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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Betsy Cavendish and Allison Herwitt to Bruce Reed et al. re: Executive Order Regarding Emergency Contraception for Rape Victims (partial) (1 page)	11/20/2000	P6/b(6)
002. note	re: phone number (partial) (1 page)	11/27	P6/b(6)
003. memo	Heather Howard to Bruce Reed re: Ideas for Executive Actions to Promote Reproductive Rights (2 pages)	11/27/2000	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21195

FOLDER TITLE:
E.O. [Executive Order] on Emergency Contraception

2012-0254-S
rc663

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(1) National security classified information [(b)(1) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

1/3

EC - Hospitals

100 diff Statutes authorizing funding
each statute - diff leg
depends on Cong. author.
Unless President has discretion to put conditions

could pick particular funding sources

EO to direct Agency to examine
legal permissibility of conditioning funds
would require rulemaking
direct HHS to issue notice of rulemaking

POTUS doesn't have direct authority
typically goes through agency
direct to take steps to condition

could only direct agencies to look into
it + do it

* POTUS doesn't have authority to directly condition funds

258
1962

Date: ____December 18, 2000_____

To: MARCY WILDER

Telephone: Fax: 690-7998

From: Heather Howard

Telephone: 456-7263 Fax: 456-2878

Subject: E.O. on Emergency Contraception

Pages: _____ (Including this cover sheet)

Comments:

Marcy – here's what I got from NARAL. Let me know what you think.

SECOND FLOOR WEST WING ❖ WASHINGTON, DC 20502
TELEPHONE (202) 456-7263 ❖ FACSIMILE 456-2878

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NARAL
Reproductive Freedom & Choice

Memorandum

To: Bruce Reed, Assistant to the President and Director of the Domestic Policy Council
Ann O'Leary, Special Assistant to the President for Domestic Policy
✓ Heather Howard, Associate Director of Domestic Policy
From: Betsy Cavendish, VP NARAL Foundation, Legal Director
Allison Herwitt, Director of Government Relations
Date: November 20, 2000
Re: Executive Order Regarding Emergency Contraception for Rape Victims

Thank you for your interest in promulgating an Executive Order providing that rape victims be offered emergency contraception in the emergency rooms of hospitals receiving federal funds. We have attached some materials in support of this proposal.

More broadly, NARAL has been so grateful for the President's support of reproductive rights, demonstrated at the outset of his administration by the signing of five pro-choice Executive Orders. It is only fitting that the administration issue at least one more pro-choice Executive Order as a legacy document. We think that this proposal is appropriate for several reasons:

- ✓ First, part of being pro-choice is being pro-contraception. This Executive Order would locate the president's support for abortion rights in the larger context that he himself espouses, in that abortion will be more rare as contraception is more accessible.
- ✓ Second, wider information about and access to emergency contraception is the single best way to reduce unintended pregnancy. Thus, by issuing this Executive Order, the President would shine a spotlight on the promise of emergency contraception and the effect of the Order would be far broader than the help it would provide to women victimized by rape.
- ✓ Third, while in principle NARAL supports much more robust measures to expand access to emergency contraception through the Title X program, this Executive Order would pose no danger to the Title X program, a frequent target of anti-choice animus in Congress.
- ✓ Finally, should Congress try to undo this Executive Order as it has so many of the President's pro-choice Executive Orders, it would expose the opponents' radical agenda to deny women vital health information and contraception.

If you have any further questions about this matter, we would be glad to assist. Allison's direct line is 973-3003 and Betsy's is 973-3012. She is reachable the rest of the week at P6/(b)(6) [001]

1156 15th Street, NW
Suite 700
Washington, DC 20005
202 973 3000
202 973 3096 fax

10951 West Pico Boulevard
Suite 100
Los Angeles, CA 90064
310 234 2805
310 234 8806 fax

http://www.naral.org
naral@naral.org

NARAL
Reproductive Freedom & Choice

Memorandum

To: Interested Parties
From: NARAL Legal Department
Date: November 2000
Re: **Requiring hospitals to provide emergency contraception to rape survivors**

Few Americans are aware that, in emergency situations, contraceptive methods are available that can prevent pregnancy after sexual intercourse. Emergency contraception may be used when contraceptive methods fail or when women are sexually assaulted. Emergency contraceptive pills (ECPs) – the most commonly used method of emergency contraception – are ordinary birth control pills that reduce a woman's chance of becoming pregnant by 75 to 89 percent when a specific dose is taken within 72 hours of unprotected sex and a second dose is taken 12 hours after the first dose. ECPs do not cause abortion; rather, they inhibit ovulation, fertilization or implantation *before* a pregnancy occurs.

Emergency contraception is a safe and effective way to prevent unintended pregnancy and reduce the need for abortion. When a woman is raped, emergency contraception can be an important tool to help her avoid the additional trauma of an unwanted pregnancy by the rapist. Emergency contraception should be hospitals' standard of care for treating survivors of sexual assault.

Why Requiring Hospitals to Provide Emergency Contraception to Rape Survivors is Necessary

- Over 300,000 women are raped in the U.S. each year.[1]

- Each year, over 32,000 women become pregnant as a result of rape and approximately 50 percent of these pregnancies end in abortion.[2] Emergency contraception is not only a safe and effective method to prevent unwanted pregnancy, but it also can empower women who

1156 15th Street, NW
Suite 700
Washington, DC 20005
202 973 3000
202 973 3096 fax

10951 West Pico Boulevard
Suite 100
Los Angeles, CA 90064
310 234 2805
310 234 8806 fax

http://www.naral.org
naral@naral.org

have been raped with a sense of control and provide an important way to help them to cope with the trauma of sexual assault.

- Very few women know about emergency contraception. A national survey found that only one in ten women aged 18-44 have heard of and know the key facts critical to using emergency contraceptive pills.[3] Unless hospitals inform women of the option to use emergency contraception, women are unlikely to know enough to ask for the treatment.

- Standards of emergency care established by the American Medical Association (AMA) require that rape survivors be counseled about their risk of pregnancy and offered emergency contraception.[4]

- Despite these facts, recent studies have found that many hospitals do not provide emergency contraception to women requesting it, even to women who have been sexually assaulted. For example:

  - Only half of all Minnesota hospitals provide emergency contraception to rape survivors.[5]

  - Nearly one in three New York hospitals fail to offer emergency contraception to rape survivors, and an additional 23 percent have no clear policy on the issue.[6]

  - In Pennsylvania, two-thirds of the general hospitals in the state do not provide emergency contraception to survivors of sexual assault.[7]

  - Nationwide, 82 percent of Catholic hospitals do not provide emergency contraception to women who have been raped.[8]

  - In 1995, 14 Catholic hospitals in Chicago treated 1004 rape victims but refused to offer them emergency contraceptive pills.[9]

Requiring hospitals to provide emergency contraception to rape survivors would rectify the current gap in emergency care and ensure that women who have been raped have access to every available means to protect their health and well-being.

Notes

[1] This estimate is limited to women 18 years or older and is not based on whether the rape is reported. Patricia Tjaden and Nancy Thoennes, "Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey," *Research in Brief* (Washington, DC: U.S. Department of Justice, National Institute of Justice, Nov. 1998, NCJ 172837), 4 <http://ncjrs.org/pdffiles/172837.pdf> (8/22/00).

[2] Melisa M. Holmes, Heidi S. Resnick, Dean G. Kilpatrick, and Connie L. Best, "Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women," *American Journal of Obstetrics and Gynecology*, vol. 175, no. 2 (Aug. 1996): 322.

[3] Kaiser Family Foundation, *Emergency Contraception: Is the Secret Getting Out?*, Summary of Findings (CA: KFF, 1997), 7-8.

[4] American Medical Association, "Strategies for the Treatment and Prevention of Sexual Assault" (1995), 18.

[5] Minnesota NARAL Foundation, "Access in Crisis: The Continuing Decline of Hospital-Based Emergency Contraceptive Services in the State of Minnesota" (2000), 7.

[6] New York State Affiliate of the National Abortion and Reproductive Rights Action League Foundation, "Preventing Pregnancy After Rape: Does Your Hospital Provide Emergency Contraception to Rape Survivors?" (Dec. 1999), 9-11.

[7] Rebecca Simons, "Emergency Contraception for Sexual Assault Survivors: A Survey of Hospital Emergency Rooms in Pennsylvania," (Clara Bell Duvall Education Fund, May 2000).

[8] Catholics for a Free Choice, *Catholic Health Restrictions Updated* (Washington, D.C.: Catholics for a Free Choice, 1999), 7.

[9] Miriam Berg, "In Merger, Catholic Hospital Can Compromise," *New York Times,* Oct. 19, 1997, Sec. 4, p. 14.

NARAL
Reproductive Freedom & Choice

EMERGENCY CONTRACEPTION: AN IMPORTANT AND UNDERUTILIZED CONTRACEPTIVE OPTION

Emergency contraceptive pills (ECPs), the most commonly used method of emergency contraception, are ordinary birth control pills that reduce a woman's chance of becoming pregnant by 75 to 89 percent when a specific dose is taken within 72 hours of unprotected sex and a second dose is taken 12 hours after the first dose. ECPs do not cause abortion; rather, they inhibit ovulation, fertilization or implantation before a pregnancy occurs. ECPs do not disrupt an established pregnancy.

GREATER USE OF ECPs WILL IMPROVE REPRODUCTIVE HEALTH AND REDUCE ABORTION

- Increased use of ECPs could reduce the number of unintended pregnancies and abortions by half annually.

BARRIERS TO ACCESS

- Eighty-two percent of Catholic hospitals do not provide emergency contraception even to women who have been raped, although in cases of sexual assault, the Catholic Church permits using medication to prevent pregnancy.
- Sixteen states have laws that permit health care facilities, health care professionals, or other individuals to refuse to provide contraception or family planning, which may include emergency contraception.

EDUCATION AND DIRECT DISTRIBUTION BY PHARMACISTS WILL INCREASE ACCESS TO AND USE OF EMERGENCY CONTRACEPTION

- Only one percent of women aged 18-44 have used ECPs, and 89 percent have not heard of or do not know the key facts critical to use of the pills.
- One survey found that 37 percent of New York City pharmacists knew nothing about emergency contraception or provided only incorrect information about emergency contraception.
- A Washington state project enabled women to receive ECPs directly from pharmacists. In 16 months, ECPs were provided to nearly 12,000 women, preventing an estimated 700 unplanned pregnancies and 350 abortions.

DO SOMETHING! **Call 1-877-YOU-DECIDE (1-877-968-3324) or log-on to www.naral.org.**

For a complete fact sheet on Emergency Contraception, please contact the NARAL Information Line at (202) 973-3018.

1156 15th Street, NW
Suite 700
Washington, DC 20005
202 973 3000
202 973 3096 fax

10951 West Pico Boulevard
Suite 100
Los Angeles, CA 90064
310 234 2805
310 234 8806 fax

http://www.naral.org
naral@naral.org

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Reproductive Freedom & Choice

EMERGENCY CONTRACEPTION: AN IMPORTANT AND UNDERUTILIZED CONTRACEPTIVE OPTION

Emergency contraception is often called "the nation's best-kept secret" because few Americans are aware that, in emergency situations, contraceptive methods are available that can prevent pregnancy after sexual intercourse. Emergency contraception may be used when contraceptive methods fail,[1] are misused or not used at all, and when women are sexually assaulted. Although emergency contraceptive methods are not a substitute for ongoing contraceptive use and do not protect against the transmission of sexually transmitted diseases, these important and underutilized contraceptive options can reduce unintended pregnancy and the need for abortion. American women should have broader access to a full range of contraceptive services, including postcoital emergency methods.

Emergency contraceptive pills (ECPs) are the most commonly used method of emergency contraception. ECPs are ordinary birth control pills that reduce a woman's chance of becoming pregnant by 75 to 89 percent when a specific dose is taken within 72 hours of unprotected sex and a second dose is taken 12 hours after the first dose.[2] ECPs do not cause abortion; rather, they inhibit ovulation, fertilization or implantation before a pregnancy occurs.[3] The FDA has approved the Gynétics Incorporated's PREVEN Emergency Contraception Kit, which became available, via prescription, in October of 1998.[4] In July of 1999, the FDA approved another ECP called Plan B developed by the Women's Capital Corporation.[5] The copper-T intrauterine device can also be used as an emergency contraceptive.[6]

Greater Use of Emergency Contraception Will Improve Reproductive Health

- Estimates show that increased use of ECPs could reduce the number of unintended pregnancies and abortions by half annually.[7] Lack of access to emergency contraception may contribute to higher rates of unplanned pregnancy in the U.S. compared to countries where emergency contraception is widely available.[8]

- A study of women who had used ECPs found that 91 percent were very satisfied or somewhat satisfied with the ECPs, and 97 percent would recommend ECPs to a friend or family member.[9]

1156 15th Street, NW
Suite 700
Washington, DC 20005
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Suite 100
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http://www.naral.org
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- Emergency contraception is cost-effective in preventing unintended pregnancy. Estimates show that in a managed care setting, a single treatment of ECPs saves $142; and advance provision of ECPs to women using spermicides, periodic abstinence, barrier contraceptives or withdrawal saves $263 to $498 annually.[10]

- The need for emergency contraception can bring women, and young women in particular, into family planning centers, where they can receive other health care services and counseling. For those who remain sexually active, emergency contraception provides a bridge to ongoing contraception and disease prevention.[11]

Barriers to Access

Despite the promise of using ECPs to reduce unintended pregnancy, efforts to limit access to them have been significant. Much of the opposition to ECPs arises from the mistaken belief that ECPs cause abortion. ECPs, however, do not disrupt an established pregnancy, which begins with implantation of the fertilized egg in the uterine lining. Rather, ECPs delay or inhibit ovulation or implantation prior to pregnancy and therefore, do not cause abortion. Nevertheless, consider the following:

- Eighty-two percent of Catholic hospitals do not provide emergency contraception even to women who have been raped, although the Catholic Church permits, in cases of sexual assault, using medication to prevent ovulation, sperm capacitation, or fertilization before conception.[12] A study conducted by NARAL of New York found that more than one-half of non-Catholic hospitals in New York have no clear policy of providing rape survivors with emergency contraception. Twenty-four percent of non-Catholic hospitals in New York do not provide emergency contraception to rape survivors.[13]

- Fewer than 10 percent of Missouri hospitals provide emergency contraception, according to the preliminary results of a survey conducted by Missouri NARAL. A study by Wyoming NARAL found that only one-third of responding hospitals and clinics in Wyoming provide emergency contraception.[14]

- Twenty percent of family planning coordinators of Title X grantees in Michigan believe that "ECPs are primarily an abortion-inducing agent." In explaining why their family planning programs did not provide ECPs, several respondents cited politics and the debate over abortion.[15]

- Wal-Mart, one of the nation's largest drug distributors, refused to carry PREVEN, but later issued a policy requiring pharmacists who object to dispensing ECPs to find someone who will.[16] A study conducted by NARAL New Mexico/Right to Choose found that nearly 15 percent of New Mexico pharmacists would not fill prescriptions for ECPs.[17]

- A 1998 South Dakota law permits pharmacists to refuse to dispense medication if there is reason to believe it would be used to "destroy an unborn child," which includes a human organism from fertilization until birth.[18] In 1999, five states (IN, KS, LA, OR, WI) introduced legislation to allow pharmacists to refuse to provide certain medicines, including ECPs.[19]

- Sixteen states (AR, CO, FL, GA, IL, ME, MA, MN, NJ, NY, OR, TN, VA, WV, WI, WY) have laws that permit health care facilities, health care professionals, or other individuals to refuse to provide contraception or family planning, which may include emergency contraception.[20]

- In 1999, North Carolina enacted a contraceptive coverage bill specifically excluding coverage for PREVEN or any equivalent drug.[21] Seven states (CA, CT, HI, ME, MD, NV, NC) with contraceptive coverage laws permit employers and/or insurers to refuse, on moral or religious grounds, to cover contraception, which includes emergency contraception.[22]

Public and Professional Education Will Improve Access and Increase Use of Emergency Contraception

- Only one percent of women aged 18-44 have used ECPs, and 89 percent of women aged 18-44 have not heard of or do not know the key facts critical to use of the pills.[23]

- Although nearly 100 percent of obstetrician-gynecologists believe ECPs are safe and effective, only 24 percent prescribe them on a regular basis (more than five times a year).[24] This low prescription rate may be due to the fact that clinicians often lack adequate knowledge about emergency contraception, and therefore do not discuss it with patients during routine contraceptive counseling sessions. In addition, many patients are not aware of emergency contraception and do not ask that it be made available. To help reverse this trend, the American College of Obstetricians and Gynecologists (ACOG) and others are conducting a national physician education campaign supporting "women's right to know about all birth control methods" and encouraging doctors to discuss and prescribe emergency contraception when appropriate.[25]

- One survey found that 37 percent of New York City pharmacists knew nothing or provided only incorrect information about emergency contraception.[26]

- A national toll-free hotline (1-888-NOT-2-LATE) that provides information on emergency contraception and referrals to health care professionals who are able to prescribe it was inaugurated on February 14, 1996 by the Reproductive Health Technologies Project. The hotline has received 201,682 calls as of December 1999. Additionally, the emergency contraception website (http://www.not-2-late.com or http://opr.princeton.edu/ec/) has been visited 519,252 times as of October 1999.[27]

- The Hawaii Health Department conducted a public service advertising campaign about emergency contraception in 1999. The ads directed listeners to contact the national toll-free hotline or the state's family planning information line. The average number of calls to the family planning information line increased from eight to ten calls per day to 40 to 50 calls per day during the month the radio spots aired.[28]

Direct Distribution by Pharmacists Will Also Increase Access to and Use of Emergency Contraception

- Although ECPs are typically available by prescription only, some state regulations permit pharmacists to dispense certain medications through a collaborative drug therapy agreement between a pharmacist and a physician or other prescriber.[29] In 1999, Washington state completed a two-year pilot project that enabled women to receive ECPs directly from pharmacists. In 16 months, the program provided ECPs to nearly 12,000 women, preventing an estimated 700 unplanned pregnancies and 350 abortions.[30] The success of Washington's program prompted the Oregon Medical Association's House of Delegates to pass a resolution in April of 1999 to work with the Oregon Board of Pharmacy to establish a one-year pilot project to permit pharmacists to dispense the PREVEN Kit.[31] In addition, in 1999, the California legislature considered a bill to allow pharmacists to initiate emergency contraception drug therapy under a collaborative agreement.[32]

- ECPs should be more readily available, such as directly through a pharmacist, because the need for ECPs can almost always be self-diagnosed, they are simple to use, the doses do not need to be adjusted to a woman's particular situation or medical condition, accidental overdoses are not dangerous, and it is doubtful that the regimen constitutes a serious risk to any identifiable group of women.[33]

Conclusion

Emergency contraception is an important but underutilized contraceptive option. Increasing access to emergency contraception will reduce unintended pregnancy and the need for abortion, and will improve women's reproductive health. Instead of restricting access to emergency contraception, policy makers should focus on better public education, professional education, and innovative programs to make emergency contraception more available.

01/17/2000

NOTES:

1. Nine in ten women at risk of unintended pregnancy use a contraceptive method. The Alan Guttmacher Institute (AGI), "Contraception Counts: State-by-State Information," *Issues in Brief* (Jan. 1998): 5.

2. James Trussell, Charlotte Ellertson and Felicia Stewart, "The Effectiveness of the Yuzpe Regimen of Emergency Contraception," *Family Planning Perspectives*, vol. 28, no. 2 (Mar./Apr. 1996): 58, 64; Women's Capital Corporation, "A New Generation of Emergency Contraception Has Arrived," July 28, 1999 (press release).

3. Robert A. Hatcher et al., *Emergency Contraception: The Nation's Best-Kept Secret* (Atlanta: Bridging the Gap Communications, 1995), 29-30; Judy Peres, "Fears Keeping 'After Sex' Pill on Back Shelf," *Chicago Tribune*, Feb. 14, 1996, A1.

4. Food and Drug Administration (FDA), "FDA Approves Application for Preven Emergency Contraceptive Kit," Sept. 2, 1998 (talk paper).

5. Plan B contains only levonorgestrel, a progestin. Women's Capital Corporation, "A New Generation of Emergency Contraception Has Arrived." PREVEN contains a combination of estrogen and progestin. Office of Population Research, Princeton University, *Emergency Contraceptive Pills* <http://opr.princeton.edu/ec/ecp.html> (1/7/2000). One study found that women using the progestin-only regimen were about one-third as likely to become pregnant, as compared to women using estrogen-progestin ECPs. The study also found that 23% of women taking only progestin experienced nausea, whereas 51% of women using estrogen-progestin ECPs experienced nausea. Task Force on Postovulatory Methods of Fertility Regulation, "Randomised Controlled Trial of Levonorgestrel Versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency Contraception," *The Lancet*, vol. 352, no. 9126 (Aug. 8, 1998): 428, 430, 431.

6. The copper-T IUD is an effective method of emergency contraception that reduces the risk of pregnancy by 99 percent. AGI, The Henry J. Kaiser Family Foundation (KFF) and National Press Foundation, "Emergency Contraception: All Talk, No Action?," Dec. 18, 1997 (Q & A factsheet), 1. The copper-T IUD may be inserted up to five days after intercourse or five days after ovulation, whichever is later. Office of Population Research, Princeton University, *Copper-T IUD as Emergency Contraception* <http://opr.princeton.edu/ec/eciud.html> (1/7/2000).

7. Based on data from the 1980s, it is estimated that increased use of ECPs could reduce the number of unintended pregnancies by 1.7 million annually and the number of abortions by 800,000. James Trussell et al., "Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives*, vol. 24, no. 6 (Nov./Dec. 1992): 269-70.

8. Richard A. Grossman and Bryan D. Grossman, "How Frequently Is Emergency Contraception Prescribed?" *Family Planning Perspectives*, vol. 26, no. 6 (Nov./Dec. 1994): 270-71. A 1998 publication concluded that 33 million U.S. women were at risk of unintended pregnancy. AGI, "Contraceptive Services," *Facts In Brief* (Jan. 1998): 1.

9. S. Marie Harvey et al., "Women's Experience and Satisfaction with Emergency Contraception," *Family Planning Perspectives*, vol. 31, no. 5 (Sept./Oct. 1999): 240.

10. James Trussell et al., "Preventing Unintended Pregnancy: The Cost-Effectiveness of Three Methods of Emergency Contraception," *American Journal of Public Health*, vol. 87, no. 6 (June 1997): 932, 934-35.

11. Reproductive Health Technologies Project (RHTP), "Emergency Contraception Hotline, Questions and Answers," Aug. 1996 (factsheet), 10.

