useful statutory framework, especially in states where the biggest barrier to compliance is lack of information.

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145 Telephone interview with Susan Chasson, Director, Sexual Assault Nurse Examiners Program (October 14, 2010).
146 Id.
147 Id.
148 Id.
In Oregon, the law requires that hospitals, "[i]f requested by the victim and if not medically contraindicated, [must] provide the victim with emergency contraception immediately at the hospital." The law also specifies that "[t]he department [of health] shall respond to complaints of violations" and "adopt rules necessary to carry out the provisions of this section." After Oregon passed its EC in the ER law in 2007, the Oregon Hospital Association’s risk management team sent out information to all hospitals regarding the EC in the ER law, and how to ensure compliance with the law.

Nurses working with the SANE program train hospital staff about the treatment of sexual assault victims, including how to comply with the EC in the ER law. The SANE nurses have not had reports of complete noncompliance, but they have had reports of hospitals getting around the law by implementing barriers to EC access. For example, some hospitals provide information about EC, and they have a physician on staff who will write prescriptions for the drug, but victims will be required to fill the prescriptions at outside pharmacies. By providing a prescription, a hospital can claim to be following provision requirements without actually dispensing the drug on-site. However, the Public Health Division of Oregon’s Department of Human Services has observed no such problems. The Department’s Survey Manager claims that the Department has received no complaints and has given no citations since Oregon’s EC in the ER law went into effect.

150 Id.
151 Telephone Interview with Patti Kenyon, SANE Technical Assistance Coordinator (Feb. 16, 2010).
152 Id.
153 Id.
154 Id.
155 Telephone Interview with Chris Campbell, Survey Manager, Oregon Department of Human Services (October 5, 2010).
Oregon has developed other promising policies to improve EC access for victims. For example, the law requires that the Department of Human Services collaborate with “victim advocates, other interested parties and nonprofit organizations that provide intervention and support services to victims of sexual assault and their families” to “develop, prepare and produce informational materials relating to emergency contraception for the prevention of pregnancy in victims of sexual assault for distribution to and use in all hospital emergency departments in the state.”\textsuperscript{156} The law requires that the information be “clearly written and easily understood in a culturally competent manner,” and that it indicate that EC is “more effective the sooner it is taken,” and that EC “will not disrupt an established pregnancy.”\textsuperscript{157}

This requirement is helpful because it gives an additional means by which victims can receive medically accurate information about EC. Further, even hospitals that may object to providing the drug might be more likely to nonetheless distribute the fact sheet provided by the Department of Human Services, which would at least let victims know about EC and that it must be taken as soon as possible.\textsuperscript{158} This requirement is also powerful as it involves outside parties with a stake in the success of Oregon’s law—such as victim advocates and nonprofits—in determining the content of the material to be distributed to victims. This not only serves to keep stakeholders informed and involved in the implementation of the law, but also keeps the Department of Health aware of the sorts of issues about which those involved with sexual assault victims on a daily basis are most knowledgeable.

Oregon’s law also requires facilities treating sexual assault victims to have a sign that reads: “Pregnancy Protection After

\textsuperscript{156} \textit{OR. REV. STAT.} \textsection 435.254 (2007).
\textsuperscript{157} \textit{Id.}
\textsuperscript{158} For a list of states requiring information about emergency contraception to be dispensed in emergency rooms, see \textit{Guttmacher Inst.}, \textit{supra} note 3.
Sexual Assault: Your Right to Emergency Contraception." The Department of Human Service's Family Planning Program developed this requirement as a method of ensuring that victims understand their right to EC access. If actually implemented, this practice could have a major impact on victims’ awareness about EC. In a state with complaint-based enforcement only, this sort of requirement might be particularly useful because it lets victims know that they have a right to emergency contraception, so victims will be more likely to complain if hospitals do not provide it. Further, even if a hospital did not provide EC, victims would still receive information (albeit potentially non-comprehensive) regarding EC, and thus might be more likely to seek it out elsewhere. Oregon's signage requirement, though not statutorily mandated, is therefore a powerful tool that other states—especially those with complaint-based enforcement only—should consider utilizing.

