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Emergency Contraception: Law, Policy and Practice

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I. INTRODUCTION

As the abortion debate rages on in the United States, access to so-called “emergency contraception” has emerged as a highly contentious and controversial issue perched on the sidelines. Emergency contraception is a medical regimen implemented by a woman within three to seven days after unprotected intercourse in order to prevent pregnancy. Proponents of abortion choice argue that it would obviate the need for approximately 800,000 abortions in the United States each year.¹ Pro-life advocates insist that emergency contraception is simply another method of terminating fetal

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¹ Anna Glasier, M.D. & David Baird, *The Side Effects of Self-Administering Emergency Contraception*, 339 NEW ENG. J. MED. 1 (July, 1998).

life after conception.² Thus, the controversy surrounding the availability of emergency contraception is deeply rooted in the abortion debate and has emerged as a surrogate dispute as deeply divisive as abortion itself.

Access to emergency contraception is being fought in two arenas: in emergency rooms, where rape survivors would be offered the regimen pursuant to the rape kit examination protocol, and in pharmacies that may now dispense emergency contraception by prescription for women under eighteen or stock it for purchase without a prescription for those eighteen years and older. Although the FDA approved over-the-counter access for those over age eighteen in the pharmacy setting, only nine states have so far enacted explicit “EC in the ER” laws that require hospital emergency rooms to provide sexual assault victims with information regarding emergency contraception and then to furnish it in the hospital upon request.³ An additional three states have passed related laws ensuring that a sexual assault survivor be given access to information about emergency contraception in hospital emergency rooms.⁴ Specifically, hospital emergency rooms must inform rape survivors of the availability of emergency contraception, as well as how to access it, even though they may refer the patient to another facility to secure it.⁵

Comment: Need to check if still accurate.

A. What is Emergency Contraception?

Emergency contraception (EC) has been referred to as the “best-kept secret” in medicine.⁶ EC is a prescribed regimen of high-dose oral contraceptive pills or use of an intrauterine device (IUD) to reduce the likelihood of pregnancy after a woman has engaged in unprotected vaginal intercourse.⁷ It can be used in the event of unanticipated sexual activity,

² Susan E. Wills, *Emergency contraception – Boon or Bane?* United States Conference of Catholic Bishops, Inc., Washington, D.C. (2001).

³ California Cal. Health and Safety Code § 13823.11 (2002), Connecticut C.T. SB 1343 Public Act No. 24 (2007), Massachusetts, Mass Gen. Laws Ann. ch. 91, § 97B (2005), Minnesota, M.N. SB 1266 Chapter No. 42 (2007) New Jersey, N.J. Stat. Ann. § 1-5 ch. 26:2H-12.6b, New Mexico, N.M. Stat. 24-10 D-3 New York N.Y. Public Health Law §2805, Oregon, O.R. HB 2700 Chapter No. 182 (2007), Washington Wash. Rev. Code Ann. § 70.41 (2002)

⁴ Arkansas A.R. SB 847 Act No. 1576 (2007), Colorado, C.O. SB 60 Chapter No. 24 (2007), Illinois, Ill. Rev. Stat. ch. 110, § 1-106 (2002)

⁵ NARAL Pro-Choice America, *Emergency Contraception (EC): An Important and Underutilized Contraception Option*, http://www.prochoiceamerica.org/issues/birth_control/emergency-contraception (last visited April 17, 2008).

⁶ Planned Parenthood Affiliates of California, *A Brief History of Emergency Contraception*, available at <http://www.ppacca.org/site/pp.asp?c=kuJYJeO4F&b=139489> (last visited April 17, 2008). See also Yuliya Fisher Schaper, *Emergency Contraception for Rape Victims: A New Face of the Old Battleground of Legal Issues in the Bi-Partisan Abortion Politics in the United States*, 29 RUTGERS L. REC. 1, 6 (2005); Francine Coeytaux & Barbara Pillsbury, *Bringing Emergency Contraception to American Women: The History and Remaining Challenges*, WOMEN’S HEALTH ISSUES 11(2) (March/April 2001).

⁷ American Civil Liberties Union, Reproductive Freedom Project, *Insuring Access to Emergency Contraception after Rape*,

failure of contraception, vaginal rape, etc.⁸ EC is generally recognized as a safe and effective means of preventing unintended pregnancy when used properly and within the prescribed timeframe. It is readily distinguishable from RU-486,⁹ commonly referred to as the “abortion pill,” which acts upon a pregnancy that has already occurred, as EC is only effective in those cases in which embryo implantation has not yet occurred.¹⁰

EC is available in two forms. The first is a regimen of one or more pills, generally designed for birth control, which contain a synthetic form of the hormones estrogen and progestin, or of progestin only.¹¹ Some EC pills are specifically dedicated to emergency contraceptive use only and contain either estrogen and progestin, or progestin only.¹² These “combination pills” are taken in two doses, generally twelve hours apart, and not longer than approximately 120 hours (or about five days) after unprotected intercourse.¹³ The progestin-only pill can be taken in one or two doses. If taken within seventy-two hours, EC pills are approximately 75% effective.¹⁴ Nausea is a common side-effect, and when it is severe enough to prevent the ingestion of the pills, the pills can be inserted into the vagina and absorbed as a suppository.¹⁵

The second form of EC is the emergency insertion of an IUD. The ParaGard (Copper-T 380A) IUD has been used safely and effectively for contraception when inserted up to five days after unprotected intercourse.¹⁶ After its insertion, the IUD can remain in place for up to twelve years to avoid future pregnancy conception, and its contraceptive effects are reversed after it is removed.¹⁷ The emergency insertion of an IUD is more

<http://www.aclu.org/reproductiverights/contraception/16425res20070213.html>, footnote 1 (last visited April 17, 2008).