12. Catholics for a Free Choice, *Catholic Health Restrictions Updated* (Washington, D.C.: Catholics for a Free Choice, 1999), 7; Susan Yanow, "A Successful Campaign -- Catholic Hospitals Agree to Offer Emergency Contraception," *ProChoice IDEA* (Aug. 1999): 12 (quoting *Ethical and Religious Directives for Catholic Health Care Services*, Directive 36).

13. "Preventing Pregnancy After Rape: Does Your Hospital Provide Emergency Contraception to Rape Survivors?" (New York: NARAL/NY Foundation, 1999), 9.

14. Missouri NARAL Foundation, "Abortion and Reproductive Health: The Access Project Survey" (1999 preliminary results); Wyoming NARAL, "Reproductive Health Services Survey Questionnaire" (1999 preliminary results); *see also* Tara Tuckwiller, "Well-Kept Secret: 'Morning-After' Contraceptive Available by Prescription in West Virginia," *Charleston Gazette & Daily Mail*, Oct. 11, 1999, 1D (survey of four major hospitals and clinics found that none provides emergency contraception).

15. Joseph Winchester Brown and Matthew L. Boulton, "Provider Attitudes Toward Dispensing Emergency Contraception in Michigan's Title X Programs," *Family Planning Perspectives*, vol. 31, no. 1 (Jan./Feb. 1999): 39, 40, 41.

16. Bill Saporito-Bentonville and David E. Thigpen, "Wrestling with Your Conscience Wal-Mart Wants to Avoid Controversy on its Shelves, but Consumers Won't Let It," *Time*, vol. 154, no. 20 (Nov. 15, 1999): 72; Dana Canedy, "Wal-Mart Decides Against Selling a Contraceptive," *New York Times*, May 14, 1999, C2.

17. Nancy Ellefson, "New Mexico NARAL Surveys Pharmacists," *ProChoice IDEA* (Winter 1998-1999): 14-15.

18. S.D. Codified Laws §§ 22-1-2(50A), 36-11-70.

19. NARAL/NARAL Foundation, *Who Decides?: A State-By-State Review of Abortion and Reproductive Rights* (Washington, D.C.: NARAL/NARAL Foundation, 2000), ix.

20. NARAL/NARAL Foundation, *Who Decides?*, xviii, 89.

21. N.C. Gen. Stat. §58-3-176(c)(4)(b).

22. NARAL/NARAL Foundation, *Who Decides?*, xviii.

23. KFF, *Emergency Contraception: Is the Secret Getting Out?*, Summary of Findings (CA: KFF, 1997), 7-8.

24. KFF, *Emergency Contraception,* 12-13.

25. The American College of Obstetricians and Gynecologists, "Physicians Emphasize Availability of Emergency Oral Contraception," Apr. 1997 (press release); Marilyn Elias, "Docs Spread Word: Pill Works On Morning After," *USA Today*, Apr. 29, 1997, A1.

26. Tammy A. Draut, *Emergency Contraception: Do Pharmacists Know About This Important Method to Prevent Pregnancy?*, (New York City: Planned Parenthood of New York City, 1999), 5.

27. RHTP, "Emergency Contraception Update - February 1998," Feb. 1998 (factsheet); Correspondence from Heather Zesiger, Program Assistant, RHTP, to Rachel Kramer, NARAL Legal Department (Jan. 7, 2000) (on file with NARAL).

28. Esme M. Infante, "State Promotes 'Morning After' Pill: Perky Radio Spots Upset Opponents," *Honolulu*

Advertiser, June 25, 1999, A1; "State Says Not Indoctrinating on Use of 'Morning-After' Pill," *Associated Press Newswires*, June 25, 1999; Correspondence from Sara Kuzmanoff, Acting Supervisor, Family Planning Services Section, Hawaii Department of Health, to Sharon Terman, NARAL Legal Department (Oct. 5, 1999).

29. The following states may permit pharmacists to establish collaborative agreements for dispensing ECPs: CA, FL, HI, IN, IA, KS, KY, MI, MS, NV, NM, ND, OR, SD, TX, WA. Program for Appropriate Technology in Health (PATH), *Emergency Contraception: A Resource Manual for Providers*, (Seattle: PATH, 1997), 14-15.

30. PATH, "Increasing Women's Access to Emergency Contraceptive Pills through Direct Pharmacy Provision" (Dec. 1999).

31. Oregon Medical Association House of Delegates, 125th Annual Meeting, Resolution No. 2 (Apr. 23-25, 1999).

32. S.B. 404, 1999-2000 Reg. Sess. (Cal. 1999).

33. Charlotte Ellertson et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" *Journal of the American Medical Women's Association*, vol. 53, no.5, supp. 2 (1998): 227-29.

NARAL
Reproductive Freedom & Choice

EMERGENCY CONTRACEPTIVE PILLS SHOULD BE AVAILABLE OVER-THE-COUNTER

Emergency contraceptive pills (ECPs) are ordinary birth control pills that significantly decrease a woman's chance of becoming pregnant when administered within 72 hours of unprotected sex.[1] Estimates show that increased use of ECPs could reduce the number of unintended pregnancies and abortions by half annually.[2] In recent years, the FDA has approved two types of ECPs – the PREVEN Emergency Contraception Kit and Plan B – both of which are available by prescription.[3]

Currently, ECPs can be difficult to obtain in a timely manner because women must obtain a prescription in order to use them. For example, a woman faced with a broken condom on a Friday night, whose doctor's office is closed over the weekend, might have to wait until the following Monday – three days later – to obtain a prescription for ECPs. Women in rural areas may have to travel great distances to reach the nearest doctor or clinic, making a prescription within 72 hours of unprotected sex difficult, if not impossible to obtain. Even under less extreme circumstances, obtaining a prescription for ECPs can be problematic. A recent study of the Emergency Contraception Hotline (1-888-NOT-2-LATE), a 24-hour, automated phone line that provides the names and telephone numbers of clinicians who prescribe ECPs in the caller's geographic area, found that even when calls to clinicians were made during business hours, only three out of every four attempts to obtain ECPs resulted in appointments or telephone prescriptions within 72 hours.[4] Because ECPs are more effective the earlier they are used – and most effective within the first 12 hours of unprotected sex[5] – the obstacles associated with obtaining a prescription for ECPs pose a serious threat to women's health.

Because ECPs are safe, effective, and easily self-administered, they are suitable for non-prescription (i.e. over-the-counter) availability. Making ECPs available over-the-counter would eliminate an unnecessary barrier to women's access to this important contraceptive option.

1156 15th Street, NW
Suite 700
Washington, DC 20005
202 973 3000
202 973 3096 fax

10951 West Pico Boulevard
Suite 100
Los Angeles, CA 90064
310 234 2805
310 234 8806 fax

http://www.naral.org
naral@naral.org

FDA CRITERIA FOR OVER-THE-COUNTER DRUGS

To be approved by the FDA for over-the counter distribution, a drug must meet certain criteria:

- the drug must be safe and effective;
- taking the drug must be safe enough that medical supervision – and thus, a prescription – is not necessary to preserve public health due to the drug's toxicity, its potential for harmful side-effects, or its method of use; and
- the drug must be simple enough to use that instructions on the drug's packaging are sufficient to ensure safe and correct self-medication.[6]

The FDA requires a prescription for drugs that, because of their toxicity, their potential for harmful side-effects, or their method of use, are not safe to use except under the supervision of a medical professional.[7] ECPs meet the criteria for non-prescription status and can be safely marketed over-the-counter.

ECPs ARE SAFE AND EFFECTIVE

- Oral contraceptives, the same drugs found in ECPs, have been studied for three decades. They have been studied more extensively and have been found safer than most drugs in medicine. No serious medical consequences from an overdose of oral contraceptives have been reported.[8]
- ECPs are 75 to 89 percent effective when a specific dose is taken within 72 hours of unprotected sex and a second dose is taken 12 hours after the first dose.[9]

ECPs HAVE MINIMAL SHORT-TERM SIDE-EFFECTS

- The most common side-effects of ECPs are nausea and vomiting; other side-effects include dizziness, fatigue, and headache. These short-term side effects are not serious and are easily manageable without medical supervision.[10]
- Long-term side-effects are unlikely given the very short duration of treatment.[11]
- All of the side-effects of ECPs are less dangerous than either pregnancy or childbirth.[12]

ECPs ARE EASY AND SAFE TO SELF-ADMINISTER

- In a study of Scottish women who were given an advance supply of ECPs to keep at home, 98 percent of the women who used ECPs used them correctly, and none experienced serious adverse effects.[13]
- Women can diagnose their own need for ECPs; taking the drug involves simply swallowing pills.[14]
- The dosage and timing of ECP use are the same regardless of the individual characteristics of the woman.[15]
- No specific medical conditions preclude a woman's use of ECPs. In fact, the only contraindication to ECPs is pregnancy – not because ECPs can harm a pregnant

woman or a developing embryo, but because ECPs will not work once pregnancy begins.[16]

NON-PRESCRIPTION ACCESS TO ECPs DOES NOT DISCOURAGE ONGOING CONTRACEPTIVE USE

- Claims that increased access to emergency contraception might encourage riskier sexual behavior or lead to less frequent use of other forms of contraception have not been supported by recent data. A Scotland study found that, compared to women who had to go through their doctors to obtain ECPs, women who had a supply of ECPs available at home did not differ in their use of other forms of contraception and were not more likely to use ECPs more frequently. In addition, 98 percent of the women reported that they did not take more risks as a result of having ECPs readily available.[17]

BETTER ACCESS TO ECPs WILL IMPROVE WOMEN'S HEALTH

- Nearly 50 percent of pregnancies in the U.S. are unintended, and over half of those pregnancies end in abortion.[18] An estimated one half of these unintended pregnancies and abortions could be prevented each year through wider use of ECPs.[19]
- Lack of access to emergency contraception may contribute to higher rates of unplanned pregnancy in the U.S. compared to countries where emergency contraception is widely available.[20] Negative health outcomes – including delayed or inadequate prenatal care, increased likelihood of low birth weight and death in the first year of life, increased risk of the mother being physically abused, and economic hardship – are strongly associated with unintended pregnancy.[21]
- ECPs are more effective the earlier they are used: delaying the first dose of ECPs more than 12 hours after unprotected sex increases a woman's chance of becoming pregnant by 50 percent. Thus, immediate access to ECPs is crucial for maximizing effectiveness.[22]
- By increasing women's contraceptive options, better access to ECPs will give women greater control over their reproductive lives.

In short, ECPs have all of the characteristics of an over-the-counter drug: they are safe, effective, and simple to use; they are not associated with any serious or harmful side-effects; they are not dangerous to women with particular medical conditions; and they do not lead to riskier behavior or less frequent use of other forms of contraception. ECPs have enormous potential to reduce unintended pregnancy and the need for abortion. In fact, wider access to and use of them is perhaps the single most promising avenue for reducing this country's high rate of unintended pregnancy. If women simply saw them in pharmacies, awareness of ECPs would increase tremendously. This could make a crucial difference to millions of women. However, without speedy and uncomplicated access to ECPs, women cannot take full advantage of this important contraceptive option. Making ECPs available over-the-counter would remove this barrier to access, and help to improve women's health.

6/22/2000

Notes

[1] James Trussell, Charlotte Ellertson and Felicia Stewart, "The Effectiveness of the Yuzpe Regimen of Emergency Contraception," *Family Planning Perspectives*, vol. 28, no. 2 (Mar./Apr. 1996): 58, 64; Women's Capital Corporation, "A New Generation of Emergency Contraception Has Arrived," July 28, 1999 (press release).

[2] Based on data from the 1980s, it is estimated that increased use of ECPs could reduce the number of unintended pregnancies by 1.7 million annually and the number of abortions by 800,000. James Trussell et al., "Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives,* vol. 24, no. 6 (Nov./Dec. 1992): 269-70.

[3] PREVEN contains a combination of estrogen and progestin. Plan B contains only levonorgestrel, a progestin. Food and Drug Administration (FDA), "FDA Approves Application for Preven Emergency Contraceptive Kit," Sept. 2, 1998 (talk paper); Women's Capital Corporation, "A New Generation of Emergency Contraception Has Arrived."

[4] James Trussell, et al., "Access to Emergency Contraception," *Obstetrics & Gynecology*, vol. 95, no. 2 (Feb. 2000): 267-270.

[5] G. Piaggio, et al., "Timing of Emergency Contraception with Levonorgestrel or the Yuzpe Regimen," *The Lancet,* vol. 353 (Feb. 27, 1999): 721.

[6] Prescription-exemption procedure, 21 C.F.R. § 310.200(b) (2000).

[7] 21 U.S.C.A. § 353(b)(1)(A) (1999).

[8] Maureen B. Gardner, Office of Research Reporting, National Institute of Child Health and Human Development (NICHD), "Facts About Oral Contraceptives," June 1983 (factsheet), reprinted by the National Institutes of Health <http://www.nih.gov/health/chip/nichd/oralcnt/> (6/13/00); Charlotte Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" *Journal of the American Medical Women's Association*, vol. 53, no. 5 (Supplement 2, 1998): 227 *citing* M. Smith and P. Kane, *The Pill Off Prescription* (London: The Birth Control Trust, 1975).

[9] Trussell, Ellertson and Stewart, "The Effectiveness of the Yuzpe Regimen of Emergency Contraception," 58, 64; Women's Capital Corporation, "A New Generation of Emergency Contraception Has Arrived."

[10] Task Force on Postovulatory Methods of Fertility Regulation, "Randomised Controlled Trial of Levonorgestrel Versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency Contraception," *The Lancet*, vol. 352, no. 9126 (Aug. 8, 1998): 431, tbl. 4; Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" 228.

[11] Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" 228.

[12] Anna Glasier, "Safety of Emergency Contraception," *JAMWA*, vol. 53, no. 5 (Supplement 2, 1998): 219.

[13] Anna Glasier and David Baird, "The Effects of Self-Administering Emergency Contraception," *New England Journal of Medicine*, vol. 339, no. 1 (Jul. 2, 1998): 1-4.

[14] Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" 227.

[15] Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" 227.

[16] Ellertson, et al., "Should Emergency Contraceptive Pills Be Available Without Prescription?" 227.

[17] Anna Glasier and David Baird, "The Effects of Self-Administering Emergency Contraception," 1-4.

[18] Stanley Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives*, vol. 30, no. 1 (Jan./Feb. 1998): 27.

[19] James Trussell et al., "Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives*, vol. 24, no. 6 (Nov./Dec. 1992): 269-270.

[20] Richard A. Grossman and Bryan D. Grossman, "How Frequently Is Emergency Contraception Prescribed?" *Family Planning Perspectives*, vol. 26, no. 6 (Nov./Dec. 1994): 270.

[21] Committee on Unintended Pregnancy, Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Sarah S. Brown and Leon Eisenberg, eds. (Washington, DC: National Academy Press, 1995), 81.

[22] Piaggio, et al., "Timing of Emergency Contraception," 721.

Betsy Cavendish — 973-3042 — E.O. ideas

(1) Map-up study — when are clinic violence issue
strengths of laws
cases still pending
hiding of assets — ~~hiding~~ using bankruptcies
Map-up when task force has done

has talked to E.D. Attorneys

(2) E.O. requiring that Hospitals give rape victims
emergency contraception
- high doses of BC — can only stop a pregnancy
from happening
- can disrupt an already set-up pregnancy

stops ovulation or implantation.

11/27 (Cynthia) EC - hospitals - rape victims

Cory/Susan - etc. - Questions:

① conscience clause how to be dealt w/ if give restrictions a conscience clause if provide institutional conscience clause for contraception (might be an exposure (most c.c. are abortion/sterilization)

② Congress will respond - they are uneducated about E.C. now ("miseducated") it's high profile - Congress is already primed will they get E.C. + school

well provide response will have in a big loss - start now to educate hospitals EC

③ provider conscience clause is fine but probably not enough

do you think you can win on this? could end up w/ exemption - no plan, etc. has to cover EC's

11/27 Betsy / Allison

Church amendment - FEHBP - lets Catholic plans

Catholic Directives are ambiguous on this (offering sympathy to ♀ who have been raped) may be daylight - may not prohibit EC

* special leg

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. note	re: phone number (partial) (1 page)	11/27	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21195

FOLDER TITLE:
E.O. [Executive Order] on Emergency Contraception

2012-0254-S
rc663

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

11/27

attn: Hannah

So sympathetic - are class of victimized & don't revictimize

Always potential for backlash

FACE - L.D. Aitcheson (Eldie)

lay predicate

make sure they don't drop pending cases a ★ investigations

Setting forth accomplishments -

(1) status report (GAO study couple years ago)

(2) pending - grand jury

(3) road maps for future

Carla Richards P6/(b)(6) [002]

Turner Foundation

Joanne Howes -- P6/(b)(6)

P6/(b)(6) HCW

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Heather Howard to Bruce Reed re: Ideas for Executive Actions to Promote Reproductive Rights (2 pages)	11/27/2000	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Heather Howard (Subject Files)
OA/Box Number: 21195

FOLDER TITLE:
E.O. [Executive Order] on Emergency Contraception

2012-0254-S
rc663

RESTRICTION CODES

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FAX

THE ALAN GUTTMACHER INSTITUTE
NEW YORK & WASHINGTON
1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Phone: 202 296-4012
Fax: 202 223-5756
E-mail: policyinfo@agi-usa.org
Web site: www.agi-usa.org

Date: November 27, 2000

To: Heather Howard
Fax #: 456-2878

From: Cynthia Dailard

Number of pages (including cover sheet): 10

COMMENTS:

I am faxing you two documents. One is an article written by Rachel Gold of AGI that discusses how "conscience clauses" in federal law have moved over time from religious exemptions for individuals and institutions over abortion and sterilization services to more indirect forms of involvement (such as insurance coverage) in a wider array of services. The article contains a useful chart on conscience clauses in federal and state law. I am also faxing you a NARAL document which I find very useful because it provides the legislative language for the various conscience clauses in federal law. You should see, in particular, the language for the Church amendment.

Here is the bottom line: The Church amendment exempts individuals and institutions from providing abortion and sterilization on religious grounds. Any exemption for institutions that object to *contraception* would be a significant expansion of federal law on the subject of conscientious objections.

Refusing to Participate In Health Care: A Continuing Debate

For nearly 30 years, policymakers have debated the circumstances in which it may be appropriate for individuals and institutions involved in health care to refuse to participate in services to which they object as a matter of conscience. The rise of managed care and recent debates over mandating insurance coverage of contraception have brought into focus the many facets of this issue, including the rights and responsibilities of such corporate players as health plans and employers.

By Rachel Benson Gold and Adam Sonfield

Among the host of national controversies unleashed by the Supreme Court's *Roe* v. *Wade* decision is the issue of whether individuals and institutions should be permitted to refuse to participate in health care services on the grounds of religious belief or moral objection. However, what had originally presented itself as a matter involving individual clinicians and facilities in the actual provision of abortion and sterilization procedures has broadened in the nearly three decades since Roe to include a range of issues concerning more indirect forms of involvement in a wider array of services. The result is a complex and interrelated web of federal and state laws and policies addressing the fundamental questions of whose nonparticipation should be allowed and for what services (see chart). Some of these public policy questions—especially as they pertain to the actual provision of medical care and, specifically, the provision of abortion and sterilization services—have not been actively debated in many years. Others, concerning involvement less directly related to the hands-on provision of medical care and the breadth of allowable reasons for noncompliance, remain highly controversial. What is certainly least developed, however, is a body of public policy addressing the other side of the equation: the ability of individuals to obtain health care services to which they are entitled, by law or under the terms of their insurance plan, in a system in which a range of key players are allowed to opt out.

Conscience and Health Care Providers

Within weeks of the *Roe* decision in 1973, Congress adopted legislation proposed by then-senator Frank Church (R-ID) that permits individual health care providers receiving federal funding or working for entities receiving such funding to refuse to perform or assist in performing abortions or sterilizations if these procedures violate their religious beliefs or moral convictions. The provision also prohibits discrimination against health care providers because of their nonparticipation—or participation—in abortions or sterilizations.

At least as related to abortion, states quickly emulated, and expanded, the federal model. More than half the states adopted laws by the end of 1974, and currently, 45 states allow health care providers—whether or not public funds are involved—to refuse to participate in the delivery of abortion services. Only three of these states require providers to notify patients of their refusal. Moreover, while 39 states protect providers who refuse to participate in abortion from discrimination, only eight follow the federal law in also protecting those who do choose to participate.

Several states apply these types of provisions to other reproductive health services. Twelve states allow individuals to refuse to provide sterilization services, while 13 states allow health care providers, public employees or both to refuse to provide contraceptive services or information related to contraception. (Two additional states have general provisions allowing providers to refuse to participate in any health care service.)

In addition to allowing individuals to opt out, the federal Church amendment allows institutional health care providers, such as hospitals, receiving federal funding to refuse to permit their facilities to be used for abortions or sterilizations if those procedures contravene the facility's religious beliefs or moral convictions. However, the law offers no criteria for determining when a health care facility—a corporate entity—appropriately may claim a religious or moral belief.

Similar provisions allowing institutions to refuse to participate in the delivery of abortion services were adopted by 12 states, although, significantly, only a handful of these statutes mirror the federal provision by limiting the grounds for refusal to religious or moral beliefs. Moreover, five states specifically allow facilities to refuse to provide even advice and counseling about or referral for abortion. And only seven require institutions to notify the public, through a posted public notice or directly to the patient, of their policy.

Federal and State Policies Allowing Nonparticipation in Reproductive Health Care

	Individual Providers	Institutional Providers	Insurers	Employers
Federal	A*, S*	A*, S*	C*, G*	
Alabama				
Alaska	A	A§		
Arizona	A	A		
Arkansas	A, S, C	A, S, C§		
California	A	A**		C††
Colorado				
Connecticut	A			C††
Delaware	A	A		
Florida	A, C	A		
Georgia	A, S, C‡‡	A, S		
Hawaii				
Idaho	A, S			
Illinois	A, G	A, G	G	
Indiana	A	A§		
Iowa	A	A§		
Kansas				
Kentucky	A, S	A		
Louisiana	A	A		
Maine	A, C	A, C§		C††
Maryland	A, S	A, S		C††
Massachusetts				
Michigan	A	A		
Minnesota	A, C‡‡	A§		
Mississippi				
Missouri	A	A		
Montana	C, S			
Nebraska	A			
Nevada	A	A§	C	
New Hampshire				
New Jersey	A, S	A§, S§, C§		
New Mexico				
New York	A‡‡	S		
North Carolina	A	A		C
North Dakota	A	A, G		
Ohio	A	A		
Oklahoma				
Oregon	A, C	A§		
Pennsylvania	A, S	A§, S§	G	
Rhode Island	A, S			
South Carolina	A	A§		
Tennessee				
Texas	A	A§		
Utah	A	A§		
Vermont				
Virginia				
Washington	A, G	A, G	G	
West Virginia	C‡‡			
Wisconsin	A, S, C‡‡	A, S		
Wyoming	A, C‡‡	A§		

*Applies to recipients of federal funds and participants in programs receiving federal funds. †Applies to five named religious plans and any other that objects on the basis of religious beliefs participating in the Federal Employees Health Benefits Program (FEHBP). ‡Applies to Medicaid managed care plans and FEHBP participating plans with respect to counseling and referral only, not to the actual provision of services. §Applies only to private institutional providers. **Applies only to religious entities. ††Applies only to religious employers. ‡‡Applies only to public employees. §§Applies only to pharmacists with respect to medication that may "destroy an unborn child...from fertilization until live birth." *Note:* A=abortion; S=sterilization; C=contraception; G=general policy applying to any medical service.