In Washington state, while the statutory enforcement scheme requires complaint-based enforcement, the statute is complimented by administrative enforcement policies. The state’s Department of Health has developed a comprehensive scheme for independently investigating hospital compliance. Because of these administrative policies, Washington’s EC in the ER law effectively functions as a complaint-based and proactive enforcement state.

Washington’s statutory enforcement scheme says only that “[t]he department [of health] must respond to complaints of violations.” However, through administrative policy, the Department of Health is required to conduct regular licensing reviews.

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160 Unfortunately, however, because Oregon does not have a proactive enforcement mechanism including site checks, it is possible that Oregon hospitals could disregard the signage requirement without any real consequences.
162 Telephone interview with Linda L. Foss, supra note 60.
to evaluate hospital compliance. If the hospital staff cannot answer the investigator’s questions, or if their answers indicate a flaw in hospital policy, the Department of Health issues a statement of deficiency to the hospital. The hospital then must submit a plan to correct their deficiencies, and the Department of Health follows up shortly after that to ensure that the hospital is actually following its revised policy.

Linda Foss, Executive Director of Investigations for the Washington State Department of Health, explains that when the law was first passed, compliance was a major issue. In conducting their evaluations, investigators found that in many cases hospital staff were unaware of the EC in the ER law, or erroneously thought that the law had conscience-related opt-out provisions. The major problem, though, was that many hospitals were giving patients referrals to get EC elsewhere, as opposed to providing it on-site. According to Foss, though, compliance has not been a major issue for several years. One of the main reasons she cites for this change is an increase in the information available to hospital staff, provided in part during the on-site investigations conducted by the Department of Health. She explains that these investigations are essential to the enforcement of the law. For example, after the passage of the law, there were many cases in which hospitals that were aware of the law actually thought they were complying, but in reality had major flaws in their policies that inhibited uniform provision of

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164 These reviews are conducted either every 18 months or every three years, depending on the type of facility. See Telephone interview with Linda L. Foss, supra note 60.
165 Id.
166 Id.
167 Id.
168 Id.
169 Id.
170 Id.
171 Id.
172 Id.
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EC. Without a proactive enforcement scheme dictated by the DOH's administrative policies, these flaws may never have been caught.

Another strong element of Washington's law is that it mandates the creation of 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." As with Oregon's inclusion of stakeholders in the creation of informational materials for hospitals, Washington's task force involves stakeholders in the implementation of the law, which keeps the Department of Health connected to advocates and keenly aware of the range of issues that sexual assault victims actually face in emergency rooms.

Although a combination of complaint-based and proactive enforcement may be ideal, states with complaint-based enforcement alone can still enact policies to improve hospital compliance. The experience in New Mexico—wherein statistics show that compliance issues are likely, but that the Department of Health has not received any complaints—highlights some of the problems with a solely complaint-based enforcement scheme. Even without a proactive enforcement scheme, however, these states have come up with unique and possibly effective ways of encouraging EC provision.

The ability to impose strong penalties on hospitals that violate the law (New Mexico), the ongoing observation and analysis of compliance issues (Pennsylvania), the use of toolkits to train advocates and hospitals (Pennsylvania), the involvement

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173 Id.
175 See supra notes 111-12 and accompanying text.
176 Id.
177 See supra notes 119-23 and accompanying text.
178 See supra note 128 and accompanying text.
of stakeholders (Oregon and Washington)\textsuperscript{179} and hospital signage indicating the right to receive emergency contraception (Oregon)\textsuperscript{180} are all strong methods of improving access to EC for sexual assault victims. Washington’s administrative policies also provide a powerful response to the absence of proactive enforcement in the state’s statute; such a strategy could be a powerful tool in states with no statutory enforcement mechanism, as well. Ideally, many of these methods could be used in conjunction to ensure higher compliance rates and compensate for laws that lack proactive enforcement mechanisms.