⁸ National Institute of Reproductive Health, *Back Up Your Birth Control Campaign: The Facts on Emergency Contraception and Plan B*, <http://www.backupyourbirthcontrol.org/ec/index.htm> (last visited April 17, 2008).

⁹ RU-486 is the name commonly used for an artificial steroid that blocks progesterone, a hormone needed to continue a pregnancy. Irving M. Spitz et al., *Early Pregnancy Termination With Mifepristone and Misoprostol in the United States*, 338 NEW ENG. J. MED. 1241–47 (1998).

¹⁰ American Medical Women’s Association, *Position Paper: Emergency Contraception*, <http://www.amwa-doc.org/index.cfm?objectid=0EF88909-D567-0B25-531927EE4CC23EFB>, (last visited March 11, 2008).

¹¹ *Id.*

¹² *Id.*

¹³ James Trussell et al., *The Role of Emergency Contraception*, 190(4) supp. 4 AM. J. OBSTETRICS & GYNECOLOGY, S30, S30 (Apr. 2004).

¹⁴ *Id.* at S31.

¹⁵ Eliran Mor et al., *Comparison of Vaginal and Oral Administration of Emergency Contraception*, 84(1) FERTILITY AND STERILITY 40, 40 (July, 2005).

¹⁶ *Selected Practice Recommendations for Contraceptive Use*. Geneva: World Health Organization, 60 (2d ed., 2004).

¹⁷ James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUBLIC HEALTH 494, 502 (1995).

than 99 % effective if accomplished within the recommended seven-day period.¹⁸

EC is popularly known as the “morning-after pill,” which is actually a misnomer for at least two reasons. First, EC need not be undertaken on the “morning after” unprotected intercourse and in some cases can be used as long as seven days later.¹⁹ Secondly, the oral form of EC generally involves the ingestion of more than one pill, although the progestin-only pill can be taken in one dose.²⁰ EC is not effective to terminate a pregnancy that has already occurred, as is it not thought to harm a fetus if taken after a pregnancy has implanted.²¹

B. Historical Context

EC has been available at least since the 1960s, when its first reported use involved a physician who prescribed a large dose of a contraceptive formulation to prevent the pregnancy of a patient who had been raped.²² In 1974, Professor A. Albert Yuzpe published the first studies demonstrating the safety and efficacy of the use of high dose oral contraceptives to prevent pregnancy.²³ The Yuzpe regimen consisted of combined oral contraceptive pills that contained the hormones estrogen and progestin taken in two doses, twelve hours apart.²⁴

In 1994, the Center for Reproductive Law and Policy petitioned the FDA “on behalf of a coalition of leading medical and public health groups,” to bring emergency contraception into the “medical mainstream.”²⁵ At that time EC was widely used for women who had unprotected intercourse either due to sexual assault, contraception failure, the miscalculation of pregnancy risk, or the failure to use birth control.²⁶ By the turn of the century, physicians and the United States Food and Drug Administration (FDA) recognized EC as safe and effective for all women

¹⁸ James Trussell & Ellertson C., *Efficacy of emergency contraception*, FERTIL. CONTROL. REV., 4:8–11 (1995).

¹⁹ Helena von Hertzen, et al., *Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial*, LANCET, 360:1803-10 (2002).

²⁰ JAMES TRUSSELL & ELIZABETH G. RAYMOND, EMERGENCY CONTRACEPTION: A LAST CHANGE TO PREVENT UNINTENDED PREGNANCY (2008), <http://ec.princeton.edu/questions/ec-review.pdf> (last visited Apr. 23, 2008).

²¹ AMWA, *supra* note 11.

²² Megan L. Ranney, et al., Nonprescription Availability of Emergency Contraception in the United States: Current Status, Controversies and Impact on Emergency Medicine Practice. *Ann. Emerg. Med.* 47(5): 461071 (May 2006); Iris F. Litt, *Placing Emergency Contraception in the Hands of Women*, JAMA 293(1), 98–99, (Jan 5, 2005); Trussell, *supra* n.13.

²³ Litt, *supra* note 22.

²⁴ *Id.*

²⁵ Trussell, *supra* note 13.

²⁶ *Id.*

in need of pregnancy intervention in the first several days following unprotected intercourse.²⁷

II. THE FDA AND THE POLITICS OF EMERGENCY CONTRACEPTION

The FDA did not formally approve an EC product until 1999,²⁸ even though studies were available as early as 1974 that confirmed the safety and effectiveness of oral contraceptive pills containing estrogen and progestin, taken in two doses approximately twelve hours apart, for post-coital contraception.²⁹ Prior to this time oral contraceptives were prescribed “off-label”³⁰ for emergency use after unprotected intercourse.³¹ EC also was available through family planning clinics, university health centers and some hospital emergency rooms.³²

Despite the widespread off-label use of EC in the United States, many physicians were reluctant to prescribe it, likely due to the fear of legal repercussions.³³ Doctors often declined to offer EC in emergency rooms, even after sexual assault.³⁴ Since there was no FDA approval, it was not a medically acceptable use and thus the principles of informed consent did not require physicians to educate their patients about EC or offer it as an option. Religiously-affiliated hospital emergency rooms, in particular, denied access to EC even when it was specifically requested.³⁵ Furthermore, since EC was not FDA-approved, there were no commercial advertisements or public visibility, and thus few women even knew to ask for it.³⁶

²⁷ Robert Steinbrook, *Waiting for Plan B: The FDA and Non-Prescription Use of Emergency Contraception*, 350(23) N. ENG. J. MED. 2327, 2327 (June 2004).