Eleven states allow some or all facilities to refuse to provide sterilization services, and seven states allow them to refuse to provide contraceptive services or information related to contraception. (Three additional states have general provisions that cover all health care services.)

Sparked in part by the Food and Drug Administration's approval in September 1998 of "emergency contraception," birth control pills packaged specifically for use within 72 hour of unprotected intercourse—as well as by concerns over the potential legalization of assisted suicide—some pharmacists, and even some pharmacies and pharmacy chains, have begun to assert a right to refuse to fill certain prescriptions (*TGR*, Vol. 2, No. 3, June 1999). In 1998, South Dakota enacted a law allowing pharmacists to refuse to fill prescriptions related to assisted suicide and euthanasia or to the destruction of "an unborn child"—defined under state statute to include a fertilized egg. Similar legislative proposals were seriously considered in four states in 1999, but none was adopted. However, many of the state laws allowing providers to refuse to provide contraception could be interpreted to apply to pharmacists or pharmacies.

Coverage Mandates and Plan Noncompliance

Federal and state mandates that a specific package of benefits be covered, and the rise of managed care, together and separately raise a series of thorny policy questions about the circumstances under which health plans that pay for care, rather than provide it, should be permitted to opt out of covering services to which they may object. In Medicaid, the joint federal-state insurance program for low-income Americans, the two issues are joined.

Medicaid covers six million women of reproductive age, almost all of whom now get their health care through some type of managed care arrangement. Family planning is one of the few services mandated by federal Medicaid law, giving Medicaid recipients nationwide a legal entitlement to unfettered access to contraceptive services and supplies.

In an effort to ensure that access to family planning would not be impeded because individual providers, or even entire managed care plans, refuse to provide the care, the federal Medicaid statute was amended in the mid-1980s to allow managed care enrollees to obtain family planning services from the provider of their choice, even if outside their managed care plan. This provision remains one of the few conscious attempts by policymakers to mitigate the impact of noncompliance on people seeking services. Because the individual states historically organized and operated their own Medicaid managed care systems, implementation of this provision was left to them (*TGR*, Vol. 1, No. 4, August 1998).

States' latitude over their Medicaid managed care efforts was limited in 1997, when Congress, as part of far-ranging budget legislation, moved to establish the first uniform national standards for Medicaid managed care. In so doing, Congress extended to Medicaid managed care enrollees key elements of a package of protections, known as the Consumers' Bill of Rights and Responsibilities, that had been developed by a presidential advisory commission. A central component of this package is an "antigag provision," designed to preclude plans from prohibiting providers from discussing treatment options not covered by the plan.

When Congress extended the antigag protection to Medicaid enrollees, however, it also added a provision allowing plans to refuse to cover counseling and referral services to which the plan has a religious or moral objection. While this provision applies only to counseling and referral and not the actual provision of services, advocates were fearful of the impact on low-income women's reproductive health of such an invitation to decline to provide time-consuming counseling and referral services.

Advocates also feared that the joining of the counseling and referral exemption to the antigag provision would be a precedent for subsequent extensions of the protections of the Consumers' Bill of Rights and Responsibilities to other groups of managed care enrollees. These fears quickly proved to be well founded. In 1998, Congress embarked on an effort to extend these consumer protections to privately insured Americans. As the measure languished in the face of stiff opposition, an impatient Clinton administration used an executive order to extend the protections where it could, including to the nearly 300 plans participating in the Federal Employees Health Benefits Program (FEHBP). Unfortunately, in doing so, the administration continued the pairing of the antigag and noncompliance provisions. Whether that pairing will be continued at such time as Congress actually passes a consumer bill of rights for privately insured Americans is now very much an open question.

The question of whether plans could refuse to comply with a federal mandate also surfaced when Congress in 1998 took the historic step of mandating contraceptive coverage for federal employees and their dependents under the FEHBP. The final measure included a provision allowing noncompliance by five named religious health plans, as well as any other existing or future plan that objects on the basis of its "religious beliefs."

Plan noncompliance with a contraceptive coverage mandate also has figured in state contraceptive coverage debates; a statute enacted in 1999 in Nevada, for example, exempts an insurer affiliated with a religious organization if it objects to such coverage on religious

grounds. At the same time, policymakers and plans alike have tried to find creative ways to mitigate the impact on enrollees. Under a 1999 Connecticut contraceptive coverage mandate, for instance, a managed care plan that objects to providing such coverage may have a financial arrangement with a third party to pay for services for enrollees, thereby keeping the plan at arm's length from the actual payment for contraception while ensuring coverage for enrollees. Similar tactics, in fact, have been adopted quietly by religious plans across the country in order to participate either in Medicaid programs that require coverage of contraception and other reproductive health care or in a private marketplace when such health care is demanded by consumers (*TGR*, Vol. 1, No. 6, December 1998).

Finally, broad-based managed care laws in at least four states (Illinois, Pennsylvania, Texas and Washington) explicitly give plans a general right to refuse to pay for any health care service that is in violation of some standard of conscience, moral belief or religious conviction. (The noncompliance provision in Washington is especially broad and also includes employers with "a religious or moral tenet opposed to a specific service.") In fact, such laws are not entirely new. A 1979 Massachusetts statute allows HMOs to refuse to pay for or provide referrals for abortions not necessary to prevent the death of a woman, and several other longstanding provisions relating to abortion or family planning are written so broadly that they could be construed to cover managed care organizations or other insurance providers.

Employer Rights and Responsibilities

Since most people in this country obtain insurance for themselves and their dependents through the workplace, calls for contraceptive coverage mandates inevitably have sparked a debate over the circumstance in which employers might be allowed to refuse to comply.

The Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), pending in both houses of Congress, would mandate contraceptive coverage in private, employment-related insurance policies nationwide. As initially proposed, neither the House nor the Senate version included a noncompliance provision. (And the issue was essentially irrelevant to the FEHBP debate, because the employer in this case is the federal government itself.)

But at the state level, where contraceptive coverage mandates have received more serious consideration and several have been enacted, the question of whether employers have a right to refuse to comply with a contraceptive coverage mandate has been a focal point of debate (*TGR*, Vol. 2, No. 4, August 1999). In 1995, a bill approved by the California legislature was vetoed by then-governor Pete Wilson (R) specifically because it failed to include such an employer exemption.

So far, 10 states have enacted comprehensive, EPICC-like contraceptive coverage legislation; six of these 10 laws allow at least some employers to decline to comply. While all six of the laws allow so-called religious employers to refuse to include contraceptive coverage in the plans they purchase for their employees, they differ significantly in how they define "religious employer." Maryland, the first state to enact a mandate, is at one end of the spectrum; its 1998 law includes no definition of religious employer at all, allowing employers to refuse to cover contraceptives if doing so would be against their "bona fide religious beliefs and practices."

California is at the other end of the spectrum. Legislation finally signed into law by Gov. Gray Davis (D), following three vetoes by his predecessor, narrows noncompliance to an employer that is a nonprofit organization whose purpose is to further "the inculcation of religious values" and that primarily employs and serves people who share the religious tenets of the employer.

One of the recent state laws contains an interesting provision aimed at balancing an employer's right to claim a conscientious exemption with ensuring access to contraception for individuals covered under the policy. Legislation enacted in Hawaii allows employees in firms claiming the exemption to purchase contraceptive coverage directly from the insurance plan itself, bypassing the employer entirely. Employees choosing this coverage would be required to pay no more than what would have been paid if contraceprive coverage had been included in the group policy.

As states return to their first legislative session of the new century, it is likely that the question of mandating contraceptive coverage will continue to occupy a prominent place on their agendas. If last year is a barometer, that discussion will often include debate over the circumstances under which employers, plans and providers may refuse to comply. The issue is also likely to arise should Congress seriously consider EPICC in this or a subsequent legislative season. For their part, those advocating for access to reproductive health services in either the federal or the state legislation will continue to search for innovative strategies to mitigate the extent to which such noncompliance impedes access to this important care.

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NARAL *Promoting Reproductive Choice*

CONSCIENCE CLAUSES IN CURRENT LAW

It is often appropriate to allow individual providers to decline to provide certain medical services because of their personal religious beliefs or moral convictions. However, if an individual opts-out of providing a service to which he or she is religiously or morally opposed, then health care personnel must make an appropriate referral for the requested care. A conscience clause must not operate to deny access to health care services.

Attached is the language of conscience clauses that are in current federal law. The first conscience clause, now known as the Church Amendment, was enacted in 1973 and has been the model for subsequent provisions in federal law. The Church Amendment states that no individual or entity (such as a religious hospital) has to perform or assist in the performance of a sterilization procedure or abortion or make facilities available for these procedures if doing so is contrary to the religious beliefs or moral convictions of an individual. It also protects against discrimination in employment against any individual who has assisted or refused to assist in an abortion. This language originally applied to programs funded under the Public Health Service Act. A year later an amendment was added to include individuals involved in any program funded by DHEW (now DHHS).

Until the FY 98 Budget Reconciliation bill, conscience clauses applied to individuals and in the case of the Church Amendment and in the Civil Rights Restoration Act also apply to entities. **But nowhere were conscience clauses extended to plans or institutions acting as insurers.**

A broadly written conscience clause can deny patients access to medically necessary services.

CURRENT LAW

Church (D-ID) Amendment to the Health Programs Extension Act of 1973, Pub. L. No. 93-45. (Enacted June 18, 1973)

SEC. 401 (b). The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act by any individual or entity does not authorize any court or any public official or other public authority to require

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to -

(A) make its facilities available for the performance of any sterilization procedure or abortion if

National Abortion and Reproductive Rights Action League
1156 15th Street, NW
Suite 700
Washington, DC 20005
Phone (202) 973-3000
Fax (202) 973-3096
10536 Culver Boulevard
Suite B
Culver City, CA 90232
Phone (310) 559-9334
Fax (310) 204-6942
http://www.naral.org
E-Mail: naral@naral.org

the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

(c)(1) No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act after the date of enactment of this Act may --

(A) discriminate in the employment, promotion, or termination of the employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortion.

The Church Amendment was amended by the National Research Act of 1974, Pub. L. No. 93-348. (Enacted July 12, 1974)

SEC. 214 (a)(2). Section 401 of such Act is amended by adding the following new subsection: (c)(2) No entity which receives after the date of enactment of this paragraph a grant or contract for biomedical or behavioral research under any program administered by the Secretary of Health, Education, and Welfare may --

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of any lawful health service or research activity, because he refused to perform or assist in the performance or assistance in the performance of such service or activity on the grounds that his performance or assistance in the performance of such activity would be contrary to his religious beliefs or moral convictions respecting to any such service or activity.

(b) Section 401 of such Act is amended by adding at the end of the following new subsection: (d) No individual shall be required to perform or assist in the performance if any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health, Education, and Welfare if his performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

Danforth (R-MO) Amendment to the Civil Rights Restoration Act, Pub. L. No. 100-259. (Enacted March 22, 1988)

SEC. 909. Nothing in this title shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to any abortion. Nothing in this section shall be construed to permit a penalty to be imposed on any person or individual because such person or individual is seeking or has received any benefit or service related to a legal abortion.

Commerce, Justice, State Appropriations from FY 97 Omnibus Appropriations, Pub. L. No. 104-208. (First Enacted, October 1, 1988 - Current Language Enacted September 30, 1996)

SEC. 103. None of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term or in the case of rape: Provided, That should this prohibition be declared unconstitutional by a court of competent jurisdiction,

this section shall be null and void.

SEC. 104. None of the funds appropriated under this title shall be used to require any person to perform, or facilitate in any way the performance of, any abortion.

SEC. 105. Nothing in the preceding section shall remove the obligation of the Director of the Bureau of Prisons to provide escort services necessary for a female inmate to receive such service outside the Federal facility: Provided, That nothing in this section in any way diminishes the effect of section 104 intended to address the philosophical beliefs of individual employees of the Bureau of Prisons.

ACGME (Accreditation Council on Graduate Medical Education), Pub. L. No. 104-134. (Amendment to the permanent authorizing statute Enacted April 25, 1996)

SEC. 245 (a) In general -- The Federal Government and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that

(1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions or to provide referrals for such training or such abortions;

(2) the entity refuses to make arrangements for any of the activities specified in paragraph (1); or

(3) the entity attends (or attended) a post-graduate physician training program or any other program of training in the health professions that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

(b) Accreditation of Postgraduate Physician Training Programs.--

(1) In General -- In determining whether to grant a legal status to a health care entity (including a license or certificate), or to provide such entity with financial assistance, services or other benefits, the Federal Government or any State or local government that receives Federal financial assistance, shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standards that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortion or make arrangements for such training regardless of whether such standard provides exceptions or exemptions. The government involved shall formulate such regulation or other mechanisms or enter into such agreements with accrediting agencies, as are necessary to comply with this subsection.

(2) Rules of Construction --

(A) In General - With respect to subclauses (I) and (II) of section 705 (a) (2) (B) (I) (relating to a program of insured loans for training in the health professions), the requirements in such subclauses regarding accredited internship or residency programs are subject to paragraph (1) of this subsection.

(B) Exceptions--This section shall not--

(i) prevent any health care entity from voluntarily electing to be trained, to train or to arrange for training in the performance of, to perform or to make referrals for induced abortions or

(ii) prevent an accrediting agency or Federal, State or local government from establishing standards of medical competency applicable only to those individuals who have voluntarily elected to perform abortions.

(c) Definitions--for the purposes of this section:

(1) The term 'financial assistance', with respect to government program, includes government payments provided as reimbursement for carrying out health-related activities.

(2) The term 'health care entity' includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.

(3) The term postgraduate physician training program includes a residency training program.

Balanced Budget Act of 1997, Pub. L. No. 105-33 (Enacted August 5, 1997)

MEDICARE+CHOICE SECTION (Title IV, Subtitle A)

SEC. 1852 (j)(3) Prohibiting interference with provider advice to enrollees---

(A) In general--Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection--Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan--

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

MEDICAID SECTION (Title IV, Subtitle H)

SEC. 4704 (b)(3) Protection of enrollees-provider communications---

(A) In general--Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a Medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) Construction--Subparagraph (A) shall not be construed as requiring a Medicaid managed care organization to provide, reimburse for, or provide coverage of a counseling or referral service if the organization--

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Contraceptive Coverage for Federal Employees -- Treasury, Postal Appropriations from FY 99 Omnibus Appropriations, Pub. L. No. 105-277 (Enacted October 21, 1998)

DEPARTMENTS, AGENCIES, AND CORPORATIONS GENERAL PROVISIONS SECTION (Title VI)

SEC. 656 (a) None of the funds appropriated by this Act may be used to enter into or renew a contract which includes a provision providing prescription drug coverage, except where the contract also includes a provision for contraceptive coverage.

(b) Nothing in this section shall apply to a contract with:

(1) any of the following religious plans:

(A) SelectCare

(B) Personal CaresHMO

(C) Care Choices

(D) OSF Health Plans, Inc.

(E) Yellowstone Community Health Plan

(2) any existing or future plan, if the plan objects to such coverage on the basis of religious beliefs

(c) In implementing this section, any plan that enters into or renews a contract under this section may not subject any individual to discrimination on the basis that the individual refuses to prescribe contraceptives because such activities would be contrary to the individual's religious beliefs or moral convictions.

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Catholic Directives

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Suite 700
Washington, DC 20005
202 973 3000
202 973 3096 fax

10951 West Pico Boulevard
Suite 100
Los Angeles, CA 90064
310 234 2805
310 234 8806 fax

http://www.naral.org
naral@naral.org

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Ethical and Religious Directives for Catholic Health Care Services

"A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the church and in American society," say the *"Ethical and Religious Directives for Catholic Health Care Services"* approved by the U.S. bishops Nov. 17 during their meeting in Washington and made public by their Committee on Doctrine Dec. 1. The text revises and updates directives approved by the U.S. bishops in 1971 and revised in 1975. The directives *"are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel and patients or residents of these institutions and services,"* says the text. But, it is added, the directives *"also will be helpful to Catholic professionals engaged in health care services in other settings."* The document includes six parts, each divided into two sections: The first section *"serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form."* The six parts cover social responsibility; pastoral and spiritual responsibility; the professional-patient relationship; the beginning of life; the dying; new partnerships with health care organizations and providers. The directives discuss abortion, euthanasia, treatment of rape victims, advance directives for health care decisions, care for the poor, medical or genetic experimentation, treatment for infertility, prenatal diagnosis, experiments on a living embryo or fetus, surrogate motherhood, in vitro fertilization, nutrition and hydration for the terminally ill, pain treatment, organ donation, employee rights and responsibilities, and many other issues. The text is accompanied by a note explaining that *"at the annual meeting of the National Conference of Catholic Bishops the directives were approved as the national code, recommended for implementation by the diocesan bishop."* The text of the directives follows.

PREAMBLE

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are

(continued on page 451)

DECEMBER 15, 1994
VOL. 24: NO. 27

origins
CNS documentary service

reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side effects, consequences and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient, or excessive expense to family or community.[18]

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence, and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

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 [illegible] 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.[19]

"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."

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these directives.

PART 4
ISSUES IN CARE FOR THE BEGINNING OF LIFE

Introduction

The church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The church cannot approve medical practices that undermine the biological, psychological and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The church's defense of life encompasses the unborn, and the care of women and their children during and after pregnancy. The church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to

Oregon voters approved a ballot measure Nov. 8 to allow physicians to prescribe lethal drugs for terminally ill patients expected to die within six months and who request the drugs. Archbishop William Levada of Portland, Ore., gave a report Nov. 16 to the U.S. bishops during their fall meeting in Washington on the vote in his state, noting that Oregon had become the "only state in our nation to decriminalize doctor-assisted suicide for terminally ill patients." The text of his report appeared in the current volume of Origins, pp. 431ff (Dec. 1, 1994). "Supporters of this new legislation have indicated their desire to promote similar changes in laws throughout our country," Levada said. The archbishop also said the results of the vote in Oregon "clearly demonstrate the need to increase our educational efforts and the importance of building coalitions with other concerned citizens in the face of the likely efforts of the euthanasia movement to take their campaign to the nation at large."

Other texts on the Oregon ballot measure appeared in the current volume of Origins, pp. 353 and 355 (Nov. 3, 1994).

Among other very recent texts in Origins on euthanasia and physician-assisted suicide, see:

— "What Euthanasia Is and What It Is Not," by the bishops of Canada, the current volume, pp. 393ff (Nov. 17, 1994).

— "Environment Where Support for Euthanasia Grows," by Archbishop Thomas Murphy of Seattle, pp. 385ff (Nov. 17, 1994).

— "Brief Asks Reversal of Assisted-Suicide Ruling," by the U.S. Catholic Conference and the West Coast State Catholic Conferences, the current volume, pp. 214ff (Sept. 1, 1994).

— "Raising the Stakes in the Euthanasia Debate," Ruling by Judge Barbara Rothstein, the current volume, pp. 17ff (May 26, 1994).

Preventing Pregnancy After Rape:

Does Your Hospital Provide Emergency Contraception to Rape Survivors?

A
Report of
The New York State Affiliate of the
National Abortion and Reproductive Rights Action League
Foundation (NARAL/NY Foundation)

December 1999

New York State Affiliate
NATIONAL ABORTION &
REPRODUCTIVE RIGHTS
ACTION LEAGUE
62 Broadway
te 540
York, NY 10013-
9-0114

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NARAL/NY is the New York State affiliate of the National Abortion and Reproductive Rights Action League. With more than 50,000 members, NARAL/NY works to protect safe, legal abortion and expand the full range of reproductive rights for all New Yorkers, regardless of age or income.

The NARAL/NY Foundation is the 501 (c) (3), tax-exempt research, educational and training arm of NARAL/NY. The Foundation produces a variety of educational materials and training programs to educate members, advocates, and the general public about reproductive rights issues.

Many individuals have offered support throughout the production of this report. NARAL/NY Foundation would like to highlight the collective effort behind this project and extend the deepest thanks to the generous funding provided to the NARAL/NY Foundation, whose grants have made this work possible.

We wish thank Catholics for Free Choice and The Abortion Access Project of Massachusetts. Both organizations have examined the provision of emergency contraception at Catholic hospitals and their work inspired our efforts in New York. Finally, the NARAL/NY staff, interns and volunteers, especially Jenn Turk and Julia Willdorf, have made this project possible with their ceaseless support and dedication.

NARAL/NY FOUNDATION STAFF:

Kelli Conlin..... Executive Director
Robert Jaffe..... Deputy Director
Kim Gerstman..... Deputy Development Director
Jeanne McMahon..... Director of the Reproductive Health Care Project
Erica Pelletreau..... Legislative Director
Eric Alterman..... Membership Director
Pauline DeMairo..... TORCH Director
Rebecca Raible..... Development Associate
Cristina Page..... Program Associate
Sima Weinsaft..... Long Island Project Coordinator
Sara Sills..... Volunteer Coordinator

AUTHORS OF THIS STUDY:

Robert Jaffe..... Project Director
Kaya Tretjak..... Research Coordinator
Ambika Panday..... Research Assistant
T.J. Ford..... Research Assistant
Mickey Ronan..... Legal Researcher

INTRODUCTION

Over 54 percent of the 215 hospital emergency rooms in New York State are failing to provide adequate health care to survivors of rape. The unwillingness of hospitals to provide survivors of sexual assault with safe and effective medication to prevent pregnancy jeopardizes the physical and emotional health of these patients. By not offering rape survivors emergency contraception (EC) as part of standard procedure, hospitals are failing to follow treatment protocols established by medical professionals and recommendations made by survivor advocacy groups on how to best treat rape survivors. Among the 38 Catholic-run hospitals, the number of emergency rooms failing to adequately provide EC to rape survivors is almost 80 percent. These hospitals are turning a blind eye to Catholic Church directives that allow the provision of emergency contraception to prevent conception in cases of rape.