\textbf{C. States with Proactive Enforcement}

The EC provision surveys in states with no enforcement mechanisms or solely complaint-based enforcement mechanisms suggest that the passage of an EC in the ER law alone does not guarantee EC provision. The barriers still faced by victims in those states—ranging from lack of enforcement of the laws to hurdles put in place to limit the provision of EC—suggest that the laws are being constricted in such a way that their effectiveness is limited. However, even states with the best-written laws are in some cases facing barriers to ensuring the uniform provision of EC in hospital emergency rooms. That is, even in states where proactive enforcement mechanisms are written into the law and responsibilities for regulation are delegated to appropriate agencies, there is often a disconnect between intention and implementation. Four states (Massachusetts, Minnesota, New Jersey and Wisconsin) have proactive enforcement mechanisms built into their EC in the ER laws.\textsuperscript{181} Washington, D.C. also has statutory language that indicates an intended proactive enforce-

\textsuperscript{179} See supra notes 147-48, 165 and accompanying text.
\textsuperscript{180} See supra note 150 and accompanying text.
\textsuperscript{181} Massachusetts, Minnesota, New Jersey and Wisconsin all require the state to investigate hospital compliance. \textsc{Mass. Gen. Laws Ann.} ch. 111, \textsection 70E (2009); \textsc{Minn. Stat.} \textsection\textsection 145.4711-.4713 (2007); \textsc{N.J. Stat. Ann.} \textsection\textsection 26:2H-12.6b to 12.6d (2005); \textsc{Wis. Stat.} \textsection 50.375 (2011).
ment scheme, though, as discussed below, the proactive enforcement does not appear to be happening in D.C.

Massachusetts’ EC in the ER law requires emergency rooms to “promptly offer emergency contraception” to sexual assault victims.\(^\text{182}\) The state has interpreted the phrase “promptly offer” to mean that victims must be given EC regardless of the performance of a rape kit exam or the filing of a police report\(^\text{183}\) (barriers often faced in other states).\(^\text{184}\) One weakness in the Massachusetts law, though, is that it allows hospitals to screen for pregnancy as a prerequisite for providing EC.\(^\text{185}\) In terms of enforcement, the law requires “each facility initiating emergency contraception” to “annually report to the department of public health the number of times emergency contraception is administered to victims of rape under this section.”\(^\text{186}\) Finally, the statute mandates that “[t]he department of public health shall promulgate regulations to carry out this annual reporting requirement.”\(^\text{187}\) Further enforcement policies—including evaluation of hospital policies and conducting site-checks to ensure compliance—were constructed administratively after the passage of the law.


\(^{183}\) See Telephone interview with Lenore Tsikitas, supra note 69.

\(^{184}\) See discussion on South Carolina, supra; see also discussion on California, supra.

\(^{185}\) The World Health Organization has established that pregnancy is not a contraindication for EC and that pregnancy tests need not be administered before dispensing the drug. See World Health Organization, Guidelines for Medico-Legal Care for Victims of Sexual Violence (2003), available at whqlibdoc.who.int/publications/2004/924154628X.pdf. According to Lenore Tsikitas, Education and Clinical Operations Specialist for the Family Planning Program, there have been ongoing discussions within the Department of Public Health regarding allowing pregnancy screening as a prerequisite to receiving EC, and that the Department of Health considering changing its policy to no longer allow pregnancy screening. See Telephone interview with Lenore Tsikitas, supra note 69.

\(^{186}\) Id.

\(^{187}\) Id.

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NARAL Pro-Choice Massachusetts has conducted surveys to analyze the provision of EC in Massachusetts’ emergency rooms both before and after the passage of the EC in the ER law. A 2004 study found that, prior to implementation of the EC legislation, one in six Massachusetts hospitals failed to offer EC to sexual assault victims.188 Thirty-two percent of those hospitals did not provide a referral for EC when asked, and many reportedly provided misinformation about EC.189 Perhaps predictably, none of the twelve Catholic hospitals in Massachusetts provided EC to rape survivors.