²⁸ Plan B Timeline, prepared by the Office of Congresswoman Carolyn B. Maloney, <http://www.house.gov/shays/news/2005/november/PlanBTimeline.pdf> (last visited Apr. 17, 2008).

²⁹ For a discussion of off-label use of emergency contraception, see David G. Weismiller, *Emergency Contraception*, 70(4) AM. FAM. PHYS. 707 (Aug. 2004); Bonnie S. Jones, *Emergency Contraception Pills: What Does the Law Say About Prescribing, Dispensing, Repackaging and Advertising?* 53(5) J. AM. MED. WOMEN'S ASS'N. 233 (Fall 1998).

³⁰ Off-label use refers to the prescribing of FDA-approved medications for conditions not specifically approved for that drug product. Once the FDA approves a drug, physicians are not prohibited from off-label use. Indeed, off-label use of approved medications is a common and legal practice. Hospital emergency rooms, family planning clinics, and university health centers have been providing women with emergency contraception for years by prescribing high doses of birth control pills.

³¹ Weismiller, *supra* note 29, at 707.

³² Weismiller, *supra* note 29.

³³ Planned Parenthood Affiliates of California, Inc., *A Brief History of Emergency Contraception*, <http://www.ppacca.org/site/pp.asp?c=kuJYJeO4F&b=139489> (last visited Apr. 17, 2008).

³⁴ *Id.*

³⁵ Annette L. Amey & David Bishai, *Measuring the Quality of Medical Care for Women Who Experience Sexual Assault With Data From the National Hospital Ambulatory Medical Care Survey*, 39(6) ANNALS EMERGENCY MED. 631 (June 2002).

³⁶ Cynthia C. Harper & Charlotte E. Ellertson, *The emergency contraception pill: a survey of knowledge and attitudes among students at Princeton University*, 173(5) AM. J. OBGYN. 1438 (Nov. 1995).

The pharmaceutical industry also made little effort to market EC,³⁷ perhaps due to the divisive climate in the United States concerning issues and products related to reproduction. During the 1990s, the abortion pill RU-486 was widely available in Europe but not promoted in the U.S.³⁸ For a number of years, many large pharmaceutical companies feared that their other products would be boycotted if RU-486 were marketed in the U.S.³⁹ RU-486, under the generic name Mifepristone, eventually did gain FDA approval for use in the United States in 2000.⁴⁰ In 2003, Republican lawmakers introduced a bill in Congress to suspend the use of Mifepristone on the basis of three deaths reportedly linked to its use.⁴¹ They alleged that the FDA wrongly approved the drug under an FDA protocol that was appropriate only for drugs that promised treatment for life-threatening conditions.⁴² There was no action on the bill, which was expected to be reintroduced in the 2005-06 Congressional session.

In 1994, the Center for Reproductive Law and Policy (CRLP) filed a “citizen petition” with the FDA on behalf of Planned Parenthood and other medical and public health groups “to bring emergency contraception into the ‘medical mainstream.’”⁴³ The petition sought to require manufacturers of oral contraceptives to include information in their package inserts about the emergency contraceptive use of their products.⁴⁴ Although the FDA approached a number of pharmaceutical companies to that end, citing the public health need for EC, the industry still declined to promote EC, either due to fear of legal liability or, more likely, out of concern to protect the profit potential of their oral contraceptives and other products.⁴⁵ The FDA was unwilling to force the pharmaceutical companies to add emergency contraceptive instructions to existing oral contraceptive packaging and

³⁷ Joseph W. Brown & Matthew L. Boulton, *Provider Attitudes Toward Dispensing Emergency Contraception in Michigan's Title X Programs*, 31(1) FAM. PLANNING PERSP.39 (Jan. 1999).

³⁸ Heather Boonstra, *Voicing Concerns for Women, Abortion Foes Seek Limit on Availability of Mifepristone*, 4(2) THE GUTTMACHER REP. ON PUB. POL.3 (Apr. 2001).

³⁹ Gayle M.B. Hanson, “‘Morning after’ pill has political side effects – controversy over ethics and safety of birth control pill RU-486”. *Insight on the News*, July 4, 1994. FindArticles.com. 15 Mar. 2008. available at, http://findarticles.com/p/articles/mi_m1571/is_n27_v10/ai_15544306 (last visited Apr. 17, 2008).

⁴⁰ Boonstra, *supra* note 39, at 3

⁴¹ Gardiner Harris, *After 2 More Deaths, Planned Parenthood Alters Method for Abortion Pill*, N.Y. TIMES, Mar. 18, 2006, at A.

⁴² *Id.*

⁴³ Planned Parenthood Affiliates of California,, *supra* note 6.

⁴⁴ Planned Parenthood of Amarillo and the Texas Panhandle, *A Brief History of Emergency Hormonal Contraception*, <http://www.ppatp.org/HistoryofEC.htm> (last visited Apr. 17, 2008). See also, *Groups Want New Labels on Birth Control Pills* ATL. J. & CONST., E8 (Nov. 1994).