The New York State affiliate of the National Abortion and Reproductive Rights Action League (NARAL/NY) undertook a comprehensive survey of all hospitals operating in New York State to determine whether these facilities provide emergency contraception to rape survivors. It is standard practice for emergency medical professionals or law enforcement officials to bring rape survivors to the nearest hospital for emergency medical care, evidence collection, and counseling. In order for survivors to receive proper medical care it is essential that all hospitals—including Catholic-run facilities—meet appropriate medical standards for the treatment of survivors of sexual assault.

Our study finds a frightening disparity in the way hospitals treat rape survivors. Few of the hospitals surveyed provide proper emergency care to rape survivors and only a handful have policies well understood by emergency room personnel, allowing for the provision of EC. More than half of hospitals in New York either do not take medically appropriate steps to prevent pregnancy, or have ambiguous policies that do not ensure the delivery of proper medical care to rape survivors. These hospitals demonstrate a lack of understanding of the medical necessity of providing rape survivors with emergency contraception in a timely manner.

Hospitals must ensure that every female survivor of rape is counseled about pregnancy prevention and offered emergency contraception, which should be provided immediately upon the patient's request. These hospitals also need to take a more aggressive stance in educating emergency room personnel about the importance of providing emergency contraception to rape survivors. New York State Department of Health officials must guarantee that survivors of rape are properly treated at emergency rooms and should closely monitor the care and treatment delivered by New York hospitals.

In this report, NARAL/NY examines the reasons why emergency contraception can and should be provided to rape survivors. The report describes the methodology of

the survey of New York State hospitals and offers recommendations on steps that should be taken to improve the care and treatment of rape survivors. Included are findings from the survey noting the availability of emergency contraception at the state's non-Catholic and Catholic hospitals.

NARAL/NY believes that women brought to an emergency room following a sexual assault must be provided with the highest quality and most compassionate medical care and treatment. The uneven care provided at New York State hospitals is deeply troubling and it is our hope that this report will encourage hospital officials and the State Health Department to look more closely at how these institutions provide medical care to rape survivors. Future surveys conducted by NARAL/NY will hopefully reveal a marked improvement in the provision of quality health care to rape survivors at New York State hospitals.

RAPE IN AMERICA

Rape is one of the most violent and prevalent crimes against women today. Certainly, it is also one of the most traumatic. Survivors of rape face the multiple threats of disease, physical injury, psychological trauma, and unwanted pregnancy, which are all further complicated by the necessity for comprehensive police investigations.[i] Their lives are forever changed.

- One in every six American women will be raped in her lifetime.[ii]
- The United States Department of Justice reported that 197,000 Americans were the survivors of rape in 1997.[iii]
- Only one-half of rape survivors in 1997 reported the crime to law enforcement officials.[iv]
- There were slightly more than 95,000 reported rapes in the United States in 1997.
- In 1994, sexual assault represented 5.5 percent of all violent crimes reported in the United States.[v]
- The New York State Division of Criminal Justice Services indicates that in 1994, 4,085 cases of rape were reported to law enforcement officials in the state.[vi]

THE EMOTIONAL AND MENTAL CONSEQUENCES OF RAPE ON THE SURVIVOR

Understandably, survivors of rape face acute physical and psychological pain and need immediate medical attention. However, the effects from having been raped do not easily fade. The long-term effects are numerous and may be highly destructive to one's life.

- All survivors experience disorganization in their lives.[vii]
- One-third of rape survivors report ongoing nightmares.[viii]

- Heightened anxiety, painful flashbacks, sleeping disturbances, and psychosomatic symptoms are common in all rape survivors.[ix]
- Some survivors never recover from the experience and develop chronic stress disorders and phobias.[x]
- 31 percent of all rape survivors develop Rape-Related Post Traumatic Stress Disorder (RRPTSD).[xi]
- Rape survivors are eight times more likely to commit suicide than non-survivors.[xii]

THE EFFECTS OF UNINTENDED PREGNANCY

Between one and five percent of sexual assaults result in pregnancy.[xiii] If a woman becomes pregnant after having been raped, this is not only an unintended pregnancy, but also a constant reminder of the survivor's attacker, her violator, her nightmare. Recognizing the severe psychological consequences of rape, medical experts unanimously agree that treatment for the prevention of pregnancy should be discussed and offered. Since emergency contraceptive interventions are most effective when taken immediately after sexual contact, it is critical that a woman receives timely counseling and that she is immediately offered emergency contraception. The consequences of an unintended pregnancy may further exacerbate the physical and psychological trauma already prevalent among rape survivors. An unintentionally pregnant woman is less likely to seek early prenatal care and more likely to expose the fetus to toxic substances like cigarette smoke, alcohol, and drugs.[xiv] Furthermore, the survivor is at greater risk of depression and of physical abuse.[xv]

Emergency contraception, when offered to rape survivors at the appropriate time, permits women to prevent an unintended pregnancy resulting from rape. EC allows these women to focus on their mental and physical health convalescence, and may increase their chances of full recovery.

THE TRUTH ABOUT EMERGENCY CONTRACEPTION

The use of emergency contraception is a safe and effective method of preventing pregnancy. [xvi] According to the United States Food and Drug Administration (FDA) and the American College of Obstetricians and Gynecologists, EC pills do not terminate an established pregnancy, which begins with implantation of the fertilized egg in the uterine lining. Rather, EC pills delay or inhibit ovulation or implantation prior to pregnancy.

- EC pills are actually birth control pills taken in different dosages, effective up to 72 hours after unprotected sex.
- EC pills are at least 75 percent effective in preventing pregnancy after unprotected sex, but *will not* work if a woman is already pregnant.
- EC pills *cannot* and *do not* cause abortions.
- The FDA has approved EC pills.

The safety of EC pills is well documented.[xvii] While there are no specific studies showing the effect of EC pills on a fetus, extensive studies of thousands of women who use birth control pills while pregnant have been undertaken. Studies examining women who have inadvertently continued to take birth control pills after becoming pregnant show no evidence of increased risk of fetal defects.[xviii] EC pills are a woman's last chance to avoid an unintended pregnancy before having to consider other reproductive health options, such as abortion.

EC: PROVEN MORE EFFECTIVE WHEN TAKEN EARLIER

If a rape survivor chooses to use emergency contraception after her attack, her chances of becoming pregnant are significantly reduced. A recent study released by The World Health Organization found that when a woman uses EC within 24 hours of unprotected intercourse, she reduces her chances of pregnancy by an astonishing 95 percent. The women who took EC pills between 24 and 48 hours after unprotected intercourse decreased their chances of becoming pregnant by 85 percent. The women who took the pills after 48 hours lowered their chances by 60 percent. The **sooner** a woman takes EC pills, the **less likely** she is to get pregnant.[xix]

TRANSPORTATION TO THE ER: THE PROBLEM WITH TIME AND EMERGENCY ROOMS

It is imperative that women wishing to obtain emergency contraception following a sexual assault are able to do so within 72 hours. While no exact figures are available, a significant number of rape survivors seek medical care through a hospital emergency room. A woman may be brought to an emergency room by law enforcement officials, a family member or friend, or by emergency medical responders. New York State regulations require emergency medical personnel to transport an injured woman to the nearest hospital with an emergency room, unless the patient requests that she be transported to a specific facility. The policy of the New York State Department of Health states "that a patient in need of emergency medical care be taken to the nearest appropriate health care facility."[xx] Further, the policy states that, "a patient's choice of hospital or medical facility should be complied with unless...complying with the patient's request would be injurious or cause further harm to the patient."

Given the trauma experienced by a survivor of sexual assault after the attack, she may be in no condition to specifically request a hospital that provides emergency contraception. Assault is often followed by Rape Trauma Syndrome, the short-term phase of which may last for hours or days and consists of the emotional shock, disbelief, and despair caused by a life-threatening event. The woman's outward response during this period varies from emotional instability to a well-controlled behavior pattern.[xxi] If

the nearest hospital does not provide emergency contraception, which is the case in many areas, and the survivor is not in the condition to request another provider, she will be transported to a hospital that does not administer EC in a timely manner. Valuable time will be lost before she is able to obtain emergency contraception. This delay, combined with forensic evidence collection, other necessary treatments, and the fact that the survivor may not have contacted the authorities immediately after the assault, may entirely prevent the survivor from obtaining EC within the 72-hour period.

MEDICAL PROTOCOLS FOR THE TREATMENT OF RAPE SURVIVORS

A woman who is either brought to a hospital by emergency medical personnel or directly seeks care at a facility should receive a medical examination to determine the extent of physical injuries and so that evidence for possible legal proceedings may be collected. She should be tested for sexually transmitted infections, pregnancy, hepatitis and human immunodeficiency virus (HIV).[xxii] Treatment of injuries and prevention of sexually transmitted infections (STIs) and pregnancy are part of the standard protocol for the treatment of a sexual assault survivor. Survivors must also be treated for psychological trauma and be provided with referrals to agencies and community based organizations that provide follow-up medical care, counseling, and information regarding legal issues.[xxiii]

The medical literature concerning the provision of emergency contraception to survivors of rape is clear. Studies that date as far back as the early 1980s advise emergency room physicians to offer emergency contraception to sexual assault survivors. A study published in the Journal of Emergency Medicine in 1985 entitled, "Emergency Department Management of the Sexual Assault Victim," states, "The physician's medical concern(s) should be...prevention of pregnancy."[xxiv] The rape survivor requires treatment considerations in the areas of: (1) physical injuries; (2) prophylaxis against venereal disease and pregnancy; and (3) psychiatric intervention. The decision whether to employ one of the pregnancy prevention methods should be made by the patient in conjunction with the physician after the patient has been properly informed as to the risk of pregnancy and the risk of the alternative treatments.[xxv] In 1980, the Annals of Emergency Medicine issued a study entitled, "Improving Emergency Department Care of the Sexual Assault Victim." In this publication, medical experts state, "The physician must treat the victim's injuries, prevent unwanted pregnancy and venereal disease, and provide emotional support and advice."[xxvi]

Elaborating upon these earlier studies, the American Medical Association (AMA) has issued comprehensive guidelines for the treatment of sexual assault survivors in the Strategies for the Treatment and Prevention of Sexual Assault.[xxvii] This publication clearly outlines the procedural and clinical management of survivors of sexual assault,

providing detailed explanations regarding the appropriate care of rape survivors. Medical guidelines established by the AMA state,

"Female patients must be counseled about options for pregnancy prevention. If the physician has moral reservations about personally delivering this counseling, he or she is responsible to have someone else inform the patient of her relative risk of pregnancy and provide prophylaxis. Physicians are obligated to ensure that sexual assault patients are properly informed of all risks and interventions to prevent conception as a result of the assault.

"Pregnancy testing is indicated in the acute setting to rule out pre-existing pregnancy. If the patient is not pregnant and can provide reliable information for her last menses, the physician can approximate the likelihood of impregnation during the assault, based on estimated time of ovulation. The physician can then help the patient decide whether she wishes to take a post-coital contraceptive medication. The fact that counseling was provided, as well as the patient's decision, should be documented."

Medical protocols specifically address the need to provide post-coital pregnancy prevention to a survivor of sexual assault. Articles in many other medical journals[xxviii] and the AMA's guidelines clearly require physicians to counsel a patient about pregnancy prevention, to perform a pregnancy test, and to provide prophylaxis.

Further, in 1991 the New York State Department of Health issued the Adult Sexual Offense Evidence Collection Protocol as a result of the passage of a law (Chapter 821, Laws of 1984) requiring every hospital that provides treatment to rape survivors to collect and properly maintain sexual offense evidence. However, the Protocol's references to pregnancy prevention are vague and make no mention of EC provision to rape survivors.

CATHOLIC HEALTH CARE DIRECTIVES AND THE MEDICAL TREATMENT OF SURVIVORS OF RAPE

Survivors of rape who are treated at Catholic hospitals in New York State receive particularly substandard care; the NARAL/NY survey of Catholic hospitals reveals that most Catholic hospitals are unwilling to provide emergency contraception to prevent pregnancy and do not make appropriate referrals to a patient. This is inconsistent with clear, published medical guidelines for the treatment of rape. Catholic hospitals are ignoring their own rules that permit the provision of emergency contraception to rape survivors.

In 1994, the National Conference of Catholic Bishops issued the Directives for Catholic Health Care Services,[xxix] which are intended to provide guidance on certain moral issues that face Catholic providers of health care. The Bishops directly address the

issue of the treatment of sexual assault survivors in Directive No. 36. The Directives state,

> *"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."*[xxx]

Catholics for Free Choice, an organization that undertook a nationwide survey of the provision of emergency contraception in Catholic hospitals, found the Directives to be confusing, leaving hospitals to "interpret when they may provide emergency contraception."[xxxi] The Directives only permit contraceptive medication to be provided prior to conception, leaving Catholic hospitals in the impossible position of determining whether conception has occurred. No conclusive medical tests are available to determine whether conception has occurred. Therefore, as the Catholic for Free Choice report explains, Catholic hospitals are relying on varying interpretations of when EC may be provided. Most hospitals take a rigid approach that denies survivors of sexual assault access to safe and effective medication to prevent pregnancy.

HOW HOSPITALS WERE SURVEYED

Over a three-month period in February, March, and April 1999, NARAL/NY undertook a survey of Catholic-run hospitals in New York State. A list of Catholic hospitals was obtained from the Catholic Health Care Association of the United States of America; 42 hospitals located in New York State were listed in the hospital directory. Of these hospitals, four did not provide emergency room services and were eliminated from the survey.

Over a four-month period in July, August, September, and October 1999, NARAL/NY surveyed all other hospitals in New York State. A list of these hospitals was obtained from the American Hospital Directory; 187 non-Catholic hospitals located in New York State were listed in this directory. Of these hospitals, four did not provide emergency room services and were eliminated from the survey. An additional six were specialized facilities, providing cancer, orthopedics, and eye, ear, and throat treatments, and were also eliminated from the survey.

NARAL/NY volunteers made at least two phone calls to each facility. The surveyor called the main number of the hospital and requested to be transferred to the

emergency room. Two different survey instruments were used; in the first survey, the caller informed the emergency room personnel she was conducting a survey and asked whether the hospital provided emergency contraception to rape survivors. If not, the surveyor asked whether a referral could be provided. The caller did not identify herself as a volunteer with NARAL/NY. In the second survey, the call was made by a licensed social worker who sought information regarding a client who had been raped. The social worker requested information about the type of services that the hospital would provide to a rape survivor, including testing for HIV and STIs as well as the availability of emergency contraception. In cases where a hospital did not provide emergency contraception, the surveyor requested a referral.

Surveyors kept careful notes of the conversations with emergency room personnel, including the length of time it took to receive information and, when provided, the names and titles of individuals responding to the request for information.

RESULTS OF THE NARAL/NY SURVEY

NON-CATHOLIC HOSPITALS

NARAL/NY found vast differences in the approach hospitals take in dispensing emergency contraceptive pills to rape survivors.

- Of the 177 surveyed non-Catholic hospitals in New York State, less than one-half (48%) were found to operate under a clear policy of providing rape survivors with emergency contraception. The staff in these emergency rooms clearly stated this in response to both survey calls.

- More than one-quarter (24%) of non-Catholic hospitals in New York State were found not to provide the survivors of rape with emergency contraception. The staff clearly stated this in response to both calls.

- One quarter (25%) of non-Catholic hospitals demonstrated no clear policy on providing emergency contraception to rape survivors. Emergency room staff either provided the two callers with contradictory answers and/or stated their uncertainty of the policy, usually after numerous phone call transfers to other staff members. In these cases, a third phone call was made, each of which resulted in an equally ambiguous response.

- Two percent of non-Catholic hospitals consistently stated that emergency contraception would be provided to rape survivors at the physician's discretion.

- One non-Catholic hospital consistently declined to answer either caller, and did not return numerous messages left for various supervisors and hospital administrators.

Of the 43 non-Catholic hospitals found not to offer EC pills to rape survivors, ten stated that the survivor will be given a prescription for emergency contraception to be filled elsewhere. Such a practice is not in accordance with protocols for treatment of sexual assault survivors established by medical experts. Since time is of the essence when attempting to obtain emergency contraception within 72 hours, hospitals that do not offer EC pills in the emergency room itself pose an obstacle to proper medical care provision to rape survivors. This unnecessary obstacle may prevent the survivor from receiving the treatment in time.

Of the 85 non-Catholic hospitals found to operate under a clear policy of providing EC pills to rape survivors, one stated that the survivor will receive EC only if she is over 18 or accompanied by a parent. Given the race against the clock involved in obtaining EC as soon as possible, such a restriction is an unreasonable obstacle to proper medical care; as with any other necessary medical treatment, action should be taken as soon as possible. Further, this is in violation of New York State law, which allows for the distribution of birth control to minors without parental consent. A parent may be entirely unavailable, the need for EC may be a result of incest, or the survivor may simply feel uncomfortable discussing the situation with a parent at the time of the crisis. None of these factors should impede administering proper treatment to the survivor.

Provision of EC at Non-Catholic Hospitals[*]

PROVIDE EC	DO NOT PROVIDE EC	NO CLEAR POLICY ON PROVIDING EC	PROVIDE EC AT PHYSICIAN'S DISCRETION
85 hospitals 48 percent	43 hospitals 24 percent	44 hospitals 25 percent	4 hospitals 2 percent

[*] One non-Catholic hospital did not respond to the survey

CATHOLIC HOSPITALS

The survey also found vast differences in the approach Catholic hospitals take in dispensing emergency contraceptive pills to rape survivors. The method of hospital categorization used for non-Catholic hospitals was also used for categorizing Catholic hospitals.

- Of the 38 Catholic hospitals in New York State that provide emergency room services, only 21 percent were found to operate under a clear policy of providing rape survivors with emergency contraception.
- Almost two-thirds (61%) of New York State Catholic Hospitals were found not to provide the survivors of sexual assault with emergency contraception.
- Another 13% of hospitals demonstrated no clear policy on providing emergency contraception to rape survivors.
- Still another five percent of hospitals consistently stated that emergency contraception would be provided to rape survivors at the physician's discretion.

Of the 23 hospitals found not to offer EC pills to rape survivors, two stated that the survivor will be given a prescription for emergency contraception to be filled elsewhere.

Provision of EC at Catholic Hospitals

PROVIDE EC	DO NOT PROVIDE EC	NO CLEAR POLICY ON PROVIDING EC	PROVIDE EC AT PHYSICIAN'S DISCRETION
8 hospitals — 21 percent	23 hospitals — 61 percent	5 hospitals — 13 percent	2 hospitals — 5 percent

Attached to this report are the complete results of the survey, including the names of all surveyed hospitals. We also include a further breakdown of EC provision by geographical location.

BEYOND THE RESULTS

UNCLEAR POLICIES AND UNINFORMED STAFF

Several emergency rooms demonstrated a disturbing lack of knowledge regarding policies on offering emergency contraception to rape survivors. The staff at St. Joseph's Hospital in Elmira, for example, provided surveyors with three different answers on three separate occasions. The first surveyor was told that the hospital would provide a woman with emergency contraception if she were a survivor of rape, while the second was told the hospital would definitely not provide this service. The third caller was told emergency contraception is given at the doctor's discretion, but that the treatment is only prescribed, and not administered.

The staff at Southampton Hospital in Long Island as well as the staff at Westfield Memorial Hospital in Western New York also provided surveyors with directly contradicting answers. The first surveyor of both hospitals was told that EC is absolutely always provided, while the second was told by the nurse in charge that she has never seen the treatment given.

The sexual assault survivor's right to proper medical care is too often up to the luck of the draw when she is admitted to such emergency rooms. All New York State emergency rooms should adopt a clear policy on this matter in accordance with medical protocols, and ensure that the staff is aware of it.

In response to whether the hospital offers EC to rape survivors:

"Not to my knowledge. Rapes used to be treated off-site at SANE. Now things are being reorganized and no one seems to know what's going on."

– Emergency room staff member, Good Samaritan Hospital Medical Center, West Islip

In response to whether the hospital provides STI testing for rape survivors:

"Between you and I, she may not be tested because it may show she was promiscuous."

– Emergency room staff member, Good Samaritan Hospital Medical Center, West Islip

RUSSIAN ROULETTE WITH "PHYSICIANS' DISCRETION"

Certain hospitals repeatedly answered that whether emergency contraception will be administered depends on the individual doctor responsible for treating the survivor. A survivor of sexual assault cannot be expected to cross her fingers at the door and hope for the best, particularly not when she was simply brought to the closest emergency room by emergency medical responders. Further, several hospitals that stated that they do not officially provide emergency contraception added that it may depend on the doctor's own discretion. All emergency rooms should follow clear guidelines in accordance with

medical protocols; physicians should not be placed in the uncomfortable position of providing EC "under the table."

"It depends on the individual doctor. I know that some do [provide emergency contraception to rape survivors.] If there's a department policy on it, I don't know it."
–Emergency room staff member, St. Charles Hospital and Rehabilitation Center, Port Jefferson

"It's offered, but it's not [EC.] The ob/gyn residents would make it available, but not officially."
–Emergency room staff member, Mercy Medical Center, Rockville Centre

"That's up to the attending physician. Don't promise it [EC] to her."
–Emergency room staff member, Good Samaritan Hospital Medical Center, West Islip

A Narrow View of Catholic Church Regulations

All Catholic hospitals that stated they do not provide emergency contraception to rape survivors claimed that they do so due to their Catholic affiliation. However, Directive No. 36 of the Ethical and Religious Directives for Catholic Health Care Services states "a female who has been raped should be able to defend herself against a potential conception from the sexual assault." Many hospitals interpret this directive in the most rigid way, denying rape survivors access to emergency contraception. Yet other hospitals seem to operate in ignorance of it, assuming that the Catholic faith simply makes no allowances for survivors of sexual assault. Steve Phelps, a spokesman for the Catholic Medical Center, which covers several New York Catholic hospitals, said, "We follow the directives, like other Catholic hospitals."[xxxii] When informed about Directive No. 36, he remarked, "I would be very surprised by that."

All hospitals that offer emergency room services to the general public should function under guidelines established by medical experts in order to provide those in need with proper medical care. Failing to do so borders on criminal negligence. In cases of sexual assault, hospitals should not interpret their Catholic affiliation as an obstruction to providing this important medical treatment in their emergency room.