In an updated survey conducted in 2006, after the passage of the law, fifty-six percent of the Catholic hospitals said they offered EC to sexual assault victims (a substantial improvement from the 2004 study in which no Catholic hospitals provided EC), while other Catholic hospitals either did not offer it or imposed serious limitations on access.190 In contrast, 95% of secular hospitals offered EC to rape survivors, with only five percent reporting policies that could impose significant barriers or delay care.191 For example, staff at five hospitals reported leaving the decision of whether to provide EC to the discretion of a doctor, or requiring a rape kit exam before providing EC.192

Though the numbers do not indicate perfect compliance, they do reflect an improvement in EC provision after the passage of Massachusetts’ law. This is likely due in part to the state’s successful enforcement scheme. In Massachusetts, the Family Planning Program (within the Department of Public Health) was charged with the implementation of the EC in the ER law. Lenore Tsikitas, Educational and Clinical Operations Specialist for the Family Planning Program, explains that though the law does

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189 Id.
190 Id.
191 Id.
192 Id.
not require proactive investigation into hospital compliance, a comprehensive proactive enforcement policy was developed through working relationships with the EC Network (a subset of NARAL Pro-Choice Massachusetts) and other organizations and advocacy groups.\textsuperscript{193}

Two years after the Massachusetts law passed, the Family Planning Program instituted its three-part enforcement plan requiring hospitals to (1) have written policies which comply with the law, (2) actually abide by those policies, and (3) submit reports detailing their provision of EC. In 2007, the Family Planning Program required hospitals to submit their current policies regarding EC provision.\textsuperscript{194} Many of the policies that hospitals initially submitted had a range of issues, including incorrect medical information (for example, stating that emergency contraception would cause birth defects, and warning that a woman might have to have an abortion because of birth defects), and contraindications that actually do not apply to EC.\textsuperscript{195}

In response to these findings, the Family Planning Program issued letters to the hospitals detailing the changes that needed to be made to their policies. For example, hospitals were informed that they needed to distribute the legislatively-mandated EC fact sheet, and that that they could not impose barriers such as the requirement of a rape kit exam to EC provision.\textsuperscript{196} With the exception of one Catholic hospital, every hospital in the state was amenable to the policy changes that the Family Planning Program suggested.\textsuperscript{197} To ensure that the updated policies were being followed, representatives from the Family Planning

\textsuperscript{193} Telephone interview with Lenore Tsikitas, \textit{supra} note 72.


\textsuperscript{195} Telephone interview with Lenore Tsikitas, \textit{supra} note 72.

\textsuperscript{196} \textit{Access to Emergency Contraception Circular Letters}, \textit{supra} note 194; see also Telephone interview with Lenore Tsikitas, \textit{supra} note 72.

\textsuperscript{197} Telephone interview with Lenore Tsikitas, \textit{supra} note 72.
Program conducted hour-long site checks at every hospital. Further, the Family Planning Program released a "best practices" checklist to help hospitals understand how to ensure total compliance.

Finally, hospitals in Massachusetts are required to report their own statistics on EC provision within their emergency rooms. Emergency room providers giving care to sexual assault victims are required to fill out a sexual crime report; this report requires providers to indicate, among other things, whether EC was administered. Massachusetts also requires hospitals to issue an annual report regarding the number of times EC was administered to sexual assault victims. This reporting requirement holds hospitals individually accountable for complying with state law by asking that they report their own statistics on a regular basis. This form of reporting requirement might be particularly useful in states with only complaint-based enforcement because it adds another method by which hospital compliance could be monitored. While such a requirement undoubtedly creates some additional work for hospital staff, at least two EC in the ER states already require reporting related to sexual assault victims in emergency rooms, and have found any associated burdens to be justified. Reporting requirements for hospitals have been

198 Id.
199 Id.
201 Id.
203 For example, Massachusetts law requires "[e]very physician attending, treating, or examining a victim of rape or sexual assault...shall report such case at once to the criminal history systems board". Mass. Gen. Laws ch. 112, § 12A 1/2 (2003). The report in Massachusetts already includes a question about whether emergency contraception was administered. See Massachusetts Executive Office of Public Safety and Security, Provider Sexual Health Crime Report Mass Policy, available at http://www.mass.gov/emergencycontraception; see also New York State Department of Health, Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault (Revised Oct. 2008) at 6-7 (recommending that
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upheld by courts in other contexts. Ultimately, if hospitals are required to report, they are more likely to provide the services that the law requires. Reporting requirements place the burden on hospitals, rather than on victims, to be aware of compliance issues.