⁴⁵ Tamar Lewin, *U.S. Agency Wants the Pill Redefined*, N.Y. TIMES, July 1, 1996.

labeling.⁴⁶ Such labeling would instruct women to take extra doses of birth control pills after unprotected intercourse to prevent pregnancy.⁴⁷

In February, 1997, the FDA made a surprising move in response to the CRLP petition. Even though there was no application pending from a drug manufacturer, the FDA filed in the *Federal Register* an official notice indicating that certain EC regimens were considered safe and effective.⁴⁸ It also solicited applications from pharmaceutical manufacturers to market EC pills, and provided an incentive by indicating that expensive new drug trials could be avoided in light of the safety and efficacy that had already been demonstrated.⁴⁹ In 1998, Gynetics, Inc. received FDA approval for the marketing of PREVEN, an EC kit consisting of pills, a pregnancy test and instructions for use.⁵⁰ This was the first product designed specifically for EC use.⁵¹ Perhaps more importantly, the advertisement of PREVEN began the first commercial efforts at publicizing EC to consumers. In 1999, Barr Pharmaceuticals, Inc. followed suit and received FDA approval of the first progestin-only EC product, commonly known as “Plan B.”⁵² A subsequent study, supported by the World Health Organization, endorsed Plan B as being more effective and containing fewer side effects than other available products.⁵³ The approval of PREVEN and Plan B was very significant because it served to galvanize support for the product and allay physicians’ fears of legal liability when otherwise they prescribed high doses of oral contraceptives off label. Furthermore, by the time the FDA approved EC, the treatment was already widely used in other countries, including the United Kingdom, Germany, Sweden, and Switzerland.⁵⁴

In February, 2001, seven years after its initial petition requesting that the FDA bring emergency contraception into the medical mainstream, CRLP filed another petition with the FDA on behalf of more than seventy medical and public health organizations requesting that the FDA grant over-the-counter status to EC.⁵⁵ No decision was ever issued for this petition.⁵⁶ In 2003, Barr Pharmaceuticals filed an application with the

⁴⁶ *Id.*

⁴⁷ See Steinbrook, *supra* note 27; Henry A. Waxman, *Politics and Science: Reproductive Rights*, 16(5) HEALTH MATRIX, 5, 19–20 (2006).

⁴⁸ Planned Parenthood Affiliates of California, *supra* note 6.

⁴⁹ Lewin, *supra* note 45.

⁵⁰ Planned Parenthood Affiliates of California, Inc., *supra* note 6.

⁵¹ *Id.*

⁵² *Id.*

⁵³ Herten, *supra* note 19.

⁵⁴ Ranney, *supra* note 22.

⁵⁵ Center for Reproductive Rights, Citizen’s Petition, http://reproductiverights.org/crt_planb_legaldocs.html (last visited Apr. 18, 2008).

⁵⁶ *Id.*

FDA to change the status of Plan B from prescription-only to over the counter for all ages.⁵⁷

In December, 2003, two FDA advisory panels found that Plan B met the criteria for availability without a prescription, and voted 23-4 in favor of granting it over-the-counter status.⁵⁸ Five months later, despite these recommendations, the FDA chose to deny the petition, citing concerns about adolescent use and a potential increase in sexual promiscuity.⁵⁹ The FDA claimed it did not follow the Advisory Committee's recommendations because the data provided was inadequate to address concerns about whether young adolescent women would safely use Plan B for emergency contraception without the professional supervision of a licensed practitioner.⁶⁰ A bifurcated proposal followed, offering prescription-only EC for women under sixteen years of age, and over-the-counter EC for women over the age of sixteen.⁶¹ This new proposal was deemed incomplete and inadequate for a full review, and thus the FDA concluded the application was not approvable.⁶² A dozen members of Congress called for the resignation of key FDA officials whom they believed denied the over-the-counter petition based upon political and ideological beliefs.⁶³ Forty-one members of Congress asked that the FDA reconsider its decision.⁶⁴

Dr. Michael Greene, a member of the FDA advisory panel that voted 23-4 to allow nonprescription sales of EC, was reportedly told that "this approval was not to happen on the Bush administration's watch."⁶⁵ Five days later, Dr. Susan Wood, Assistant Commissioner for Women's Health and Director of the Office of Women's Health at the FDA, resigned in

⁵⁷ Center for Reproductive Rights, *The Fight for Emergency Contraception: Every Second Counts*, http://reproductiverights.org/crt_planb_timeline.html (last visited March 14, 2008).

⁵⁸ Go2EC.org, *Plan B OTC Application*, <http://www.go2ec.org/PlanBOTCApplcation.htm> (last visited March 12, 2008).

⁵⁹ Brian Vastag, *Plan B for "Plan B"? 291(23)* JAMA 2805-06 (June 2004).

⁶⁰ U.S. Food and Drug Administration, *FDA's Decision Regarding Plan B: Questions and Answers*, <http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm> (last visited Apr. 10, 2008). See also Cynthia C. Harper et al., *The effect of increased access to emergency contraception among young adolescents*, 106(3) OBSTET. & GYNECOL. 483-91 (Sept. 2005).

⁶¹ Heather Boonstra, (2004) *FDA Rejects Expert Panel Recommendation, Blocks OTC Switch for Plan B Emergency Contraception*, 7(2) THE GUTTMACHER REP. ON PUB. POL., 2 available at <http://www.guttmacher.org/pubs/tgr/07/2/gr070213.html> (June 2004).