On denying rape survivors emergency contraception:

"You're talking to a Catholic hospital, so that should answer your question."
–Emergency room staff member, Benedictine Hospital, Kingston

"We are not allowed legally to give emergency contraception because we're a Catholic hospital."
– Emergency room staff member, St. Francis Hospital, Poughkeepsie

RECOMMENDATIONS

Overall, the results of the NARAL/NY survey demonstrate the overwhelming need for clear, enforced guidelines, in accordance with established medical protocols, for the treatment of rape survivors in New York State emergency rooms. These emergency rooms should be regulated to ensure compassionate, medically appropriate care.

- Emergency contraception should be offered, and immediately provided upon the request of the patient, at the time of treatment. To enforce this, the state legislature should pass a law mandating the state Department of Health to develop regulations that require all hospitals offering emergency room services to meet medical standards for the care of sexual assault survivors. Such standards should include testing for STIs, including HIV, as well as appropriate treatment protocols. Patients must be treated for psychological trauma and receive referrals to agencies where they may obtain follow-up care. All female patients who have survived a sexual assault must receive counseling regarding pregnancy prevention and be presented with the option of immediately receiving emergency contraception. If the physician has personal reservations against providing the patient with this information, he/she must be responsible for ensuring someone else informs the patient of her options and provides immediate treatment. In developing such hospital regulations, the Department of Health should utilize current medical standards, such as those outlined by the American Medical Association, as well as consult with other physicians' organizations and sexual assault survivor advocacy groups.

- The Department of Health should monitor emergency rooms to ensure that sexual assault survivors are given medically appropriate care. The state legislature should also require the Department of Health to report to the legislature, on an annual basis, the results of a review of hospital procedures pertaining to medical care of rape survivors. The Department of Health should also report any complaints regarding specific procedures.

- Upon developing such regulations, the Department of Health should mandate hospital officials to inform all emergency room personnel of these protocols. The Department of Health should strengthen programs to inform hospital staff of the standards for treatment of rape survivors and provide interdisciplinary updates on the issue to the hospital staff.

- The New York State Department of Health should provide funding to permit the Sexual Assault Nurse Examiner (SANE) program to be expanded to all hospitals. Our study found that all New York State hospitals that worked with the Sexual Assault Nurse Examiner (SANE) program complied with medical protocols for the treatment of rape survivors. The SANE program provides

sexual assault nurse examiners who are on-call for survivors of sexual assault. The program is a collaborative effort in which rape crisis centers work with health care providers, law enforcement, and the prosecutor's office to meet the needs of the survivor.

- To ensure the provision of medically appropriate care to survivors of sexual assault nationwide, hospital regulations should also be established on a national level. The U.S. Congress should pass legislation mandating the U.S. Department of Health and Human Services to develop regulations similar to those that should be established by the State Department of Health. In developing such regulations, the U.S. Department of Health and Human Services should follow the steps outlined above for the State Department of Health.

- Further, the results of this study show that most New York Catholic hospitals either do not currently provide EC to rape survivors and attribute this to their Catholic affiliation, or have no clear policies regarding EC provision. The New York State Catholic Conference should inform all Catholic hospitals, which currently do not offer EC, that Catholic regulations do permit offering survivors of rape the option of immediately receiving emergency contraception. The Conference should also call upon all hospitals with ambiguous policies regarding this issue to take a clear stance and provide all rape survivors with medically appropriate care.

- Until the Department of Health develops clear standards for the provision of EC in emergency rooms, all hospitals should review their own policies and inform sexual assault advocacy groups and the local police of their individual procedures. As long as hospitals providing inadequate medical care to sexual assault survivors remain unregulated, organizations and authorities should be informed of these insufficient policies in order to avoid referring or taking rape survivors to these facilities whenever possible. In publishing the results of this study, it is the hope of NARAL/NY that the Department of Health takes action against the substandard care provided to sexual assault survivors by many hospitals.

- Survivors who are in need of emergency contraception should be eligible for reimbursement. Currently such reimbursement can be covered under Crime Victim's Compensation; however, to qualify a survivor must report the sexual assault to the police as well as lack medical insurance. Given that survivors face significant medical risks and expenses, including potential HIV exposure and the need for immediate prophylactic treatment, all sexual assault survivors who undergo the rape exam should have access to Crime Victim's Compensation.

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[xxiii] Ibid, p. 923

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[xxvii] American Medical Association. Strategies for the Treatment and Prevention of Sexual Assault.

[xxviii] See ii and vii

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En Inglés y Español. Para la traducción Española, dé vuelta por favor a la página 13.

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Minnesota NARAL Foundation

ACCESS in CRISIS

minnesota

hospital provider project

The Continuing Decline of Hospital-Based Emergency Contraceptive & Abortion Services in the State of Minnesota

It is YOUR RIGHT...

The Minnesota Constitution protects reproductive choice as a **fundamental right** of privacy.

- ***It is your right*** to choose an abortion (up to the point of fetal viability) without government interference. During the first trimester of pregnancy a state may not ban or regulate abortions. During the second trimester the state may regulate abortion to protect your health. In the third trimester the fetus may be able to live outside the womb, so an abortion is only permitted when necessary to preserve your life or health.
- ***It is your right*** to give informed consent to an abortion procedure after a full explanation of the procedure and any potential complications.
- ***It is your right*** to access a hospital or medical facility to obtain any medical procedure, including an abortion, without harassment.
- ***It is your right***, if you receive state or county public medical assistance funds for health care, to use these funds to pay for an abortion to preserve your life, for health reasons, to prevent "substantial and irreversible impairment of a major bodily function," or if the pregnancy resulted from rape or incest.
- ***It is your right***, as a minor (unemancipated, under 18), to an abortion only if both of your parents have been notified. You can receive an abortion without your parents' consent by obtaining a court order, commonly known as a judicial bypass.
- ***It is your right***, as a minor, to confidential reproductive health service, including contraceptives and emergency contraception, pregnancy-related care, and STD treatment. Your physician can notify your parents if she finds that not informing them would seriously jeopardize your health. *(According to Hennepin County's reading of MN Statute 144.343)*

YOU MAY **HAVE** THE RIGHT,
BUT CAN YOU **EXERCISE** THE RIGHT?

CONTENTS

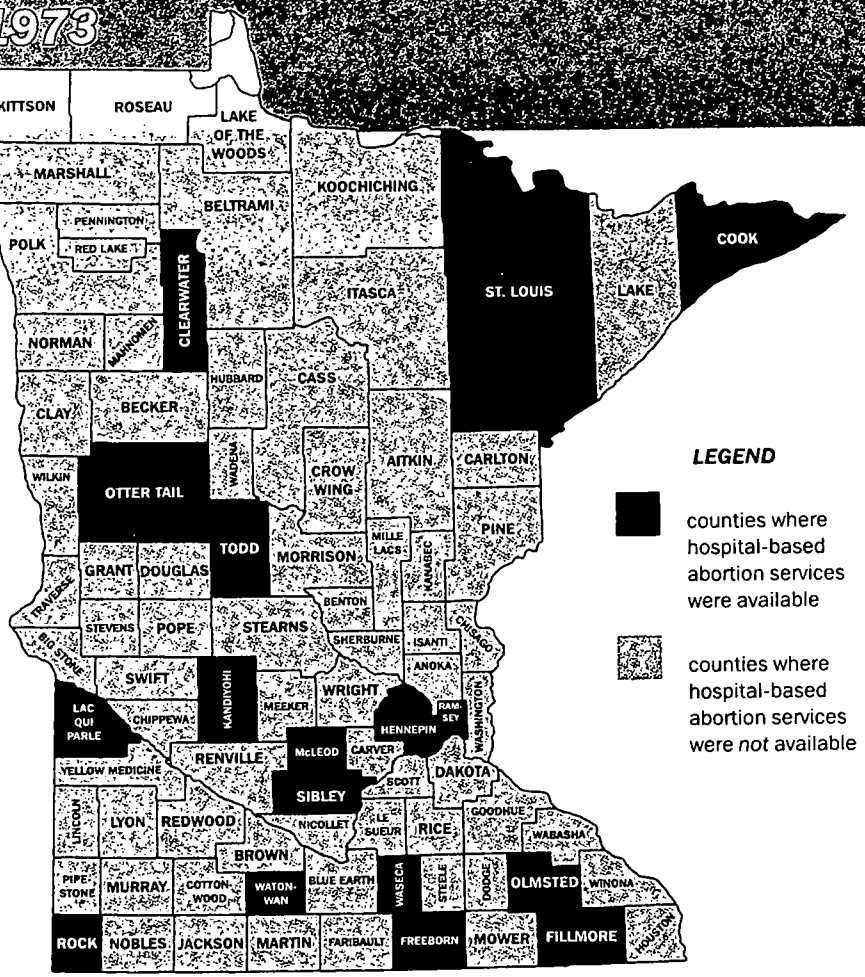
The Minnesota Hospital Provider Project Survey: Identifying the Barriers

This brochure is intended to identify the *barriers* to accessing reproductive health care services in Minnesota hospitals. The Minnesota Hospital Provider Project (MHPP) conducted a detailed survey of Ob/Gyn Departments, Emergency Rooms, Nursing Departments, and administrators at hospitals throughout Minnesota to determine hospital policies regarding access to abortion services, emergency contraceptives, and referrals for these services. The MHPP also conducted extensive anonymous phone inquiries into each hospital to uncover the actual practices of Minnesota hospitals.

The following pages reflect the major barriers to reproductive health care in Minnesota. This brochure should be seen as an educational tool for health care professionals and health care consumers alike who are concerned about decreasing access to reproductive health care and are interested in expanding access to this care in Minnesota.

Access to Hospital-Based Abortion Services in Minnesota

1973

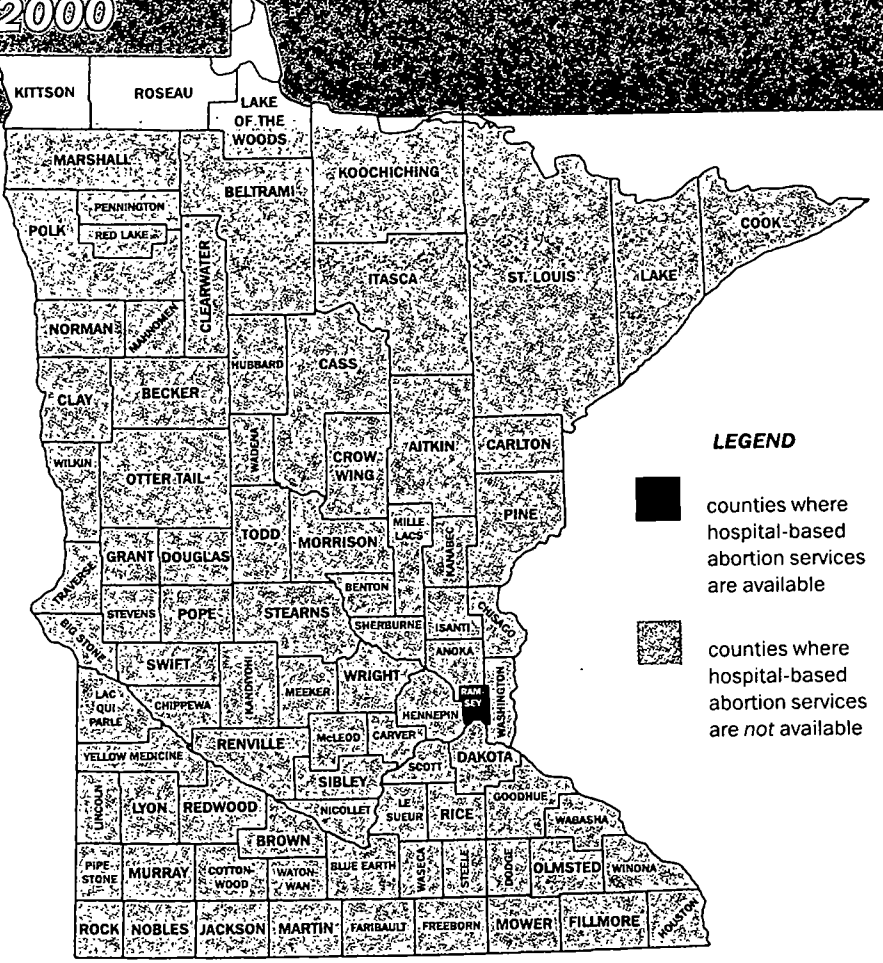


LEGEND

counties where hospital-based abortion services were available

counties where hospital-based abortion services were *not* available

2000



LEGEND

counties where hospital-based abortion services are available

counties where hospital-based abortion services are *not* available

THE DECLINE OF ACCESS

In 1973 the United States Supreme Court legalized abortion.

This decision paved the way for the improvement of all reproductive health care, and the development of newer and safer pregnancy prevention options. However, such reproductive health services, in particular abortion services, have become less accessible to women because of the dramatic decline in trained physicians, lack of funding, threats of anti-choice violence, restrictive legislation, and the demonizing of reproductive health care by anti-choice extremists.

Today, only 1 out of 140 hospitals in Minnesota provides abortion services.

CONSIDER THESE FACTS:

Only 3 out of the 87 counties in Minnesota have a single abortion provider (including hospital and clinic-based providers): Hennepin, Ramsey, and St. Louis counties, all serving large cities.

The largest drop in abortion services has been in hospital-based abortion services. Although the majority of abortions are currently performed in clinics, hospitals play a crucial role in abortion accessibility, particularly for rural women, low-income women, and women with health conditions.

In fact, in 1973, over 50% of all abortions in the U.S. were performed in hospitals. Today, only 7% of abortions are performed in hospitals.

HOSPITALS ARE A CRITICAL RESOURCE

⊞***Most clinics in rural Minnesota do not offer reproductive health care services.*** Even though most abortion and emergency contraceptive services are offered through clinics, these clinics are only viable in heavily populated areas. 97% of counties in Minnesota have no abortion provider, forcing most women in rural areas to travel 50-100 miles or more to obtain abortion services. For women in rural areas, hospitals are often the only resource available for their reproductive health care.

⊞***Many of the women who need abortions cannot afford them.*** Many low-income women get their health care from hospitals, not from private physicians. Hospital services are an important resource for low-income women because all hospitals accept Medicaid, whereas most clinics do not accept this aid.

⊞***Most reproductive health clinics are not equipped to provide care for women with medical conditions.*** Women with heart trouble, anemia, severe asthma, seizures, or other physical concerns need to be seen at a hospital. Hospitals are also essential for managing rare but possible complications from abortions.

ABORTION PROVIDERS
(hospitals & clinics)

HENNEPIN COUNTY

Dr. Mildred Hanson,
Minneapolis
612/870-1334

Meadowbrook Women's Clinic,
Minneapolis
612/376-7708

Midwest Health Center for Women,
Minneapolis
612/332-2311

Robbinsdale Clinic,
Robbinsdale
763/533-2534

RAMSEY COUNTY

Regions Hospital,
St. Paul
651/221-3200

Planned Parenthood,
St. Paul
651/698-2405

ST. LOUIS COUNTY

Women's Health Center,
Duluth
218/727-3352

⊞***Hospitals train new physicians.*** When teaching hospitals do not provide abortions, they cannot train physicians to perform the procedure, adding to the state-wide decline in abortion providers. Despite the fact that abortion is one of the most common surgical procedures in the U.S., almost half of all graduating Ob/Gyn residents have never performed a first-trimester abortion.

⊞***Reproductive health care has been stigmatized by anti-choice extremists.*** Including the full range of reproductive health care services, such as abortion and emergency contraceptive services, in hospital care reduces the stigmatization of these health care services for the providers and the women who choose it.

Increasing hospital-based abortion services ensures that abortion is part of comprehensive medical care, and that women have access to the full range of reproductive choices.

ACCESS TO OTHER CRUCIAL REPRODUCTIVE SERVICES

⊞*EMERGENCY CONTRACEPTION:*
An important pregnancy prevention option

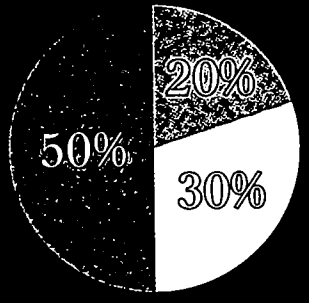
What is Emergency Contraception?
Emergency Contraception ("the morning after pill") is a high dose of birth control that **prevents pregnancy** by disrupting ovulation, fertilization, or implantation **before** a pregnancy can begin. Emergency Contraception is 98% effective when taken within 72 hours of unprotected intercourse.

Emergency Contraception **cannot interrupt an already established pregnancy** and cause an abortion. It prevents unwanted pregnancies, reducing the need for abortion.

⊞*It is estimated that increased use of Emergency Contraception could annually reduce the number of unintended pregnancies by 1.7 million and the number of abortions by 800,000* (Family Planning Perspectives, *Nov./Dec. 1992).*

Access to Emergency Contraception is an important step toward reducing unintended pregnancy, especially for survivors of sexual assault.
Protection against unwanted pregnancy is crucial in emergency care treatment for rape survivors.

% of all hospitals in Minnesota offering emergency contraceptive services to women



LEGEND

- % of hospitals offering emergency contraception services to **all women** (including rape survivors)
- % of hospitals offering emergency contraception services only to **rape survivors**
- % of hospitals **without** emergency contraception services

DID YOU KNOW?

The Ethical and Religious Directives for Catholic Health Care Providers, which guides the policies of Catholic hospitals, states that a woman who has been raped can be offered emergency contraception, though it prohibits many other reproductive health care services such as contraception, abortion, and sterilization.

Only **50%** of the **Catholic hospitals in Minnesota** offer emergency contraception to **rape survivors!**

⊞*The MHPP found that only **30%** of Minnesota hospitals offered Emergency Contraception to **all women*** (including rape survivors).

⊞*Only about **half** of all hospitals offered Emergency Contraception to even **rape survivors!***

⊞*MEDICAL ABORTION:*

Medical abortion is an early non-invasive alternative to surgical abortion. The procedure terminates a pregnancy through a series of prescription drugs. The most promising of these medications is **mifepristone** (RU-486). Recently approved by the FDA, the widespread availability of mifepristone has the potential to expand access to abortion services by offering greater privacy to the clinician and patient.

WHERE EMERGENCY CONTRACEPTION IS AND IS NOT AVAILABLE

⊡Only **43** of the **140** hospitals in Minnesota provide emergency contraceptives to **all women** (including rape survivors).

⊡**34** of the **140** hospitals in Minnesota offer emergency contraceptives only to **survivors of rape.**

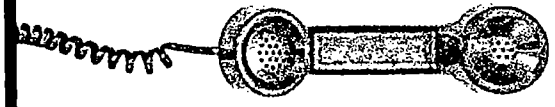
(see map on pages 10 & 11)

To find out if your local hospital provides emergency contraception, contact the Minnesota NARAL Foundation at:

naralsurvey@mtn.org
1-888-546-7895
or
www.mnnaral.org

For more information on the emergency contraceptive provider nearest you, contact:

emergency contraception hotline



1-888-NOT-2-LATE
http://not-2-late.com
http://opr.princeton.edu/ec

printed with permission from Reproductive Health Technologies Project

In **24** of Minnesota's **87** counties, Hospital-Based Emergency Contraceptive and Abortion care is **UNAVAILABLE:**

Chippewa
Clearwater
Cottonwood
Faribault
Fillmore
Houston
Kandiyohi
Koochiching
Lac Qui Parle
Mahnomen
Meeker
Morrison
Mower
Murray
Nobles
Norman
Redwood
Renville
Rock
Roseau
Steele
Traverse
Wabasha
Waseca

Sampling of actual responses from hospital staff members given to questions asked during the MHPP survey:

Can I get emergency contraception at your hospital?

"We don't offer any abortion techniques here. I have no idea if anyone in Minnesota does abortions."

"I don't know where, try calling around to the clinics."

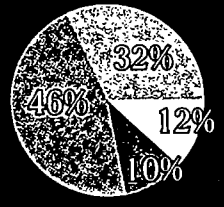
Can I schedule an abortion at your hospital?

"Try the Yellow Pages!"

"Call a Crisis Pregnancy Center [fake clinic] *or Planned Parenthood."*

"I don't believe in abortion." [then she hung up!]

Quality of referrals given by staff members to MHPP callers asking about reproductive health services unavailable at their particular hospital



LEGEND

- % of good referrals (12%)
- % of adequate referrals (32%)
- % of bad referrals (46%)
- % refused to refer (10%)

INADEQUATE REFERRALS

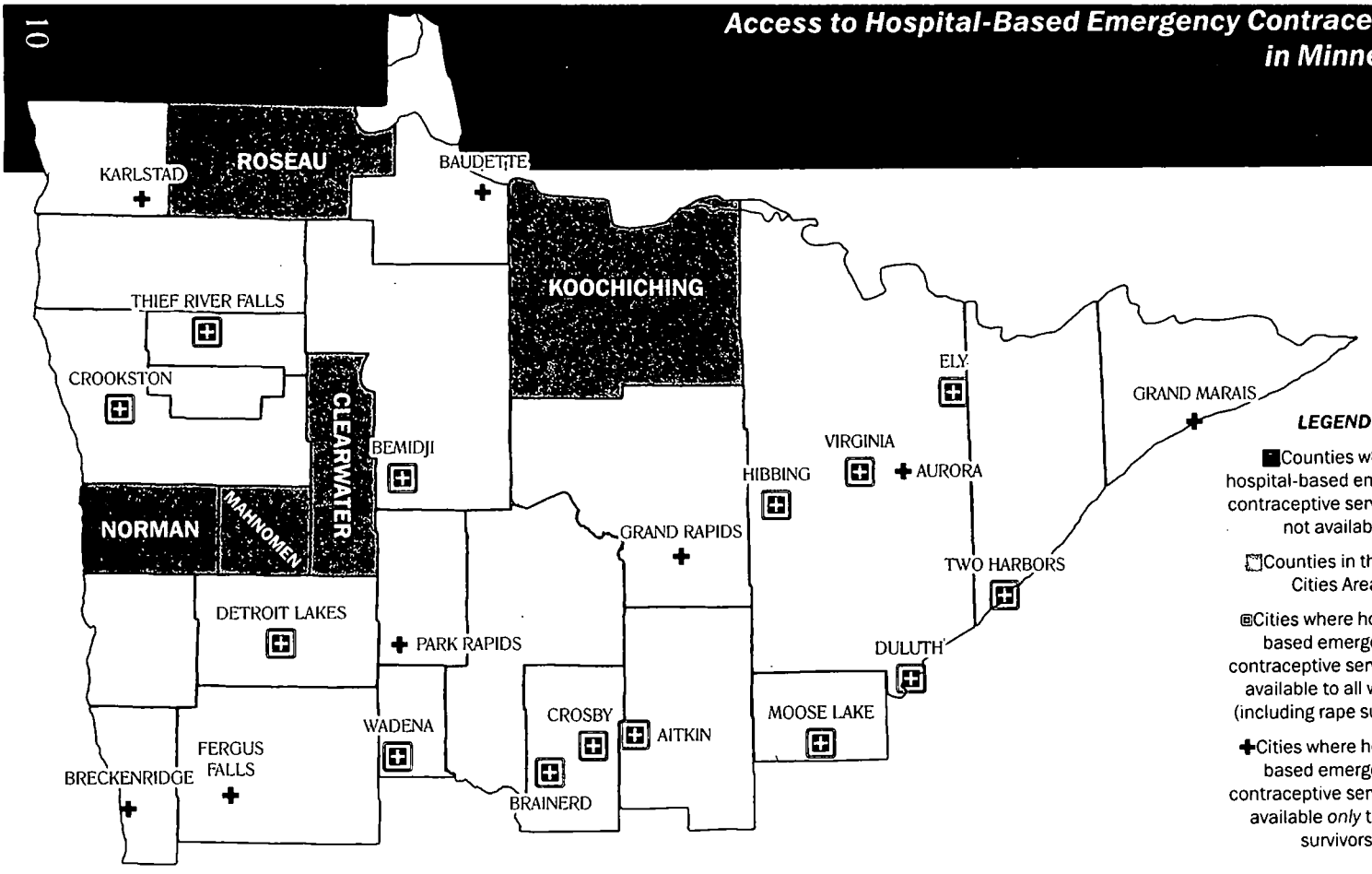
Hospital operators in Minnesota generally tell someone who calls where they can receive treatment that is unavailable at their facility. Since abortion and emergency contraceptive services are not available at many Minnesota hospitals, referrals for these services are essential. Unfortunately, referrals for reproductive health care are typically inadequate.