Minnesota has a complaint-based and proactive enforcement scheme. Minnesota’s law mandates that “the commissioner shall periodically determine whether hospitals are in compliance,” and that “[t]he commissioner shall accept and investigate complaints regarding hospital compliance.” However, the proactive component of the enforcement scheme seems to be failing in terms of implementation. Similar to the issues faced in Washington, D.C., investigators in Minnesota’s Department of Health do not seem to be aware of the EC in the ER law or their implementation responsibilities. One investigator who has been with the Department for sixteen years had never heard of the law. Another investigator in charge of hospital compliance was aware of the law, but said that she had never had a complaint about noncompliance. This investigator’s focus on complaints

hospitals document sexual assault statistics, including whether victims are given emergency contraception).


206 Telephone Interview with Dave Orren, Chief Legal Counsel, Minnesota Department of Health (Dec. 21, 2009).

207 Id. Mr. Orren spoke to Pat Fitzgibbon, who is in charge of intake for compliance; Ms. Fitzgibbon reported that she has never had an EC in the ER compliance issue.
and the fact that the only responsibilities about which she was aware were complaint-related suggests that proactive investigation may not actually be taking place in Minnesota.

Without active enforcement of the law, advocates in the state report that they are facing compliance issues due to health care providers claiming religious or moral objections. Individual doctors have gotten away with not providing EC (citing religious or moral reasons), as long as another member of the hospital staff is willing to provide it.208 Thus far, “opting out” of EC provision has not been considered a violation of the law,209 since the law regulates hospitals, not individual doctors, and the hospitals are technically still able to say that they provide EC.210 Unfortunately, in rural areas where there is only one hospital and only one doctor on duty to examine a sexual assault victim, victims have been left waiting for a shift change in order to see a doctor that will provide them with the EC.211 Requiring a sexual assault victim to spend hours in an emergency room waiting for a shift change in order to receive emergency contraception indicates a major failure in the execution of Minnesota’s EC in the ER law.

This failure might be due in part to the fact that the statutorily mandated proactive enforcement does not seem to be taking place. On the other hand, it is possible that the major issue faced in Minnesota—lack of compliance by individual providers—may be the type of issue that even a better enforcement mechanism would not solve; that is, even if the Department of Health were to regularly investigate hospital compliance, such an investigation would do little as long as this behavior were considered compliant. One possible solution would be for the Department

208 Telephone interview with Caroline Palmer, Staff Attorney with the Minnesota Coalition Against Sexual Assault (Nov. 10, 2009).
209 However, since it does not seem as though proactive enforcement is taking place, and the DOH says that it has not received complaints about compliance, it is unclear how this scenario would be evaluated if the Department of Health were to actually investigate it.
210 Telephone Interview with Caroline Palmer, supra note 208.
211 Id.
of Health to release a set of guidelines detailing how hospitals can better serve sexual assault victims, and requiring that hospitals always have someone on staff that is willing to dispense EC. But ultimately, and especially because it is required by state law, Minnesota should enliven its proactive enforcement scheme.

Like Minnesota, Wisconsin also has a complaint-based and proactive enforcement scheme. Wisconsin’s EC in the ER law requires that hospitals “immediately provide to the victim upon her request emergency contraception.”212 The law also mandates that “[t]he department shall respond to any complaint received by the department concerning noncompliance. . .and shall periodically review hospital procedures to determine whether a hospital is in compliance with the requirements.”213

The law further attempts to prevent providers from imposing barriers to EC provision: for emergency contraception that needs to be taken in two doses (before the recent release of “Plan B One Step,” all EC pills were administered in two doses),214 the law requires that “hospitals shall provide all subsequent dosages to the victim for later self-administration.”215 Thus, hospitals cannot be in compliance if they provide patients with only the first dose of the two-dose treatment. Though this provision is no longer highly relevant now that EC is available in one pill, it serves as an example of how legislation can expressly prevent hospitals from imposing particular barriers to EC provision.216