⁶² *Id.*

⁶³ Planned Parenthood Affiliates of California, *supra* note 6.

⁶⁴ *Id.*

⁶⁵ *Id.*

protest over the FDA's handling of the application to make Plan B available over-the-counter.⁶⁶ Dr. Wood's statement read, in part:

I have spent the last 15 years working to ensure that science informs good health policy decisions. I can no longer serve as staff when scientific and clinical evidence, fully evaluated and recommended for approval by the professional staff here, has been overruled. I therefore have submitted my resignation effective today.⁶⁷

By January 21, 2005, the FDA failed to issue a decision on the Plan B application within the previously scheduled time.⁶⁸ The FDA justified its extended inaction primarily on the grounds that the number of women aged 14 to 16 years in the manufacturer's actual use study was too small to allow meaningful inferences about the consequences of its use in younger women.⁶⁹ Although "that narrow statistical point may have some merit, it cannot explain the tortuous and highly irregular process of decision making...that led the FDA to withhold its initial approval."⁷⁰

Within hours of the FDA's announcement that it would further delay its decision on whether Plan B should be made over the counter for women 16 and older, the Center for Reproductive Rights filed a lawsuit against the FDA on behalf of the Association of Reproductive Health Professionals, the National Latina Institute for Reproductive Health, and individuals from a grassroots advocacy group, the Morning-After Pill Conspiracy.⁷¹ The lawsuit, *Tummino v. Eschenbach*, alleges that the FDA failed to follow proper procedure in rejecting Barr's application for over the counter status.⁷² Specifically, in an April 2004 internal memo, the Director of the FDA's Office of New Drugs, Dr. John Jenkins, wrote that "the available data clearly support a conclusion that Plan B meets the statutory and regulatory requirements for availability without a prescription for all age groups..."⁷³ The Government Accountability Office released a report on

⁶⁶ Planned Parenthood Federation of America, FDA Official Resigns, <http://www.plannedparenthood.org/pp2/portal/media/pressreleases/pr-050831-fda.xml> (last visited Apr. 10, 2008).

⁶⁷ *Id.*

⁶⁸ Center for Reproductive Rights, *supra* note 57.

⁶⁹ James Trussell & Frank Davidoff, *Plan B and the Politics of Doubt*, 296(14) J. AM. MED. ASS'N 1775, 1775 (2006).

⁷⁰ *Id.*

⁷¹ Center for Reproductive Rights, *supra* note 57.

⁷² Center for Reproductive Rights, Center Sues FDA for Denying Women Over-the-Counter Access to Emergency Contraception, http://reproductiverights.org/pr_05_0121planb.html (January 21, 2005).

⁷³ *Id.*

October 12, 2005, titled “Decision Process to Deny Initial Application for Over-the-Counter Marketing of Emergency Contraception Drug was Unusual.”⁷⁴ The GAO report concluded that the decision to reject the findings of the scientific advisory panel (that voted 23-4 in favor of making EC available over the counter) “was not typical of the other 67 prescription-to-O.T.C. switch decisions made from 1994 to 2004.”⁷⁵

In a move CRR calls “suspicious,” the FDA finally announced its approval of Plan B for over-the-counter use for women over 18 on July 31, 2006, a day before the acting FDA Commissioner Dr. Andrew von Eschenbach’s Senate confirmation hearing and several days before a scheduled hearing by CRR regarding its request to subpoena documents from the White House in its *Tummino v. Eschenbach* case.⁷⁶ CRR maintains that the age restriction on over the counter access is unjustified, and the lawsuit is still pending in federal court in New York.⁷⁷

Today, EC continues to be an underutilized and misunderstood medical option. Anti-choice activists have labeled EC an “early abortion” pill, and have obfuscated the important issues by blurring the distinction between Mifepristone (RU-486), an abortifacient that terminates early pregnancy, and EC, which inhibits ovulation, fertilization, and may prevent implantation before pregnancy occurs.⁷⁸ RU-486 had previously suffered a similar fate when it was available in Europe but not promoted in the United States due to the marketing concerns of the large pharmaceutical companies. Even as RU-486 gained FDA approval in 2000 it still suffered from “bad press” and political wrangling for years.⁷⁹ Indeed, it still has not been mainstreamed in the U.S. today to the extent it has in other countries.⁸⁰

III. CONSTITUTIONAL BASIS OF ACCESS TO EMERGENCY CONTRACEPTION

The right to obtain and to use contraception was specifically addressed by the U.S. Supreme Court in 1965 in *Griswold v. Connecticut*.⁸¹ In *Griswold*, a Connecticut law prohibited the use or distribution of contraceptive devices.⁸² Griswold, the Executive Director of Planned

⁷⁴ Center for Reproductive Rights, *supra* note 68.

⁷⁵ Russell Shorto, *Contra-Contraception*, N.Y. Times, May 7, 2006, § *, (Sunday Magazine), at *.

⁷⁶ Center for Reproductive Rights Press Release, Center for Reproductive Rights Questions Timing of FDA Plan B Announcement (July 31, 2006), http://reproductiverights.org/pr_06_0731TimingFDA.html (last visited April 10, 2008).

⁷⁷ *Id.*

⁷⁸ Schaper, *supra* note 6.

⁷⁹ See Harper *supra* n. 36.