Anonymous phone calls were placed to survey the emergency contraceptive and abortion services offered at Minnesota hospitals. When the caller was told that a hospital did not provide either of these services, the caller then asked to be referred to a providing facility. The vast majority of responses ranged from misinformed and unhelpful to rude and hostile. In fact, of the 139 hospitals in Minnesota that do not offer abortion services, only **12%** gave the woman who called *an accurate and respectful referral* to an *appropriate facility*.

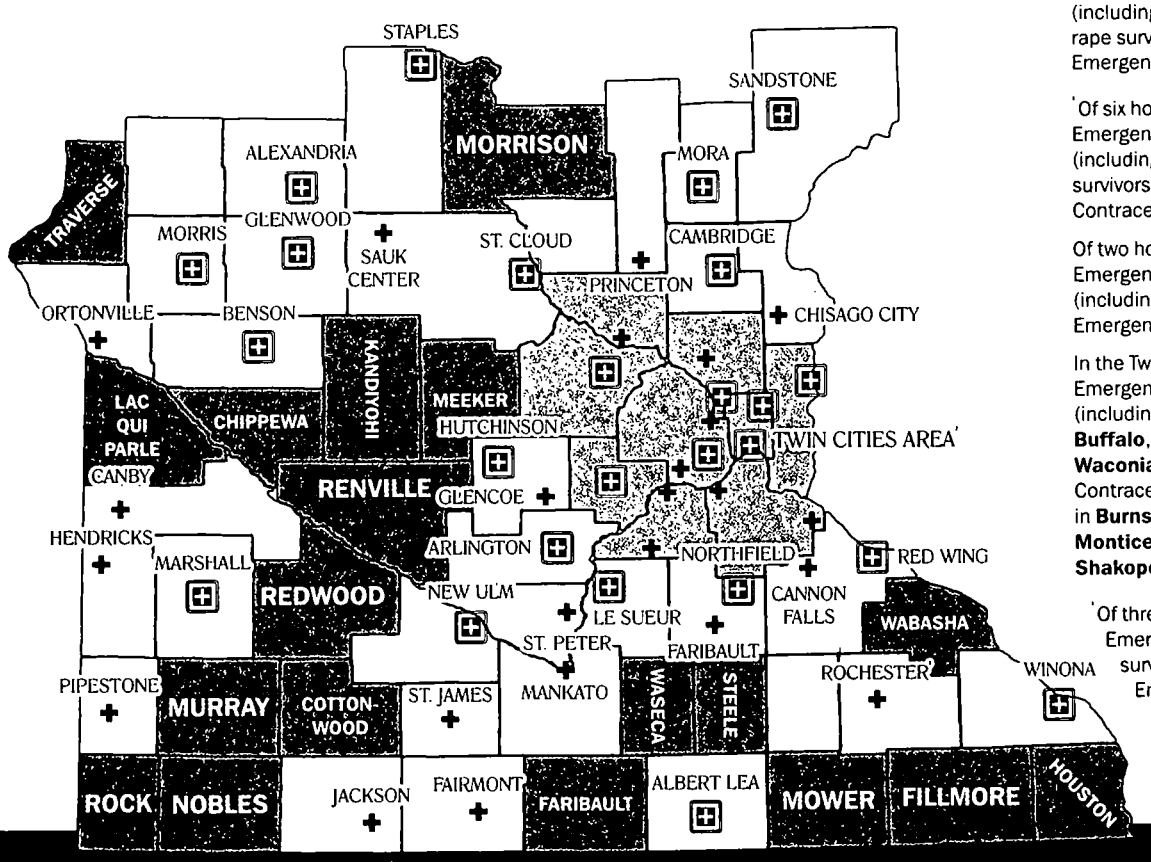
88% of Minnesota hospitals were either **unable** or **not willing** to handle these calls. (A sampling of the responses is shown at left.) In addition, numerous hospitals gave us referrals to facilities that do not provide the service. Most callers were transferred around hospitals to 3 or more staff members and still didn't end up with a referral to a providing facility! These barriers make it that much more difficult for women to ask for, and obtain the care they need.

Women needing referrals for reproductive health care should not be treated with disrespect, nor should they expect less than a clear, direct, and accurate referral to a specific facility.

Access to Hospital-Based Emergency Contraception in Minnesota



Northern Minnesota is shown above (page 10); Southern Minnesota is shown below (this page).



NOTES

[1] Of three hospitals in **Duluth**, one offers Emergency Contraception to all women (including rape survivors), one offers *only* to rape survivors, and one does not offer Emergency Contraception.

[2] Of six hospitals in **Minneapolis**, three offer Emergency Contraception to all women (including rape survivors), two offer *only* to rape survivors, and one does not offer Emergency Contraception.

Of two hospitals in **St. Paul**, one offers Emergency Contraception to all women (including rape survivors) and one does not offer Emergency Contraception.

In the Twin Cities Area, hospitals that offer Emergency Contraception to all women (including rape survivors) are located in **Buffalo**, **Fridley**, **Maplewood**, **Stillwater**, and **Waconia**. Hospitals that offer Emergency Contraception *only* to rape survivors are located in **Burnsville**, **Coon Rapids**, **Edina**, **Hastings**, **Monticello**, **New Prague**, **Robbinsdale**, and **Shakopee**.

[3] Of three hospitals in **Rochester**, two offer Emergency Contraception *only* to rape survivors, and one does not offer Emergency Contraception.

WHAT WE'RE DOING TO IMPROVE ACCESS AND HOW YOU CAN HELP!

1. **Talk to your friends** about emergency contraception. Make sure they know what it is and how they can obtain it.
2. **Ask your doctor** if they are pro-choice. Find out if they provide abortions, make referrals, and offer emergency contraception.
3. **Call the Minnesota NARAL Foundation** to find out if the hospital in your community provides accessible abortion and emergency contraceptive services.
4. **Ask your local hospital why** they don't offer accessible abortion and emergency contraceptive services.
5. **Join Minnesota NARAL Foundation's Action Alert list** (via email or snail-mail) and stay updated on reproductive issues and events.
6. **Write a letter to the editor** of your local paper on the importance of reproductive health care that includes abortion and emergency contraception.
7. **Invite the Minnesota NARAL Foundation** to a community meeting in your area to discuss how you can move your local hospital to improve its policy regarding abortion and emergency contraception.
8. **Make a contribution to the Minnesota NARAL Foundation.** Your tax-deductible donation supports our programs to promote and protect the full range of reproductive choices.

Until now, the availability of hospital-based reproductive health services such as abortion and emergency contraceptives was virtually unknown. The MHPP survey reveals a dismal picture of women's access to reproductive health care in Minnesota's hospitals. Fortunately, this landscape is always changing. By working together as community members, health care providers, and the individuals who need this care we can create changes and increase access to the full range of reproductive health services!

For More Information, Call the Minnesota NARAL Foundation:

1-888-546-7895

Email us:

naralsurvey@mtn.org

or Check Out Our Website:

www.mnnaral.org

MHPP

un estudio de
Minnesota NARAL Foundation

ACCESO en CRISIS

La Continua Baja en los Hospitales de los Servicios Básicos de Emergencia para Abortos y Contraconceptivos en el Estado de Minnesota

minnesota

hospital provider project

Catholic Health Restrictions Updated

CATHOLICS FOR A FREE CHOICE

ISBN 0-915365-35-9

INTRODUCTION

When Catholics for a Free Choice first began reporting in 1994 on the Catholic health care system and how mergers between Catholic and non-Catholic hospitals impact on access to reproductive health, the issue was just gaining momentum. Big changes in health care were underway. President Clinton was pursuing his ambitious but ultimately ill-fated attempt to reform the country's health care system. "Merger mania" was sweeping the health care industry. The Catholic bishops were seeking exemptions from providing reproductive health care under the Clinton reform plan as Catholic and non-Catholic hospitals began combining at a dizzying pace without much public scrutiny. Since then, these mergers, and the resulting threats to reproductive health care, have become a permanent part of the landscape. Recently, in an attempt to bring to life the real world impact of these mergers, Catholics for a Free Choice undertook a survey of the provision of emergency contraception (EC) at Catholic hospital emergency rooms. We wanted to find out what a woman seeking the "morning after pill" would be told if she called a Catholic facility. The findings were striking: 82 percent of the hospitals surveyed said they did not provide EC, even to a woman who had been raped. And of those hospitals, only 22 percent would provide a referral that had enough information to help a woman obtain emergency contraceptive services.[1]

The survey further exposed the ambiguity of the provision of reproductive health services in Catholic health care settings, piqued media interest in the consequences of Catholic health care restrictions for women, and served as a useful tool for advocates in the reproductive health care field seeking to reduce the impact of Catholic mergers. But the most interesting, and perhaps the greatest achievement of our merger research to date, is the manner in which our EC survey has affected the Catholic health care system—particularly in its dealings with requests for information about reproductive health services in Catholic facilities and the increased attention Catholic health care is giving to the issue of Catholic/non-Catholic mergers.

The survey further exposed the ambiguity of the provision of reproductive health services in Catholic health care settings and piqued media interest in the consequences of Catholic health care restrictions for women.

This report will provide an overview of the impact of the EC survey. It will also serve as an interim 1999 report on merger activity between Catholic and non-Catholic hospitals and systems and the ongoing impact of and opposition to such mergers. This activity is detailed in the appendices. One note: the term "merger" is used loosely. Check the appendix for specifics on each affiliation as to the actual structure of the deal.

MERGERS AND ACQUISITIONS: THE PACE SLOWS BUT NOT THE IMPACT

Merger and acquisition activity between Catholic and non-Catholic hospitals and health systems has slowed somewhat in the first three quarters of 1999 compared to the breakneck pace of 1998. According to our tracking, between January 1 and the end of September of this year, there was a total of 12 Catholic/non-Catholic mergers or acquisitions completed. Another 10 deals are pending. This compares to the 43 completed mergers and acquisitions between Catholic and non-Catholic facilities that we identified in 1998.[2] This slowing of activity is consistent with larger trends in the health care industry. According to Irving Levin Associates, merger and acquisition activity within the health care industry has fallen to its lowest level since 1995. The number of all hospital mergers fell 35 percent between the second and third quarters of 1999, and third quarter activity was 24 percent below third quarter 1998 activity.[3] The consensus within the health care industry is that most of the "low hanging fruit"—the financially ailing hospitals that either had to merge or die—has been picked. As a result, 1998 can be seen as somewhat of an anomaly in terms of merger activity.

Having scooped up many of these troubled hospitals in recent years, the Catholic health care industry is now engaged in a process of internal consolidation. Small and mid-sized Catholic systems are merging into larger regional systems and new systems are being created. Significantly, the largest and third-largest Catholic hospital systems in terms of revenue were created this year. The newly created Ascension Health, the largest Catholic system in the nation with $5.6 billion in annual revenue, owns or is affiliated with 66 hospitals in 15 states and the District of Columbia.[4] This trend speaks to the growing influence of Catholic systems as they come to dominate certain geographic areas. For instance, Catholic Healthcare West is now the largest operator of hospitals in California, running 46 hospitals, 18 of which were formerly secular.[5] San Antonio-based Incarnate Word Health System and Houston-based Sisters of Charity Health Care System merged in February to create the five-state Christus Health system, which owns over 30 hospitals concentrated in Louisiana, the Louisiana-Texas border and the Texas Gulf coast.[6] The Sisters of St. Francis Health Services now controls acute-care facilities in four northwestern Indiana cities: Hammond, Crown Point, Dyer and Michigan City.[7]

The Catholic health care industry is now engaged in a process of internal consolidation. Small and mid-sized Catholic systems are merging into larger regional systems and new systems are being created.

Several other trends are worth noting. One is the fruits of activism in opposition to hospital mergers. A glance through the appendices finds a good number of mergers are facing organized community opposition. Having seen successes in this area, activists have created models of community opposition that are now successfully being replicated. The increased attention that CFFC and others have brought to the issue has made it harder and harder for these deals to be completed in the dark of night. Letting some light into the process has in some cases halted mergers and in others resulted in compromises or solutions that preserved at least some access to reproductive health services, although often at considerable inconvenience to the women involved. And in the instance of Optima Heathcare, created by the merger of Elliot Hospital and Catholic Medical Center, consistent community opposition to the merger resulted in its dissolution after five years.[8]

Another trend is less heartening. It is the undoing of compromises or the discontinuation of reproductive health services in the years following the completion of a merger. In two high-profile cases in the last

two years—one in Little Rock, Arkansas, and one in Austin, Texas—the Vatican has nixed compromises that had allowed mergers to pass community activists' muster.[9,10] This is a worrisome trend, because it suggests that promises made are not being kept or cannot be kept in the face of Vatican opposition. It also highlights the importance of monitoring hospitals following mergers, as changes in policy can be made once the limelight has faded. For instance, when Palm Beach's non-Catholic Good Samaritan Medical Center and Catholic St. Mary's Medical Center merged in 1995 to form Intracoastal Health, the hospitals announced that reproductive health services would be preserved at Good Samaritan. This year however, Intracoastal announced that Good Samaritan's maternity ward would be closed, effectively scuttling the compromise because women will have no choice but to deliver at a Catholic maternity ward that does not perform postpartum tubal ligations.[11]

Another disquieting trend is the structuring of hospital acquisitions in a manner that completely evades community or regulatory review. Catholic Healthcare West has pioneered this technique in California. When it looked like its purchase of a hospital in Gilroy from Columbia/HCA Healthcare would face opposition, Columbia simply shut down Valley Medical Center and surrendered its license. CHW then purchased the hospital building. Since this was simply a "real estate transaction," according to CHW, it required no review.[12]

The following anecdotes provide a snapshot of some of the merger and acquisition activity, opposition and consequences in the past nine months:

Vatican Overturns Compromise

On September 28, 1999, over a year after a compromise ensured the continuation of tubal ligations at St. Vincent Doctor's Hospital in Little Rock, which was purchased by St. Vincent Health System, the Vatican ordered the hospital to halt provision of the procedure. The deal entailed allowing St. Vincent Health System to lease space in St. Vincent Doctor's Hospital to the Arkansas Women's Health Center, which performed tubal ligations for women who wanted them. Arkansas Bishop Andrew McDonald had given approval of the arrangement, but asked the Vatican for a review. He revoked his approval when the Sacred Congregation for the Doctrine of the Faith in Rome, the arm of the Vatican that examines questions of interpretation related to the moral teachings of the church, decided that the arrangement was inappropriate. Hospital officials estimated that about 30 sterilization procedures were performed each month. An estimated 370 have been performed since the agreement began, which accounts for approximately ten percent of the women who deliver annually at the facility.[13]

Services Quietly Restricted

A secular hospital in Florida has been curtailing abortion services for two years, but most people in the community were not aware of it. When Bayfront Medical Center in St. Petersburg, Florida, became part of the newly formed, eight-hospital BayCare Health System two years ago, it agreed to limit severely abortion services as part of the deal in deference to the two Catholic partners in the system. But it kept the new policy quiet. The policy came to light this year when the city challenged it as a violation of the hospital's lease, which says care must be provided "without regard to sex, race, color or creed." Under BayCare's policy, all late-term abortions must be approved by a review committee, which is headed by a nun. Late-term abortions for reasons of genetic defects are not provided unless the baby would only be expected to survive a few hours after delivery.[14]

Keeping the Heat on For Five Years

A five-year-old merger that was troubled from the very beginning over the curtailment of abortion services has ended. Unable to resolve differences over abortion and other reproductive health services, New Hampshire's Elliot Hospital and Catholic Medical Center agreed to end their merger, dissolving Optima Health in early 1999. Abortions were banned at Elliot in 1996 when it became clear that a handful were being performed each year contrary to the *Ethical and Religious Directives for Catholic Health Care Services*, which Catholic Medical Center insisted Elliot follow. Elliot came under fierce fire from reproductive health advocates in 1998 when it refused to perform an emergency abortion, forcing the woman to go 80 miles away to receive the procedure. Apparently the boards of the two hospitals were unable to reach an agreement over abortion policy, which had not been clearly articulated at the outset of the merger. The dissolution of the merger came after almost three years of effort by physicians, the New Hampshire

chapter of the ACLU, and the anti-merger Coalition for Live-Free-or-Die Healthcare in Greater Manchester.[15]

Plans for Restrictive Women's Health Center End

A plan by Enid, Oklahoma's two acute care hospitals —St. Mary's Mercy Hospital and Integris Bass Baptist Health Center—to build a $12 million women's health center that wouldn't offer tubal ligations was derailed by community opposition. The new center would have offered the only obstetrical services in town, as both hospitals were scheduled to close their obstetrics units once the facility was built. Women who wanted a tubal ligation after delivery were to be driven to Integris Bass following delivery. A majority of doctors in the community signed a petition opposing the ban on tubal ligations, and community opposition generated a statewide coalition to protect reproductive health services, an impassioned town meeting, a petition drive and a protest advertisement in the local newspaper from the county's two medical societies.[16]

Merger Becomes Ownership Switch

Community activists in Genesee County, New York, have been successful in protecting access to reproductive health services in their county. In a deal brokered to end community dissent, St. Jerome's Hospital will be taken over by Genesee Memorial Hospital. The original plan called for the hospitals, the only two in the county, to merge and both follow the *Directives*. As a result of the new agreement, abortions and sterilizations will remain available to women in the region. St. Jerome's will no longer be a Catholic hospital, but it will continue to follow the *Directives* for five years. A community coalition, People Against Lost Services, had battled the merger plans for three years.[17]

THE EC SURVEY: CALLING CATHOLIC PROVIDERS

In the winter of 1999, CFFC conducted a survey of 589 Catholic hospital emergency rooms to determine if emergency contraception is available to women—especially rape victims—from these important sources of care.[18] This is an important area of exploration because while the *Directives* allow for the provision of emergency contraception for women who have been raped—and it is a widely accepted standard of care for rape victims—anecdotal evidence suggested that many Catholic hospitals were not providing EC.[19] We designed the survey to assess the "real world" availability of EC—not the theoretical availability that may be stated in hospitals' official policies. We called the place that women seeking such care would be likely to call—the emergency room—not an administrative or public relations office. We asked the question much as we imagined women seeking such care would ask it: "Hi, I was wondering if you have the morning after pill?"

If respondent answered "yes," the caller thanked them and hung up. If the answer was "no," the caller asked the respondent about the availability of EC in cases of rape. For hospitals that said EC wasn't available even for women who had been raped, the caller asked for a local referral. If the emergency room told the caller to call her OB/GYN, the caller said her OB/GYN was not available and again requested a referral. If the respondent gave the name of a local clinic or Planned Parenthood, the caller asked for the phone number.

If the emergency room did not give an absolute yes or no, the caller asked under what circumstances EC would be available. If the respondent did not mention rape in the explanation of circumstances in which EC would be available, the call asked directly if EC would be available in cases of rape. The caller than asked about referrals for EC in the same manner as above.

Of the hospitals surveyed, 82 percent said they did not make emergency contraception available in any circumstance. Of those, only 22 percent provided a useful referral—one with a specific source of care and a phone number. Many of the referrals were so vague as to be virtually useless. For instance, in some cases the caller was told: "Call the health department." In some cases, as detailed in *Caution: Catholic Health Restrictions May Be Hazardous to Your Health*, callers were given totally inaccurate information, such as EC was not available anywhere in the city, or chastised or belittled.[20]

TV coverage included a discussion of the survey on Bill Maher's "Politically Incorrect," and an ABCNews.com story that featured a woman who became pregnant after a Catholic hospital failed to provide EC as part of her after-rape care.[33] Frances Kissling did numerous radio interviews on the study, including one for NPR. The survey also received additional coverage in the *Kaiser Daily Reproductive Health Report*, a news summary service which is widely read in the reproductive health community. The scope of the coverage illustrates the intense interest in this issue. The survey helped bring home two points about Catholic/non-Catholic mergers that many had previously failed to grasp: Catholic hospitals are providers of care to the larger community and Catholic hospitals deny services that are standard components of medical care. The survey in effect forced Catholic hospitals to "come out" as providers.

THE RESPONSE TO "CATHOLIC HEALTH RESTRICTIONS MAY BE HAZARDOUS TO YOUR HEALTH"

It was in part at the urging of collegial organizations working to preserve access to EC in merger situations that CFFC decided to focus on EC in the last merger update and we are pleased that other groups have been able to build on our survey. In California, Massachusetts and Pennsylvania, local groups used the EC survey to follow-up with hospitals in attempts to have EC policies reviewed and revised. On Long Island, New York, local activists used the survey to help pressure merging facilities into guaranteeing the availability of EC following the acquisition of Mid-Island Hospital by Catholic Health Services of Long Island and Winthrop South Nassau University Health System.[21] EC for rape victims is now one of three key concessions that New York State activists are demanding in their efforts to preserve reproductive health services when Catholic and non-Catholic facilities merge.[22] Using the data in our survey, the American Society for Emergency Contraception sent a mailing to the CEO of every hospital identified by CFFC as not offering EC to women who had been raped and to corresponding local newspapers.[23] This resulted in local reporters following up on the issue and forced hospitals to clearly state their EC policies to the local public.