216 New Mexico also has a requirement about the administration of both doses. N.M. Stat. Ann. § 24-10D-3(B) (2009) (“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.”)
A survey conducted in Wisconsin in 2005 (two years before the passage of the state’s EC in the ER law) found that forty-two percent of responding hospitals were not dispensing emergency contraception on-site. Of those not dispensing, only about half referred patients to a pharmacy with a prescription for EC. The Compassionate Care for Rape Victims (CCRV) Coalition has also produced a toolkit to help Wisconsin emergency departments ensure that every sexual assault victim is offered EC when she receives treatment at a hospital. This involvement of stakeholders, though not statutorily mandated, is a powerful tool to ensuring compliance. The toolkit includes facts about EC, guidelines to EC provision, a resource guide, and even a model hospital protocol that hospitals could adopt to ensure that they have a strong policy of EC provision. Giving hospitals a model policy regarding EC provision, and especially one that they can easily reproduce in their own policies, is a helpful practice that advocacy groups in all EC in the ER states should consider.

Despite the passage of Wisconsin’s law and the hard work of advocates, EC provision remains a problem in the state. In a follow-up survey conducted by the CCRV to determine the impact of the EC in the ER law, the group found that 78% of hospitals reported that they “always” offer EC onsite, as compared

218 See id. 24 out of 46 hospitals referred patients to a pharmacy.
220 Id.
221 Massachusetts’ Family Planning Program similarly evaluates hospital policies and advises changes to ensure full compliance with the state’s EC in the ER law. Telephone Interview with Lenore Tsikitas, supra note 72.
to only 58% in 2005. Though this statistic reflects a positive change, the CCRV found that 22% of hospitals were still noncompliant. The survey showed that barriers to compliance of the law included “lack of available resources” and “individual provider beliefs or variations in provider practices.” Other barriers included “unfamiliarity with the law” and “religious affiliation of hospital.”

New Jersey’s EC in the ER law also has a detailed complaint-based and proactive enforcement policy. The law requires the commissioner of the Department of Health to “investigate every complaint of noncompliance with the provisions of this act” and to “determine, at least annually, whether an emergency health care facility is complying with the provisions of this act.” It also requires the commissioner to “prepare an annual report, which shall be available to the public, summarizing the substantiated complaints, the actions taken...to address the complaints, and the commissioner’s findings concerning any pattern of failure to provide services.” Thus, New Jersey’s law mandates complaint-based enforcement, proactive enforcement, and a report to the public.

New Jersey’s reporting scheme is different than Massachusetts’ in that it requires the Department of Health to release a report regarding EC compliance throughout the state, as opposed to requiring individual hospitals to report their own compliance. Though it does not have the same effect of putting the responsibility of reporting on individual hospitals, it does, at least in theory, keep the Department of Health responsible for

223 Id.
224 Id.
225 Id.
227 Id.
228 See MASS. GEN. LAWS ANN. ch. 111, § 70E (West 2011).
reporting their investigations and findings, so that there is some transparency in the enforcement system. Because the report is public, it also allows advocates and general members of the public to inform themselves about which hospitals have had issues with compliance, and which have provided more uniform care.

New Jersey's law also codifies the participation of stakeholders, requiring that the commissioner of the Department of Health, "in collaboration with the Director of the Division on Women, the New Jersey Coalition Against Sexual Assault and the Sexual Assault Nurse Examiner program, shall develop, prepare and produce...written information relating to: emergency contraception for the prevention of pregnancy." Like Oregon and Washington, New Jersey involves stakeholders—in this case, advocates and nurses trained in working with sexual assault victims—in its development of written materials.

Washington, D.C.'s law, while appearing to require proactive enforcement on its face, has thus far failed in terms of implementation. The law explains that the Department of Health is responsible for ensuring compliance, and that failure to comply "may result in a civil fine to be determined by the Mayor." Further, the Fiscal Impact Statement for the bill clarifies that the Health Regulation and Licensing Administration is responsible for implementation. The fact that the statute tasks the Department of Health with compliance indicates that some form of proactive enforcement was likely intended. However, because the Department of Health has not implemented the policy, D.C.'s law functions as though it has no enforcement mechanism.