⁸⁰ See Heather Boonstra, *Emergency Contraception: The Need to Increase Public Awareness*, THE GUTTMACHER REPORT ON PUBLIC POLICY, December 2002, at 10..

⁸¹ 381 U.S. 479 (1965).

⁸² *Id.* at 480.

Parenthood League of Connecticut, brought the case on behalf of its Medical Director, a licensed physician, who sought to prescribe contraception for his patients.⁸³ The Court held that “the Due Process Clause of the Fourteenth Amendment . . . operates directly on an intimate relation of husband and wife”⁸⁴ The Court stated that “specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance Various guarantees create zones of privacy.”⁸⁵ The Court noted that the dispute “concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale seeks to achieve its goal by means having a maximum destructive impact upon that relationship.”⁸⁶ Finally, the Court specifically identified the protections of the Ninth Amendment, which ensure that the laws enumerated in the Constitution “shall not be construed to deny or disparage others retained by the people.”⁸⁷

Following *Griswold*, the U.S. Supreme Court in *Eisenstadt v. Baird* overturned a Massachusetts law prohibiting the distribution of contraceptive devices to single persons.⁸⁸ Justice Brennan, writing for the majority, determined that the Massachusetts provision was unconstitutional in that it violated equal protection principles of the Fourteenth Amendment.⁸⁹ In an oft-quoted opinion, the Court specifically held “[i]f the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters to fundamentally affecting a person as the decision whether to bear or beget a child.”⁹⁰

And finally, in *Carey v. Populations Services*, decided after *Roe v. Wade*,⁹¹ the U.S. Supreme Court upheld the decision of a New York federal district court invalidating a New York law that made it a crime to sell or distribute contraceptive devices to minors under the age of sixteen.⁹² *Carey* specifically protected the individual’s right of access to contraceptives, rather than focusing its attention on the right of privacy for marital relations.⁹³ Again writing for the majority, Justice Brennan clarified that *Griswold* “may no longer be read as holding only that a state may not prohibit a married couple’s use of contraceptives . . . [but that] the

⁸³ *Id.*

⁸⁴ *Id.* at 482.

⁸⁵ *Id.* at 484.

⁸⁶ *Id.* at 485.

⁸⁷ *Id.* at 488 (Goldberg, J., concurring).

⁸⁸ 405 U.S. 438 (1972).

⁸⁹ *Id.* at 447.

⁹⁰ *Id.* at 453.

⁹¹ 431 U.S. 678 (1977); 410 U.S. 113 (1972).

⁹² *Id.* at 681.

⁹³ *Id.* at 687–8.

Constitution protects individual decisions in matters of child bearing . . .”⁹⁴ This right of privacy is “fundamental” and cannot be undermined in the absence of a “compelling state interest.”⁹⁵

The *Griswold/Eisenstadt/Carey* line of cases makes it clear that the right to privacy as recognized by the U.S. Supreme Court’s interpretation of the Constitution’s substantive due process powers rooted in the Fourteenth Amendment specifically includes the right of individuals to obtain and use contraceptive devices. Indeed, in 2003, the U.S. Supreme Court addressed another related issue: whether the constitution protects the individual’s right of private sexual activity apart from procreation. In *Lawrence v. Texas*, the Supreme Court considered whether a Texas statute prohibiting same sex partners from engaging in sodomy violated their constitutional right to liberty.⁹⁶ Overturning its previous decision in *Bowers v. Hardwick*,⁹⁷ the Court invalidated the Texas statute and held that the right of liberty extends beyond procreative purposes.⁹⁸

Although there is no right to privacy specifically articulated in the Constitution, the term “liberty” in the Fourteenth Amendment’s Due Process clause has been interpreted expansively over many decades to include fundamental liberties not explicitly identified in the Constitution. This line of constitutional thinking was borne out of the U.S. Supreme Court’s decision in *Lochner v. New York*, where the petitioners challenged a New York statute limiting the number of hours that bakers would be allowed to work.⁹⁹ The provision was found to be in violation of the Fourteenth Amendment’s Due Process clause because it deprived bakers of their liberty to contract with employers as they wished.¹⁰⁰ The Court held that the Due Process clause implicitly includes a fundamental right to contract.¹⁰¹ Following *Lochner*, the Court struck down numerous other laws that posed regulatory controls over labor relations.¹⁰² However, *Lochner*’s impact was not limited strictly to labor and economic regulations; the decision was followed by an increasingly expansive

⁹⁴ *Id.* at 687.

⁹⁵ *Id.* at 688.

⁹⁶ 539 U.S. 558 (2003).

⁹⁷ 478 U.S. 186 (1986).

⁹⁸ 539 U.S. at 578 (2003).

⁹⁹ 198 U.S. 45 (1905).

¹⁰⁰ *Id.* at 57.

¹⁰¹ *Id.* at 53.