In one case, after an article appeared in a local paper, St. Cloud Hospital in Saint Cloud, Indiana, a Catholic facility, clarified its policy to the public. In a letter to the editor the hospital stated: "Our policy also dictates that the drug [to prevent pregnancy] must be administered within 72 hours of the rape. If we believe the woman is pregnant, and that the drug would abort a fetus, we will not administer it."[24]

The results of the survey were widely reported in the media. In total, there was coverage of the survey in over 30 media outlets ranging from *USA Today*, Newsweek.com and the "Harper's Index" to TV's "Politically Incorrect." The survey received significant national print coverage, with two articles by *USA Today's* DeWayne Wickham that ran in at least eight different national, regional and local papers, and coverage in the *Los Angeles Times*, *Boston Globe*, *Washington Times* and the *Chicago Tribune*.[25] The articles highlighted the fact that EC is not an abortifacient and that EC for rape victims is the medically accepted standard of care, as well as the lack of referrals by Catholic facilities. The articles also tied the EC story into the larger issue of Catholic/non-Catholic hospitals mergers and the impact on non-Catholic populations. In some instances, such as the *Boston Globe* article, the survey was tied into a specific local merger.[26] The *Los Angeles Times* and *Chicago Tribune* articles focused on the ambiguity in Catholic doctrine over whether or not EC is acceptable for rape victims and the resulting inconsistency in Catholic hospitals' policies.[27,28]

The story received high-profile coverage in consumer magazines as well, including Newsweek.com, *Glamour* and *Harper's Magazine*. *Glamour*, a monthly women's magazine well-regarded for the quality of its reproductive health coverage, featured an editorial on the issue that asked the question, "Are Catholic hospitals playing God with women's lives?" and urged women to put pressure on lawmakers to prevent mergers that cut services.[29] *Harper's Magazine* featured the statistic "Chances that a U.S. Catholic hospital does not provide emergency contraception to rape victims: 4 in 5," in its "Harper's Index," and Newsweek.com featured the report in its "Periscope" section.[30,31] *Modern Healthcare*, one of the most widely read trade publications in the health care industry, did an article about the growing incidence of Catholic/non-Catholic hospital deals.[32]

The survey helped bring home two points about Catholic/non-Catholic mergers that many had previously failed to grasp: Catholic hospitals are providers of care to the larger community and Catholic hospitals deny services.

CATHOLIC HOSPITALS COME OUT— AND GO ON THE DEFENSIVE

As a result of CFFC's report and work by groups like MergerWatch and the Abortion Access Project, Catholic hospitals have been called to greater accountability, both in their communities and in the media. The report focused attention on the inconsistent interpretation and application of the *Directives*. It also offered concrete evidence that vital services were being denied as the result of Catholic/non-Catholic mergers. The sheer amount of media coverage forced Catholic hospitals and their trade association, the Catholic Health Association (CHA) to respond and clarify their policies regarding EC.

On the local level, Catholic hospitals found themselves on the receiving end of phone calls from reporters who wanted to know what their EC policy was, forcing some hospitals to go on the record with their EC policies. Some hospitals launched internal communications reorganizations so that only specific employees would be allowed to answer outside questions about services provided.[34] The CHA also urged hospitals to obtain a copy of the CFFC report. In a memo to member hospitals, CHA President Michael Place requested that hospitals review the data in the report regarding their facility and report back any "inaccurate or misleading information about your organization."[35] This suggests that in many hospitals, employees may not be aware of official EC policies, so different messages are being communicated to patients and potential patients.

CHA also went on the defensive in the media, contesting the findings of CFFC's report. In a letter to ABC News regarding its story about the rape victim who became pregnant because she was denied EC at a Catholic hospital, Place disputed the survey's findings.[36] He claimed that callers only asked if the morning-after pill was available, and then "wrongly concluded that the Catholic hospital does not treat victims of rape." This is not accurate. After asking about the general availability of the morning-after pill, the CFFC caller then specifically asked if it was provided in instances of rape. If the respondent answered "no," the conclusion was correctly reached that the hospital does not treat rape victims according to the medically accepted standard of care. As a matter of fact, some states require hospitals to inform rape victims of the availability of EC.[37]

Place's letter also highlights a fundamental dilemma regarding the use of EC by Catholic hospitals that CFFC identified in its report. He stated in his letter to ABC News that "Catholic hospitals can provide contraceptive services to rape victims."[38] This is exactly CFFC's point. The *Directives* clearly state that EC is an acceptable option for women who have been raped if conception has not occurred:

> *"A female who has been raped should be able to defend herself against a potential conception from 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."* (Directive No. 36)

But the reality is that many Catholic hospitals don't provide EC for women who have been raped because their interpretations of the directive vary widely and each hospital develops its own guidelines under the direction of the local bishop. Some Catholic institutions, such as Mercy Medical Center in Baltimore and Catholic Health West, the California-based hospital chain, say they offer EC to all rape victims when appropriate.[39] Other Catholic hospitals, such as those in the Archdiocese of Chicago, are officially supposed to question patients about their menstrual cycle and refuse EC to anyone who may have recently ovulated and therefore might conceive as a result of rape.[40] Still other Catholic hospitals insist that the method is an abortifacient and refuse it to all rape victims.[41] As the CFFC survey found, some hospitals that don't provide EC to women who have been raped do provide counseling and referrals about the method and some don't.[42] In some cases where EC is denied, women end up aborting their pregnancies, as did the woman in the ABC News story.[43]

Place also claims that CFFC researchers "called emergency rooms and asked if the 'morning-after pill' was provided there, thus confusing the issue of

abortion and emergency contraception for the purpose of obtaining a preordained result."[44] It is not CFFC that confuses emergency contraception and abortion, but Catholic hospitals. CHA and CFFC agree that EC is not an abortifacient. However, many Catholic hospitals deny EC to women who have been raped in the mistaken belief that it is an abortifacient. Six years ago, Bishop John Myers of Peoria, Illinois, ordered the Catholic hospital in the diocese to cease using EC because he said it could cause abortion.[45] The medical fact is that EC will not and cannot disrupt an already-established pregnancy—one in which implantation has already occurred.[46] CFFC used the term "morning-after pill" when calling hospitals because that is the term a woman is more likely to use.

In a letter to the editor of *USA Today*, Place further stated that "Catholic hospitals all over the country offer immediate, compassionate, sensitive care to women who are victims of sexual assault."[47] Routinely denying a key tool to alleviate the already devastating long-term impact of rape is not "compassionate, sensitive care." Not informing women of all of their options is not good medical or ethical protocol. Also, nowhere does Place state that hospitals actually provide EC, leaving them to define what constitutes "immediate, compassionate, sensitive care."

The confusion over the issue of the provision of EC to rape victims is not surprising as the Catholic church cannot seem to get its story straight on EC. The Vatican has consistently labeled the method as an abortifacient. In May, Monsignor Elio Sgreccia, vice president of the Pontifical Academy for Life and a close advisor to the pope, said in reference to the provision of EC to women in Kosovo who had been raped, "The 'morning-after pill' does not exist. This is an abortion."[48] During the preparatory conferences for the five-year review of the Cairo International Conference on Population and Development in New York, the Holy See delegation denounced emergency contraception as "abortive practices, camouflaged as a means of contraception."[49]

CONCLUSIONS

The CFFC survey on Catholic hospitals' provision—or lack thereof—of emergency contraception illustrated the "real world" availability of emergency contraception by asking hospitals if EC was available in language real women would use. It also specifically explored the question of the provision of EC for rape victims. The survey is a valuable addition to the limited public information that is available on the presence of Catholic providers in the U.S. health care system and the impact of Catholic/non-Catholic mergers. The survey opened public debate not only on the emergency contraception issue, but also on the larger issue of the role of Catholic providers in a largely sectarian health system. It also created the need for Catholic hospitals to respond with specifics as to their standard of care for rape victims and forced some to make specific provisions for protecting EC services in mergers.

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NOTES

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GLOSSARY

Acquisition: the outright purchase of one facility by another.

Affiliation: a cooperative venture that may entail joint purchasing arrangements, apportionment of medical specialties among separately owned facilities, or the sharing of laboratory and other ancillary services.

Directives: the *Ethical and Religious Directives for Catholic Health Care Services*, which are promulgated in the United States by the National Conference of Catholic Bishops. Last revised in 1994, the *Directives* outline the mission and spiritual responsibilities of Catholic health care, instruct institutions on maintaining Catholic identity when forming partnerships with non-Catholic health care providers, and prohibit abortion, contraception counseling, in vitro fertilization, fetal tissue research, reproductive sterilization (temporary or permanent), and euthanasia. Where questions arise, the *Directives* are interpreted by the hospital's sponsor and its local bishop.

Emergency Contraception: two specific doses of oral contraceptives that work to prevent pregnancy after unprotected sexual intercourse. Depending on the time during the menstrual cycle when it is taken, emergency contraception (EC), which can be taken up to 72 hours after unprotected sex, may inhibit or delay ovulation, or it may alter the endometrium (the lining of the uterus), thereby inhibiting implantation of a fertilized egg. EC is approximately 75 percent effective in preventing pregnancy; the sooner after unprotected intercourse it is used the more effective it is. The copper-T intrauterine device (IUD) can be inserted up to five days after unprotected intercourse. This method reduces the risk of pregnancy by more than 99 percent.[1]

Integrated delivery network, or network: a system that may combine delivery, financing, and management of care in one organization, giving physicians, hospitals, and insurers shared responsibility for health care delivery and risk management.

Lease: a contract under which one health care system or hospital operates another health care facility for a specified time.

Merger: the establishment of shared assets, liabilities, and administrative functions between two entities.

Reproductive health services: in this report, the reproductive health services discussed are those prohibited by the *Directives*, as these have been the focus of controversy in mergers between Catholic and non-Catholic hospitals. These services include contraceptive counseling; tubal ligation, vasectomy or other reproductive sterilization, whether temporary or permanent; abortion; emergency contraception for rape victims; and most assisted reproduction services.

Sponsor: while Catholic hospitals are owned by the church, under canon law, stewardship of each health care facility rests with a sponsoring organization. A sponsor is a Catholic group (religious institute or order, diocese, or private association) that ensures that the hospital follows church guidelines and a specific "healing mission." Sponsors usually have certain governance responsibilities, known as "reserved powers," over their facilities.[2] The sponsor generally appoints and removes the hospital's trustees.

[1] Office for Population Research: Emergency Contraception Website: <www://opr.princeton.edu/ec/>.

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APPENDIX D
PROVISION OF EMERGENCY CONTRACEPTION IN CATHOLIC EMERGENCY ROOMS

The following is a reprint of the emergency contraception study that originally appeared in *Caution: Catholic Health Restrictions May Be Hazardous to Your Health*. Catholics for a Free Choice researchers contacted the emergency rooms of 589 Catholic hospitals between [illegible] and January 6, 1999 to inquire if emergency contraception was provided, if it was provided to women who have been raped or if referrals were available. Please note that in some cases our findings contradict hospitals' official policies. This survey is not intended to represent official hospital policy, but what callers to the emergency room were told.

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
ALABAMA						
Mercy Medical, Daphne			x			x
Providence Hospital, Mobile			x			x
St. Vincent's Hospital, Birmingham			x			x
ALASKA						
Ketchikan General Hospital, Ketchikan			x			x
Providence Alaska Medical Center, Anchorage			x			x
Providence Kodiak Island Medical Center, Kodiak		x				
Providence Seward Medical Center, Seward			x			x
ARIZONA						
Carondelet Holy Cross Hospital, Nogales			x		x	
Carondelet St. Joseph's Hospital, Tucson			x		x	
Carondelet St. Mary's Hospital, Tucson			x		x	
St. Joseph's Hospital & Medical Ctr., Phoenix			x			x
ARKANSAS						
Conway County Hospital, Morrilton			x		x	
Conway Regional Medical Center, Conway			x	x		
Mercy Hospital & Pinewood Nursing Home, Waldron			x			x
Mercy Hospital-Turner Memorial, Ozark			x		x	
St. Bernard's Regional Medical Center, Jonesboro			x	x		
St. Edward Mercy Medical Center, Fort Smith			x		x	
St. Joseph's Regional Health Center, Hot Springs			x			x
St. Mary-Rogers Memorial Hospital, Rogers			x	x		
St. Vincent Infirmary Medical Center, Little Rock			x		x	

Hospital	Policy permits EC	No policy exists	Hospital denies EC			
			Total	Provides referral w/number	Provides referral w/o number	Provides no referral
CALIFORNIA						
Alexian Brothers Hospital, San Jose			x	x		
Citrus Valley Medical Center, West Covina (Queen of the Valley Campus)			x	x		
Daniel Freeman Marina Hospital, Marina Del Rey			x			x
Daniel Freeman Memorial Hospital, Inglewood			x	x		
Dominican Santa Cruz Hospital, Santa Cruz			x		x	
Lassen Community Hospital, Susanville			x			x
Little Company of Mary Hospital, Torrance			x	x		
Marian Medical Center, Santa Maria			x			x
Mercy American River Hospital, Carmichael (Mercy American River Campus)			x		x	
Mercy American River Hospital, Carmichael (San Juan Campus)			x	x		
Mercy General Hospital, Sacramento			x		x	
Mercy Hospital, Bakersfield			x	x		
Mercy Hospital of Folsom, Folsom			x	x		
Mercy Hospital & Health Services, Merced			x		x	
Mercy Medical Center, Redding			x	x		
Mercy Medical Center Mount Shasta, Mount Shasta			x		x	
Mercy Southwest Hospital, Bakersfield			x		x	
Mission Hospital Regional Medical Center, Mission Viejo			x		x	
O'Connor Hospital, San Jose		x				
Providence St. Joseph Medical Center, Burbank		x				
Queen of Angels, Hollywood Presbyterian Medical Center, Los Angeles			x			
Queen of the Valley Hospital, Napa			x			x
Petaluma Valley Hospital, Petaluma			x			x
Providence Holy Cross Medical Center, Mission Hills			x		x	
Redwood Memorial Hospital, Fortuna			x	x		
Robert F. Kennedy Medical Center, Hawthorne			x	x		
San Pedro Peninsula Hospital, San Pedro			x	x		
Santa Marta Hospital, Los Angeles			x	x		
Santa Rosa Memorial Hospital, Santa Rosa			x	x		
Santa Teresita Hospital, Duarte			x			x
Scripps Mercy Medical Center, San Diego		x				
Seton Medical Center, Daly City		x				
St. Agnes Medical Center, Fresno			x			x
St. Bernardine's Medical Center, San Bernardino			x			x
St. Dominic's Hospital, Manteca			x		x	
St. Elizabeth Community Hospital, Red Bluff			x	x		
St. Francis Medical Center, Lynwood		x				
St. Francis Medical Center of Santa Barbara, Santa Barbara			x	x		
St. John's Health Center, Santa Monica			x			x
St. John's Pleasant Valley Hospital, Camarillo			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
St. John's Regional Medical Center, Oxnard			x			x
St. Joseph Hospital, Eureka		x				
St. Joseph Hospital, Orange			x			x
St. Joseph's Medical Center of Stockton, Stockton			x	x		
St. Jude Hospital, St. Jude Medical Center, Fullerton			x			x
St. Louise Hospital, Morgan Hill		x				
St. Mary Medical Center, Long Beach			x		x	
St. Mary Regional Medical Center, Apple Valley			x		x	
St. Mary's Medical Center, San Francisco			x		x	
St. Rose Hospital, Hayward			x		x	
St. Vincent Medical Center, Los Angeles			x		x	
COLORADO						
Centura Health-Mercy Medical Center, Durango			x		x	
Exempla/St. Joseph Hospital, Denver			x	x		
Penrose Community Hospital, Colorado Springs			x		x	
Penrose Hospital-St. Francis Health Services, Colorado Springs			x		x	
St. Anthony Hospital Central, Denver			x	x		
St. Anthony Hospital North, Westminster			x		x	
St. Francis Health Center, Colorado Springs			x		x	
St. Mary-Corwin Regional Medical Center, Pueblo		x				
St. Mary's Hospital & Medical Center, Grand Junction			x		x	
St. Thomas More Hospital & Progressive Care Center, Canon City	x					
CONNECTICUT						
Hospital of St. Raphael, New Haven			x		x	
St. Francis Hospital & Medical Center, Hartford (St. Francis Campus)		x				
St. Joseph Medical Center, Stamford		x				
St. Mary's Hospital, Waterbury			x	x		
St. Vincent's Medical Center, Bridgeport			x			x
DELAWARE						
St. Francis Hospital, Wilmington			x	x		
DISTRICT OF COLUMBIA						
Georgetown University Hospital			x		x	
Providence Hospital			x	x		
FLORIDA						
Bon Secours-St. Joseph Hospital, Port Charlotte			x	x		
Bon Secours-Venice Hospital, Venice		x				

Hospital	Policy permits EC	No policy exists	Hospital denies EC			
			Total	Provides referral w/number	Provides referral w/o number	Provides no referral
Holy Cross Hospital, Fort Lauderdale			x	x		
Mercy Hospital, Miami			x		x	
Sacred Heart Hospital of Pensacola, Pensacola			x			x
St. Anthony's Hospital, St. Petersburg			x	x		
St. Joseph's Hospital, Tampa			x		x	
St. Joseph's Women's Hospital, Tampa			x		x	
St. Mary's Hospital, West Palm Beach			x		x	
St. Vincent's Medical Center, Jacksonville			x		x	
GEORGIA						
St. Joseph's Hospital of Atlanta, Atlanta			x		x	
St. Francis Hospital, Inc., Columbus			x		x	
St. Joseph Hospital, Augusta			x			x
St. Joseph's Hospital, Savannah			x		x	
St. Mary's Health Care System, Athens	x					
HAWAII						
St. Francis Medical Center West, Honolulu		x				
IDAHO						
Clearwater Valley Hospital, Orofino	x					
Mercy Medical Center, Nampa	x					
St. Alphonsus Regional Medical Center, Boise			x	x		
St. Benedict's Family Medical Center, Jerome			x			x
St. Joseph Regional Medical Center, Lewiston			x	x		
St. Mary's Hospital, Cottonwood			x		x	
ILLINOIS						
Alexian Brothers Medical Center, Elk Grove Village			x		x	
Columbus Hospital, Chicago			x			x
Good Samaritan Regional Health Center, Mt. Vernon			x	x		
Holy Cross Hospital, Chicago	x					
Holy Family Medical Center, Des Plaines			x	x		
Little Company of Mary Hospital & Health Care Centers, Evergreen Park			x			x
Loyola University Medical Center-Foster G. McGraw Hospital, Maywood			x			x
Mercy Hospital & Medical Center, Chicago			x	x		
Oak Park Hospital, Oak Park			x	x		
OSF St. Anthony Medical Center, Rockford			x			x
OSF St. James Hospital, Pontiac			x	x		
OSF St. Joseph Hospital, Belvidere			x		x	
Our Lady of Resurrection Medical Center, Chicago			x		x	
Provena Covenant Medical Center, Urbana			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
Provena Mercy Center, Aurora			x			x
Provena St. Joseph Hospital, Elgin			x			x
Provena St. Joseph Medical Center, Joliet			x		x	
Provena St. Therese Medical Center, Waukegan			x			x
Provena St. Mary's Hospital, Kankakee	x					
Provena United Samaritans Medical Center-Logan Campus, Danville	x					
Provena United Samaritans Medical Center-Sager Campus, Danville	x					
Resurrection Medical Center, Chicago			x	x		
St. Anthony Hospital, Chicago			x	x		
St. Anthony's Health Center, Alton			x	x		
St. Anthony's Memorial Hospital, Effingham			x		x	
St. Bernard Hospital & Health Care Center, Chicago	x					
St. Clare's Hospital, Alton			x	x		
St. Clemet Hospital, Red Bud			x		x	
St. Elizabeth Medical Center, Granite City		x				
St. Elizabeth's Hospital, Belleville	x					
St. Elizabeth's Hospital of Chicago, Chicago	x					
St. Francis Hospital, Litchfield			x	x		
St. Francis Hospital & Health Center, Blue Island			x	x		
St. Francis Hospital of Evanston, Evanston			x	x		
St. Francis Medical Center, Peoria			x		x	
St. John's Hospital, Springfield	x					
St. Joseph Hospital, Chicago	x					
St. Joseph Medical Center, Bloomington			x	x		
St. Joseph Memorial Hospital, Murphysboro			x	x		
St. Joseph's Hospital, Breese		x				
St. Joseph's Hospital, Highland		x				
St. Margaret's Hospital, Spring Valley			x		x	
St. Mary Medical Center, Galesburg			x	x		
St. Mary of Nazareth Hospital Center, Chicago			x		x	
St. Mary's Hospital, Centralia			x			x
St. Mary's Hospital, Decatur	x					
St. Mary's Hospital, East St. Louis			x			x
St. Mary's Hospital, Streator			x	x		
INDIANA						
Memorial Hospital & Health Care Center, Jasper			x		x	
St. Anthony Medical Center, Crown Point			x		x	
St. Anthony Memorial Center, Michigan City			x	x		
St. Catherine Hospital of East Chicago, East Chicago			x		x	
St. Elizabeth Ann Seton Hospital, Boonville			x	x		
St. Elizabeth Medical Center, Lafayette			x		x	
St. Francis Hospital & Health Centers, Beech Grove			x		x	

