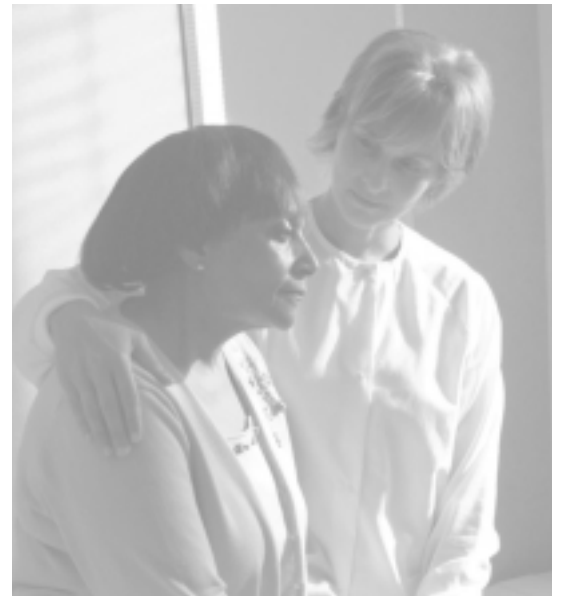
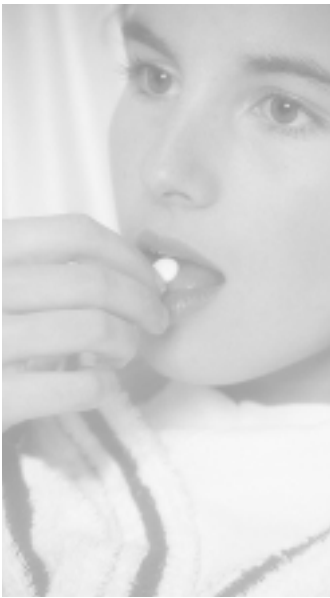


# Strategy 1: Legislation



# Legislation

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## Introduction

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

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

## Advantages:

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

## Disadvantages:

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

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

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

# Evaluating your readiness to seek legislation

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

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

# Keysteps in preparing a legislative campaign

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

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

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

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

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

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

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

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

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

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

# Legislative Resources

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## Key elements of your bill's language

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

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

**2 Findings section:** Usually a piece of legislation starts with a list of what are known as legislative findings. The findings recite the important facts that lawmakers have considered in putting forward the legislation. Examples of the types of facts that should be included in the findings are:

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

**3 Definitions of terms:** This section of the legislation defines the terms that will be used in the text. Although this section may seem pro forma, you should pay close attention to the definitions. Here are examples of specific things to watch for in the drafting of the definitions:

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

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

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

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

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

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

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

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

# Federal “EC in the ER” Legislation CARE Act

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

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

## **Key Features of the CARE Act**<sup>1</sup>

Under the Act, hospitals would be required to:

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

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

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

# Responding to requests from Catholic hospitals for exemptions from the law

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## Overview

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

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

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

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

- **Hospital emergency departments routinely receive and treat patients of many faiths.** In many cases, these patients (including rape victims) have arrived by ambulance or in a police car and are unaware of any religious policies in place at the hospital. They have not chosen to receive health care restricted by religious doctrine. In fact, these hospitals are licensed by the state to serve entire communities. It would be unfair to allow a hospital to impose its religious beliefs on patients who do not share that faith.
- **Religious or moral objections should never entitle a health care provider to refuse to give adequate medical treatment to a patient in an emergency.** Rape victims are in need of emergency medical care and should be offered EC as part of this care.
- **Emergency contraception is time-sensitive.** The sooner it is taken, the more effective it is. Any delay that would be introduced by sending a rape victim elsewhere to obtain the medication, such as to a pharmacy or an outpatient clinic, would increase the chance of that victim become pregnant from the assault. Significant delay could prevent the victim from obtaining the medication in time.
- **Community hospitals, including those with religious affiliations, rely heavily on public money for their basic operating expenses.** A 2002 study released by the Education Fund of Family Planning Advocates of New York State reported that half the operating expenses of religious hospitals come from Medicare and Medicaid. Nationwide, religious hospitals receive more than \$40 billion a year in public funds. When hospitals take public money and are licensed to serve the general public, they should not be allowed to refuse emergency care because of religious objections. To obtain a copy of this study, contact [info@mergerwatch.org](mailto:info@mergerwatch.org) or 518-436-8408, ext. 214.

## Responses of States

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

- **In Illinois**, lawmakers balked at requiring Catholic hospitals to dispense emergency contraception and instead watered down the overall bill requirements. Hospitals are required only to provide information about EC to rape victims. Patients may be referred elsewhere to obtain the treatment.
- **In Maryland**, the legislature refused to act on a proposed EC in the ER bill and then also rejected a measure similar to the Illinois law that would have required hospitals only to provide information about EC. Objections from the state Catholic conference were the major reason for the legislature's inaction.
- **In Washington, California and New Mexico**, laws requiring all hospitals to dispense emergency contraception were enacted without any special exemptions for religious hospitals.
- **In New York**, the state Catholic Conference dropped its objections to the proposed EC in the ER bill only when the following language was added: "No hospital shall be required to provide emergency contraception to a rape victim who is pregnant." (This language is discussed in more detail in the question-and-answer section on Catholic hospitals' use of pregnancy testing.)
- **In Hawaii**, the governor vetoed an EC in the ER bill that had passed both houses of the Legislature on the basis that the measure should have included a religious exemption for Catholic hospitals.

## Questions and Answers

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

**Q** Does emergency contraception cause abortion?

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

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

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

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

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

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

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

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

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

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

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

“ Catholic teaching allows for the administration of emergency contraception within certain moral limits. ”

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

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

Catholic hospitals to ban the provision of emergency contraception to rape victims. After affirming the right of a rape victim to protect herself from conception, the *Directive* states: “If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization. It is not permissible, however, to initiate or recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum.”

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

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

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

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

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

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

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

<sup>2</sup> Hamel, R.P., and Panicola, M.R., “Emergency Contraception and Sexual Assault,” *Health Progress*, Journal of the Catholic Health Association of the United States, September-October 2002 issue.

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

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

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

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

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

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

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

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