¹⁰² *Adkins v. Children’s Hospital*, 261 U.S. 525 (1923), invalidated a District of Columbia minimum wage law for women because, after the Nineteenth Amendment, women’s inferiority had been reduced to a “vanishing point.” However, in *Muller v. Oregon*, 208 U.S. 412 (1908), the Court distinguished from *Lochner* and upheld a limitation on women’s working hours.

interpretation of personal fundamental rights guaranteed to the people pursuant to the due process clause.¹⁰³

In *Meyer v. Nebraska* and *Pierce v. Society of Sisters*, the Supreme Court upheld a liberty interest in the ability of parents to choose how to raise and educate their children.¹⁰⁴ This increasingly expansive interpretation of fundamental rights dominated the Court's Fourteenth Amendment jurisprudence until the necessities of the Great Depression forced the Court to rethink its liberal interpretation of liberty and due process, particularly as it was faced with President Roosevelt's ambitious New Deal legislation.¹⁰⁵

After engendering criticism for the liberal creation of new rights under the Due Process clause of the Fourteenth Amendment, and after facing political pressures to reassess its view of economic regulations, the U.S. Supreme Court was apparently reluctant to base the expansion of new rights solely in due process considerations.¹⁰⁶ *Skinner v. Oklahoma*, which came before the Court in 1942, required it to address the constitutionality of an Oklahoma statute that provided for the sterilization of inmates who had committed multiple violent offenses "involving moral turpitude."¹⁰⁷ Inmates who committed other offenses, such as embezzlement, were exempted from the statute. In finding the provision unconstitutional, the Court based its argument on both due process and equal protection grounds.¹⁰⁸ Forced sterilization violated equal protection provisions in that not all inmates were treated in the same manner.

When in 1965 the *Griswold* Court sought to apply a liberty interest to reproductive freedoms, it chose to ground the right to contraception in something stronger than the Due Process clause, which, post-*Lochner*, had

¹⁰³ See *Meyer v. Nebraska*, 262 U.S. 390 (1923), *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), and *Griswold v. Connecticut*, *infra* note 104. While the Court retreated from *Lochner* in matters of economic regulation, it held that substantive due process in matters of personal liberties would be upheld. By the time *Griswold* was decided in 1965, the Court had fully retreated from *Lochner* and paved the way for *Roe v. Wade*, *infra*, and the progeny of fundamental rights cases that followed in its wake.

¹⁰⁴ *Meyer*, 262 U.S. 390 (1923); *Pierce*, 268 U.S. 510 (1925).

¹⁰⁵ The Supreme Court's constant invalidation of laws protecting workers and consumers due to its encroachment on individual liberties became unrealistic when faced with the realities of the economic landscape following the Great Depression. *Nebbia v. New York*, 291 U.S. 502 (1934), upheld a milk price fixing regulation because the business affected the public interest, and *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937), upheld a minimum wage for women, explicitly overruling *Adkins*.

¹⁰⁶ President Franklin Roosevelt, after being reelected in 1936, presented Congress with a plan to alleviate supposedly overcrowded federal court dockets, which would allow him to appoint a new judge to supplement every judge over 70 who failed to retire. This would allow the President to appoint six new Supreme Court justices, and therefore ensure support for his New Deal economic regulations and prevent the Court from continually striking them down. After the proposed "court-packing plan," the Court reversed course and overruled *Adkins* in *West Coast Hotel*. See PAUL BREST ET AL., PROCESS OF CONSTITUTIONAL DECISIONMAKING: CASES AND MATERIALS 426–27 (2000).

¹⁰⁷ *Skinner v. Oklahoma*, 316 U.S. 535, 62 S. Ct. 1110 (1942).

¹⁰⁸ *Id.* at 541.

proven a weak argument. Justice Douglas explicitly rejected the *Lochner* line of reasoning: “We do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch economic problems, business affairs, or social conditions.”¹⁰⁹ Issuing an admonition of sorts, Douglas warned: “The overtone of some arguments suggests that *Lochner v. New York* should be our guide. But we decline that invitation.”¹¹⁰ Instead, Justice Douglas listed the U.S. Supreme Court decisions issuing an expansive interpretation of the First Amendment, and thus concluded: “the First Amendment has a penumbra where privacy is protected from governmental intrusion.”¹¹¹ He also cited the Third, Fourth, Fifth¹¹² and Ninth Amendments¹¹³ in his quest to apply the right to personal autonomy and the privacy and sanctity of the home to the right to use contraception. His interpretation of the various Amendments includes peripheral rights – rights that, although not specifically enumerated in the Constitution, are necessary to make those enumerated rights more secure.¹¹⁴ From these peripheral rights or “penumbras” in the Third, Fourth, Fifth, and Ninth Amendments, Justice Douglas concluded that a zone of privacy protects the right to contraception.¹¹⁵ Justice Goldberg’s concurrence focused on the Ninth Amendment, suggesting that a right of privacy in the marital relationship is a basic, fundamental and personal right “retained by the people” within the meaning of the Ninth Amendment.¹¹⁶ This argument remains one of the strongest bases for reproductive freedom in the 21st century as the Court allows states to chip away at privacy as the foundation for the individual’s right to control procreation.

In *Eisenstadt v. Baird*, the Supreme Court held that, “whatever the rights of the individual to access to contraceptives may be, the rights must be the same for the unmarried and the married alike.”¹¹⁷ Without revisiting the constitutionality of *Griswold*, *Eisenstadt* relied upon its reasoning to extend the right of access to contraceptives to unmarried people.¹¹⁸ Just

¹⁰⁹ *Griswold* (no italics), 381 U.S. at 482.

¹¹⁰ *Id.* at 481–82.

¹¹¹ *Id.* at 483..

¹¹² *Boyd v. United States* (no italics), 116 U.S. 616 (1886) (describes the “sanctity of a man’s home and the privacies of life.”) *Mapp v. Ohio* (no italics), 367 U.S. 643 (1961) (established a “right to privacy” within one’s home.)”