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
St. John's Health System/St. John's Medical Center, Anderson			x		x	
St. Joseph Community Hospital, Mishawaka		x				
St. Joseph Hospital & Health Center, Kokomo			x		x	
St. Joseph's Regional Medical Center, Plymouth			x	x		
St. Joseph's Regional Medical Center, South Bend		x				
St. Margaret Mercy Healthcare Centers-North Campus, Hammond			x		x	
St. Margaret Mercy Healthcare Centers-South Campus, Dyer			x		x	
St. Mary's Medical Center, Hobart	x					
St. Mary's Medical Center of Evansville, Evansville		x				
St. Mary's Warrick, Boonville			x		x	
St. Vincent Carmel Hospital, Carmel			x	x		
St. Vincent Hospitals & Health Services, Indianapolis			x		x	
St. Vincent Mercy Hospital, Elwood	x					
St. Vincent New Hope, Indianapolis			x		x	
St. Vincent Williamsport, Williamsport			x	x		
IOWA						
Alegent Health-Mercy Hospital, Council Bluffs			x			x
Avera Holy Family Health, Estherville			x	x		
Covenant Medical Center, Waterloo			x			x
Marian Health Center, Sioux City			x			x
Mercy Health Center-St. Mary's Unit, Dyersville			x	x		
Mercy Hospital, Corning			x			x
Mercy Hospital, Iowa City			x			x
Mercy Hospital Medical Center, Des Moines			x		x	
Mercy Hospital of Franciscan Sisters, Oelwein			x			x
Mercy Medical Center, Cedar Rapids			x	x		
North Iowa Mercy Health Center, Mason City			x		x	
Samaritan Health System, Clinton		x				
St. Joseph Community Hospital, New Hampton			x		x	
St. Joseph's Mercy Hospital, Centerville			x	x		
KANSAS						
Central Kansas Medical Center-St. Rose Campus, Great Bend		x				
Mercy Hospital, Fort Scott			x		x	
Mercy Hospital, Independence			x	x		
Mt. Carmel Medical Center, Pittsburgh			x			
Providence Medical Center, Kansas City			x		x	
St. John Hospital, Leavenworth	x					
St. Catherine Hospital, Garden City			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
St. Francis Hospital & Medical Center, Topeka			x	x		
Via Christi Regional Medical Center-St. Francis Campus, Wichita			x		x	
Via Christi Regional Medical Center-St. Joseph Campus, Wichita			x			x
KENTUCKY						
CARITAS Medical Center, Louisville			x		x	
Flaget Memorial Hospital, Bardstown			x		x	
Lourdes Hospital, Paducah			x		x	
Marcum & Wallace Memorial Hospital, Irvine			x	x		
Marymount Medical Center, London			x		x	
Our Lady of Bellefonte Hospital, Ashland			x		x	
Our Lady of the Way Hospital, Martin			x	x		
St. Claire Medical Center, Morehead			x			x
St. Elizabeth Grant County, Williamstown			x		x	
St. Elizabeth Medical Center-North, Covington			x			x
St. Joseph Hospital, Lexington			x		x	
LOUISIANA						
Our Lady of Lake Regional Medical Center, Baton Rouge			x		x	
Our Lady of Lourdes Regional Medical Center, Lafayette			x			x
Sisters of Charity Coushatta Health Care Center, Coushatta			x		x	
Sisters of Charity-Schumpert Health System, Shreveport			x		x	
Sisters of Charity-St. Patrick Hospital, Lake Charles			x		x	
St. Frances Cabrini Hospital, Alexandria			x		x	
St. Francis Medical Center, Monroe			x		x	
St. Patrick's Hospital, Monroe			x		x	
MAINE						
Mercy Hospital, Portland			x		x	
St. Joseph Hospital, Bangor	x					
St. Mary's Regional Medical Center, Lewiston			x		x	
MARYLAND						
Bon Secours Hospital, Baltimore			x		x	
Holy Cross Hospital of Silver Spring, Silver Spring			x			x
Liberty Medical Center, Baltimore			x	x		
Mercy Medical Center, Baltimore	x					
Sacred Heart Hospital, Cumberland	x					
St. Agnes HealthCare, Baltimore			x			x
St. Joseph Medical Center, Towson		x				
St. Luke Institute, Silver Spring			x	x		
The Good Samaritan Hospital of Maryland, Baltimore			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
MASSACHUSETTS						
Caritas Norwood Hospital, Norwood			x		x	
Caritas Southwood Hospital, Norfolk			x		x	
Carney Hospital, Boston			x		x	
Good Samaritan Medical Center, Brockton			x		x	
Holy Family Hospital & Medical Center, Methuen			x			x
Mercy Hospital, Springfield			x		x	
St. Anne's Hospital Corp, Fall River			x		x	
Saints Memorial Medical Center, Lowell			x		x	
St. Elizabeth's Medical Center, Boston			x		x	
Youville Hospital & Rehabilitation Center, Cambridge			x			x
MICHIGAN						
Battle Creek Health System, Battle Creek			x			x
Bon Secours Hospital, Grosse Pointe		x				
Borgess Medical Center, Kalamazoo			x		x	
Community Hospital, Battle Creek			x			x
Genesys Regional Medical Center, Grand Blanc	x					
Holy Cross Hospital of Detroit, Detroit			x		x	
Lee Memorial Hospital, Dowagiac		x				
Leila Hospital, Battle Creek			x			x
McPherson Hospital, Howell			x			x
Mercy General Hospital Partners-Sherman Boulevard Campus, Muskegon			x		x	
Mercy Health Services North, Grayling			x	x		
Mercy Hospital, Cadillac			x	x		
Mercy Hospital, Detroit			x			x
Mercy Hospital, Port Huron			x	x		
Providence Hospital & Medical Centers, Southfield			x	x		
Saline Community Hospital, Saline		x				
St. Francis Hospital, Escanaba		x				
St. John Detroit Riverview Hospital, Detroit			x		x	
St. John Hospital & Medical Center, Detroit			x	x		
St. John Macomb Hospital, Warren			x	x		
St. John Oakland Hospital, Madison Heights	x					
St. John River District Hospital, East China		x				
St. Joseph Mercy Hospital, Ann Arbor	x					
St. Joseph Mercy-Oakland, Pontiac			x		x	
St. Joseph's Mercy-East, Mt. Clemens			x			x
St. Joseph's Mercy-West, Clinton Township			x		x	
St. Mary Hospital, Livonia	x					
St. Mary's Health Services, Grand Rapids			x		x	
St. Mary's Medical Center of Saginaw, Saginaw			x		x	
Tawas St. Joseph Hospital, Tawas City			x			x

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
MINNESOTA						
Divine Providence Health Center, Ivanhoe			x			x
Graceville Health Center, Graceville			x			x
HealthEast St. Joseph's Hospital, St. Paul			x		x	
LakeWood Health Center, Baudette	x					
Queen of Peace Hospital, New Prague	x					
Regina Medical Center, Hastings			x			x
South Suburban Medical Center, Farmington	x					
St. Cloud Hospital, St. Cloud			x		x	
St. Francis Medical Center, Breckenridge			x		x	
St. Francis Regional Medical Center, Shakopee			x			x
St. Gabriel's Hospital, Little Falls	x					
St. Joseph's Area Health Services, Park Rapids			x			x
St. Joseph's Medical Center, Brainerd			x	x		
St. Mary's Hospital, Rochester			x		x	
St. Mary's Medical Center, Duluth			x	x		
St. Mary's Regional Health Center, Detroit Lakes	x					
MISSISSIPPI						
St. Dominic/Jackson Memorial Hospital, Jackson			x			x
MISSOURI						
Alexian Brothers Hospital, St. Louis			x		x	
Breech Regional Medical Center, Lebanon			x		x	
St. Joseph Health Center, Kansas City			x			x
SSM Arcadia Valley Hospital, Pilot Knob			x	x		
SSM DePaul Health Center, Bridgeton			x		x	
SSM St. Joseph Health Center, St. Charles			x		x	
SSM St. Joseph Hospital of Kirkwood, St. Louis			x			x
SSM St. Joseph Hospital West, Lake St. Louis			x			x
SSM St. Mary's Health Center, St. Louis			x	x		
St. Anthony's Medical Center, St. Louis			x		x	
St. Francis Hospital, Mountain View	x					
St. Francis Hospital & Health Services, Maryville		x				
St. Francis Medical Center, Cape Girardeau			x	x		
St. John's Mercy Hospital, Washington			x		x	
St. John's Mercy Medical Center, St. Louis			x	x		
St. John's Regional Health Center, Springfield			x		x	
St. John's Regional Medical Center, Joplin			x		x	
St. Mary's Health Center, Jefferson City	x					
St. Mary's Hospital of Blue Springs, Blue Springs			x		x	

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
MONTANA						
Benefis Healthcare, Great Falls			x	x		
Holy Rosary Health Center, Miles City			x	x		
St. Vincent Hospital & Health Center, Billings		x				
St. James Community Hospital, Butte			x		x	
St. Joseph Hospital, Polson			x		x	
St. Patrick Hospital, Missoula			x		x	
NEBRASKA						
Alegent Health-Bergan Mercy Medical Center, Omaha			x			x
Faith Regional Health Services-East Campus, Norfolk			x		x	
Good Samaritan Hospital Health System, Kearney			x		x	
Providence Medical Center, Wayne	x					
St. Anthony's Hospital, O'Neill			x	x		
St. Elizabeth Community Hospital, Lincoln			x			x
St. Francis Medical Center, Grand Island			x		x	
St. Francis Memorial Health Center, Grand Island			x			x
St. Francis Memorial Hospital, West Point			x			x
St. Mary's Hospital, Nebraska City			x			x
NEW HAMPSHIRE						
Catholic Medical Center, Manchester			x			x
St. Joseph Hospital & Trauma Center, Nashua			x			x
NEVADA						
St. Mary's Regional Medical Center, Reno			x		x	
St. Rose Dominican Hospital, Henderson			x		x	
NEW JERSEY						
Holy Name Hospital, Teaneck			x		x	
Our Lady of Lourdes Medical Center, Camden			x	x		
St. Clare's Hospital, Boonton Township			x		x	
St. Clare's Hospital, Denville			x	x		
St. Clare's Hospital, Dover		x				
St. Clare's Hospital, Sussex		x				
St. Elizabeth Hospital, Elizabeth			x	x		
St. Francis Hospital-Franciscan Health System of NJ, Jersey City			x			x
St. James Hospital of Newark, Newark			x	x		
St. Joseph's Hospital & Medical Center, Paterson			x			x
St. Mary's Hospital, Passaic			x		x	
St. Mary's Hospital-Franciscan Health System of NJ, Hoboken			x			x
St. Michael's Medical Center, Newark			x		x	
St. Peter's University Hospital & Health System, New Brunswick			x		x	

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
NEW MEXICO						
St. Joseph Northeast Heights Hospital, Albuquerque			x			x
St. Joseph Rehabilitation Hospital, Albuquerque			x			x
St. Joseph West Mesa Hospital, Albuquerque			x			x
NEW YORK						
Benedictine Hospital, Kingston	x					
Cabrini Medical Center, New York			x		x	
Florence D'Urso Pavilion, Bronx			x		x	
Good Samaritan Hospital, Suffern			x			x
Good Samaritan Hospital Medical Center, West Islip			x			x
Kenmore Mercy Hospital, Kenmore			x			x
Mary Immaculate Hospital, Jamaica			x			x
Mercy Community Hospital, Port Jervis			x		x	
Mercy Hospital of Buffalo, Buffalo	x					
Mercy Medical Center, Rockville Centre			x			x
Mount St. Mary's Hospital of Niagara Falls, Lewiston	x					
Our Lady of Lourdes Memorial Hospital, Binghamton			x			x
Our Lady of Mercy Medical Center-Florence D'Urso Pavilion, Bronx			x		x	
Our Lady of Victory Hospital, Lackawanna			x		x	
Seton Health System-St. Mary's Division, Troy	x					
Sisters of Charity Hospital of Buffalo, Buffalo			x		x	
St. Agnes Hospital, White Plains			x			x
St. Anthony Community Hospital, Warwick			x		x	
St. Clare's Hospital, Schenectady		x				
St. Clare's Hospital & Health Center, New York	x					
St. Elizabeth Medical Center, Utica			x			x
St. Francis Hospital, Beacon		x				
St. Francis Hospital, Poughkeepsie	x					
St. James Mercy Hospital, Hornell			x		x	
St. Jerome Hospital, Batavia		x				
St. John's Queens Hospital, Elmhurst			x			x
St. Joseph Hospital, Cheektowaga	x					
St. Joseph's Hospital, Elmira			x		x	
St. Joseph's Hospital, Flushing			x			x
St. Joseph's Hospital Health Center, Syracuse		x				
St. Mary's Hospital, Rochester			x		x	
St. Mary's Hospital at Amsterdam, Amsterdam		x				
St. Mary's Hospital of Brooklyn, Brooklyn			x	x		
St. Peters' Hospital, Albany			x		x	
St. Vincents Hospital & Medical Center, New York			x			x
St. Vincent's Medical Center of Richmond, Staten Island			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
NORTH CAROLINA						
St. Joseph of the Pines, Pinehurst			x			x
NORTH DAKOTA						
Carrington Health Center, Carrington		x				
Mercy Hospital, Devils Lake		x				
Mercy Hospital, Valley City			x			x
Mercy Medical Center, Williston			x			x
Oakes Community Hospital, Oakes			x			x
Presentation Medical Center, Rolla	x					
St. Aloisius Medical Center, Harvey			x		x	
St. Alexius Medical Center, Bismarck	x					
St. Andrew's Health Center, Bottineau			x			x
St. Ansgar's Health Center, Park River			x		x	
St. Joseph's Hospital & Health Center, Dickinson			x			x
OHIO						
Clermont Mercy Hospital, Batavia			x		x	
Community Health Partners, Lorain			x			x
Franciscan Hospital-Mt. Airy Campus, Cincinnati			x		x	
Franciscan Hospital-Western Hills Campus, Cincinnati			x			x
Franciscan Medical Center-Dayton Center, Dayton			x		x	
Good Samaritan Hospital, Cincinnati			x		x	
Good Samaritan Hospital, Dayton			x			x
Good Samaritan Medical Center, Zanesville			x		x	
Marymount Hospital, Garfield Heights			x		x	
Mercy Hospital, Hamilton		x				
Mercy Hospital of Fairfield, Fairfield			x		x	
Mercy Hospital of Tiffin, Tiffin			x	x		
Mercy Hospital of Willard, Willard		x				
Mercy Medical Center, Springfield			x			x
Mercy Memorial Hospital, Urbana	x					
Mount Carmel East Hospital, Columbus			x		x	
Mount Carmel Medical Center, Columbus	x					
Providence Hospital, Sandusky			x			x
Riverside Mercy Hospital, Toledo			x		x	
St. Ann's Hospital, Westerville			x			x
St. Charles Mercy Hospital, Oregon			x	x		
St. Elizabeth Health Center, Youngstown			x		x	
St. Joseph Health Center-Eastland Campus, Warren			x			x
St. Rita's Medical Center, Lima			x		x	
St. Vincent Mercy Medical Center, Toledo			x		x	
Trinity Health Systems, Steubenville			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
OKLAHOMA						
Broken Arrow Medical Center, Broken Arrow			x			x
Hillcrest Health Center, Oklahoma City		x				
Mercy Health Center, Oklahoma City			x		x	
Mercy Memorial Health Center, Ardmore			x			x
St. Anthony Hospital, Oklahoma City			x		x	
St. Francis Hospital, Tulsa			x		x	
St. John Medical Center, Tulsa			x		x	
St. Joseph Regional Medical Center of Northern Oklahoma, Ponca City			x		x	
St. Mary's Mercy Hospital, Enid			x	x		
OREGON						
Holy Rosary Medical Center, Ontario			x		x	
Mercy Medical Center, Roseburg			x		x	
Peace Harbor Hospital, Florence			x		x	
Providence Milwaukie Hospital, Milwaukie			x	x		
Providence Newberg Hospital, Newberg			x			x
Providence Portland Medical Center, Portland			x		x	
Providence Seaside Hospital, Seaside			x		x	
Providence St. Vincent Medical Center, Portland			x			x
Sacred Heart Medical Center, Eugene			x			x
St. Anthony Hospital, Pendleton		x				
St. Charles Medical Center, Bend		x				
St. Elizabeth Health Services, Baker City	x					
PENNSYLVANIA						
Bon Secours Holy Family Regional Health System, Altoona			x		x	
Divine Providence Hospital, Williamsport			x			x
Good Samaritan Medical Center, Johnstown			x			x
Good Samaritan Regional Medical Center, Pottsville			x		x	
Hazleton-St. Joseph Medical Center, Hazleton			x			x
Holy Redeemer Hospital & Medical Center, Meadowbrook			x			x
Holy Spirit Hospital, Camp Hill			x		x	
Jeannette District Memorial Hospital, Jeannette			x		x	
Marian Community Hospital, Carbondale			x			x
Mercy Fitzgerald, Darby			x		x	
Mercy Hospital, Scranton			x			x
Mercy Hospital, Wilkes-Barre			x			x
Mercy Hospital of Philadelphia, Philadelphia			x			x
Mercy Hospital of Pittsburgh, Pittsburgh			x		x	
Mercy Providence Hospital, Pittsburgh			x		x	
Muncy Valley Hospital, Muncy			x	x		

Hospital	Policy permits EC	No policy exists	Hospital denies EC			
			Total	Provides referral w/number	Provides referral w/o number	Provides no referral
Nazareth Hospital, Philadelphia			x	x		
Sacred Heart Hospital, Allentown			x	x		
St. Agnes Medical Center, Philadelphia			x	x		
St. Francis Central Hospital, Pittsburgh			x		x	
St. Francis Hospital of New Castle, New Castle			x		x	
St. Francis Medical Center, Pittsburgh			x		x	
St. John Vianney Hospital, Downingtown			x		x	
St. Joseph Hospital, Lancaster			x		x	
St Joseph Medical Center, Reading			x			x
St. Mary Medical Center, Langhorne			x		x	
St. Vincent Health Center, Erie			x			x
RHODE ISLAND						
Our Lady of Fatima Hospital, North Providence			x		x	
St. Joseph Hospital for Specialty Care, Providence			x		x	
SOUTH CAROLINA						
Bon Secours-St. Francis Xavier Hospital, Charleston			x		x	
St. Eugene Community Hospital, Dillon			x			x
St. Francis Hospital, Greenville			x		x	
St. Francis Women's Hospital, Greenville			x			x
SOUTH DAKOTA						
Avera McKennan Hospital, Sioux Falls			x			x
Avera Queen of Peace Health Services, Mitchell			x		x	
Avera St. Luke's, Aberdeen			x		x	
Sacred Heart Health Services, Yankton			x		x	
St. Benedict Health Center, Parkston			x		x	
St. Bernard's Providence Hospital, Milbank			x		x	
St. Mary's Heathcare Center, Pierre	x					
St. Mary's Hospital, Pierre	x					
TENNESSEE						
Memorial Hospital, Chattanooga			x	x		
St. Thomas Health Services, Nashville			x			x
St Mary's Health System, Knoxville	x					
TEXAS						
Baptist-St. Anthony's Health System, Amarillo			x		x	
Burleson St. Joseph Health Center, Caldwell			x			x
Cogdell Memorial Hospital, Snyder		x				
Crosbyton Clinic Hospital, Crosbyton	x					
Grimes St. Joseph Health Center, Navasota			x		x	
Highland Lakes Medical Center, Burnet			x			x

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
Jasper Memorial Hospital, Jasper			x	x		
Madison St. Joseph Health Center, Madisonville			x			x
Mercy Regional Medical Center, Laredo			x		x	
Providence Health Center, Waco			x			x
Santa Rosa Hospital, San Antonio			x		x	
Seton East Community Health Center, Austin			x			x
Seton Medical Center, Austin		x				
Seton Northwest, Austin			x		x	
Seton South Community Health Center, Austin			x		x	
Spohn Bee County Hospital, Beeville			x			x
Spohn Hospital Shoreline, Corpus Christi			x		x	
Spohn Hospital South, Corpus Christi			x		x	
Spohn Kleberg Memorial Hospital, Kingsville			x		x	
Spohn Memorial Hospital, Corpus Christi			x			x
St. Elizabeth Hospital, Beaumont			x			x
St. John Hospital, Nassau Bay			x	x		
St. Joseph Hospital, Houston			x			x
St. Joseph's Hospital & Health Center, Paris			x			x
St. Joseph Regional Health Center, Bryan			x		x	
St. Mary Hospital of Port Arthur, Port Arthur			x			x
St. Mary of the Plains Hospital, Lubbock			x		x	
St. Michael Health Care Center, Texarkana			x	x		
St. Paul Medical Center, Dallas			x			x
Swisher Memorial Hospital, Tulia		x				
Trinity Medical Center, Brenham			x		x	
Trinity-Mother Frances Health System, Tyler			x	x		
United Regional Health Care System, Eleventh Street Campus, Wichita Falls			x		x	
Villa Rosa Hospital, San Antonio			x			x
Yoakum County Hospital, Denver City			x			x
VERMONT						
Fletcher Allen Health Care, Burlington	x					
VIRGINIA						
Bon Secours De Paul Medical Center, Norfolk			x		x	
Bon Secours Maryview Medical Center, Portsmouth			x	x		
Bon Secours Memorial Regional Medical Center, Mechanicsville			x		x	
Bon Secours-Richmond Community Hospital, Richmond			x			x
Bon Secours-St. Mary's Hospital, Richmond			x			x

Hospital	Policy permits EC	No policy exists	Hospital denies EC: Total	Provides referral w/number	Provides referral w/o number	Provides no referral
Bon Secours Stuart Circle Hospital, Richmond			x			x
Mary Immaculate Hospital, Newport News			x		x	
St. Mary's Hospital, Norton			x			x
WASHINGTON						
Deer Park Health Center & Hospital, Deer Park			x		x	
Holy Family Hospital, Spokane			x	x		
Mount Carmel Hospital, Colville			x		x	
Our Lady of Lourdes Health Center, Pasco			x	x		
PeaceHealth-St. John Medical Center, Longview			x			x
Providence Centralia Hospital, Centralia			x		x	
Providence General Medical Center, Everett		x				
Providence Pacific Clinic, Everett	x					
Providence Seattle Medical Center, Seattle		x				
Providence St. Peter Hospital, Olympia			x		x	
Providence Toppenish Hospital, Toppenish		x				
Providence Yakima Medical Center, Yakima			x		x	
Sacred Heart Medical Center, Spokane			x			x
St. Clare Hospital, Tacoma			x		x	
St. Francis Hospital, Federal Way			x		x	
St. Joseph Hospital, Bellingham			x		x	
St. Joseph Hospital, Chewelah			x		x	
St. Joseph Medical Center, Tacoma			x		x	
St. Mary Medical Center, Walla Walla		x				
WEST VIRGINIA						
St. Joseph's Hospital of Buckhannon, Buckhannon		x				
St. Mary's Hospital of Huntington, Huntington			x		x	
Wheeling Hospital, Wheeling			x		x	
WISCONSIN						
Elmbrook Memorial Hospital, Brookfield		x				
Franciscan Skemp Healthcare-Mayo Health System, Arcadia	x					
Franciscan Skemp Healthcare-Mayo Health System, La Crosse Campus Medical Center, La Crosse			x		x	
Franciscan Skemp Healthcare-Mayo Health System, Sparta			x			x
Good Samaritan Health Center of Merrill, Merrill			x	x		
Holy Family Hospital, New Richmond			x		x	
Holy Family Memorial Medical Center, Manitowoc			x		x	
Langlade Memorial Hospital, Antigo		x				
Mercy Medical Center of Oshkosh, Oshkosh			x			x
The Monroe Clinic, Monroe			x		x	