229 N.J. STAT. ANN. § 26:2H-12.6e (West 2007).
D.C.'s law requires the Health Care Facilities Division to enforce violations of the law within D.C. hospitals. The Division is responsible for conducting regular on-site surveys to monitor and investigate hospital compliance with all laws including licensure, health, and safety regulations. Because the law charges the Division with implementation, the inclusion of an EC in the ER evaluation in the on-site licensing review that the Division already conducts regularly could be a successful and cost-effective method of ensuring hospital compliance, and indeed, seems to be what the law intended when it gave the Division enforcement responsibilities.

However, investigators within the Division have not yet investigated compliance with the EC in the ER law, apparently because they do not know that the law exists or what it requires of them. One investigator charged with conducting on-site hospital evaluations explained that hospitals in D.C. are not required to provide emergency contraception to sexual assault victims. When told about the District's EC in the ER law, the investigator admitted that, were there such a law, she would be the person in charge of regulating compliance.

D.C.'s problems thus seem to be due in large part to a lack of knowledge about the law, which was just passed in 2009. Lottie McClorin, an advocate in South Carolina (where the EC in the ER law has been in existence for ten years) suggests that raising awareness about the requirements of an EC in the ER law takes time and commitment on the part of advocates.

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233 Telephone Interview with Sharon Lewis, Investigator, Health Care Facilities Division (Nov. 24, 2009).
234 Gandhi, supra note 231.
235 Telephone Interview with Sharon Lewis, supra note 233.
236 Id.
237 Telephone Interview with Lottie McClorin, supra note 78.
traitis, a leading advocate of EC in the ER in Pennsylvania, agrees that educating hospital staff about EC in the ER laws and how to comply with them is a major task that takes a lot of work on the part of advocates.238

Clearly, even laws with proactive enforcement cannot be successful if those charged with compliance are not aware that the law exists. And even in states where proactive enforcement is taking place, advocates and government agencies can still improve their policies to ensure the best possible access for sexual assault victims.

Washington’s taskforce and New Jersey’s involvement of the sexual assault advocacy groups and the Sexual Assault Nurse Examiner program are good examples of how states have involved stakeholders in their EC in the ER schemes. Further, the creation of model policies—as the Family Planning Program does in Massachusetts—helps hospitals construct compliant policies and minimize confusion. Finally, proactive enforcement laws can benefit from reporting requirements—either requiring the hospital to report EC provision (as in Massachusetts)239 or requiring the Department of Health to report on its investigations and findings (as in New Jersey).240

**Conclusion**

Ultimately, while the passage of an EC in the ER law signifies a legislature’s interest in the treatment of sexual assault victims in emergency rooms, the mere passage of a law is not enough to actually ensure that this care is provided. The lack of enforcement mechanisms in some EC in the ER statutes makes those laws essentially powerless. And in states where enforcement is entirely complaint-based, the responsibility is on victims, rather than hospitals or state agencies, to be aware of the law’s require-

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238 Telephone Interview with Carol Petraitis, supra note 136.
239 See supra notes 190-191 and accompanying text.
240 See supra note 57 and accompanying text.
ments and ensure that hospitals are complying. Finally, even when a statute has an enforcement mechanism that is proactive and powerful on its face, it is useless if the players on the ground are not actually enforcing it.

States drafting EC in the ER legislation should consider potential compliance issues and include enforcement schemes in their laws. The most effective enforcement scheme would include both complaint-based and proactive enforcement. Further, like New Jersey and Massachusetts, states should require reporting of EC provision, either by the hospitals themselves (as in Massachusetts) or by the Department of Health (as in New Jersey). For states that have already passed EC in the ER laws, it is essential that the laws are carried out with as much force as intended—that is, that there is clear delegation of enforcement responsibilities to the appropriate agencies. Even in cases where a comprehensive enforcement scheme seems to be intended (as in Washington, D.C.), or where proactive policy is actually detailed in the law (as in Minnesota), the laws will not be successful if those charged with implementation do not know about the laws or are unwilling to enforce them. Finally, the involvement of advocates in all stages of the EC in the ER process—including developing, implementing and monitoring the law—is key to improving understanding about the needs of sexual assault victims and ensuring that the laws are as effective as possible.  

See Providing Emergency Contraception to Sexual Assault Survivors, supra note 26, at 3.