¹¹³ The Ninth Amendment to the Constitution states, “The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.”

¹¹⁴ Jennifer M. Lichtler and Jonathan A. Massimino, *Fourth Annual Review of Gender and Sexuality Law: Constitutional Law Chapter: Contraception*, 4 GEO. J. GENDER & L. 59, 62 (2002).

¹¹⁵ *Griswold*, 381 U.S. at 486.

¹¹⁶ *Id.* at 486–87.

¹¹⁷ *Eisenstadt*, 405 U.S. at 453.

¹¹⁸ *Id.* at 448–49. (“What Mr. Justice Goldberg said in *Griswold v. Connecticut*, *supra*, at 498 (concurring opinion), concerning the effect of Connecticut’s prohibition on the use of contraceptives in discouraging extramarital sexual relations, is equally applicable here. ‘The rationality of this justification is dubious, particularly in light of the admitted widespread availability to all persons in the

five years later, the Court issued its ruling in *Carey*, striking down the New York law prohibiting the sale of contraceptives to minors.¹¹⁹ It also struck down another provision of the law forbidding anyone but a licensed pharmacist to dispense even nonprescription contraceptives to persons of any age.¹²⁰ Justice Brennan, writing for the majority, chose a wide interpretation of *Griswold*, stating: “the teaching of *Griswold* is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State.”¹²¹

The battle lines between the right to abortion and the right to emergency contraception have been blurred in the debate about how EC functions. Because different moral and religious perspectives recognize the beginning of life at different times, and to further political propaganda, EC is entangled in the debate about whether the treatment operates as an abortifacient. Despite medical evidence to the contrary,¹²² opponents of EC champion the position that because EC inhibits ovulation, fertilization or implantation, it interferes with potential human life and thus it is akin to abortion.¹²³

No court has ever held that EC constitutes abortion, nor has the Supreme Court ever addressed the issue. Several state courts, however, have confronted the issue, and each has determined that EC does not constitute abortion.¹²⁴ For example, in *Margaret S. v. Edwards*, a federal district court in Louisiana held that “abortion, as it is commonly understood, does not include IUD’s, the ‘morning-after’ pill, or, for example, birth control pills.”¹²⁵ Nine years later, in *Brownfield v. Daniel Freeman Marina Hospital*, a California appeals court was confronted with a case brought by a rape victim who was not offered pregnancy prophylaxis when she sought medical treatment at a local hospital.¹²⁶ The rape victim sought declaratory and injunctive relief, seeking to force the hospital to provide rape victims with information and access to pregnancy prophylaxis.¹²⁷ Citing the finding in *Margaret S. v. Edwards*, the court

State of Connecticut, unmarried as well as married, of birth-control devices for the prevention of disease, as distinguished from the prevention of conception.).”

¹¹⁹ *Carey v. Population Services International* (*no italics*), 431 U.S. 678 (1977).

¹²⁰ *Id.* at 689.

¹²¹ *Id.* at 678.

¹²² The World Health Organization defines an established pregnancy as one in which a fertilized egg has already attached itself to the wall of the uterus. All hormonal contraceptive methods, depending on when during the menstrual cycle a woman initiates the method, act by delaying or inhibiting ovulation, inhibiting fertilization or inhibiting implantation of a fertilized egg, which in medical terms is considered to mark the beginning of pregnancy. Guttmacher Institute, Emergency Contraception News Release (2002).

¹²³ Schaper, *supra* note 6 at 8.

¹²⁴ *Id.*

¹²⁵ *Margaret S. v. Edwards* (*no italics*), 488 F. Supp. 181, 191 (E.D. La. 1980)

¹²⁶ *Brownfield v. Daniel Freeman Marina Hospital* (*no italics*), 208 Cal. App. 3d 405 (1989)

¹²⁷ *Id.* at 408.

clearly articulated that “estrogen pregnancy prophylaxis is ‘post-coital contraception,’ not abortion.”¹²⁸ In denying relief to the plaintiff, the court held that because she did not become pregnant as a result of the incomplete medical care, she did not suffer injuries that warranted compensation.¹²⁹ Nevertheless, the court conceded:

. . . when a rape victim can allege: that a skilled practitioner of good standing would have provided her with information concerning and access to estrogen pregnancy prophylaxis under similar circumstances; that if such information had been provided to her she would have elected such treatment; and that damages have proximately resulted from the failure to provide her with information concerning this treatment option, said rape victim can state a cause of action for damages for medical malpractice.¹³⁰

Brownfield recognized two important rights. First, a woman has a right to privacy in making decisions concerning her own body.¹³¹ Secondly, a woman has a right to receive necessary and comprehensive medical care from the physician attending to her.¹³² Failure to provide such a level of care makes a physician vulnerable to a malpractice action.¹³³

IV. ACCESS TO EMERGENCY CONTRACEPTION IN U.S. EMERGENCY ROOMS

While products and information are now available to consumers about EC, access and widespread knowledge are still limited. Both pharmacists and hospital emergency room physicians routinely impede the efforts of women to obtain EC products, even in cases of sexual assault.¹³⁴ Pro-life groups and religious organizations such as the Catholic Church raise moral and religious objections, and often resort to tactics that include disseminating misinformation about EC products. Some physicians refuse

¹²⁸ *Id.* at 412.

¹²⁹ *Id.* at 414.

¹³⁰ *Id.*

¹³¹ *Id.* at 412.

¹³² *Id.* at 413.

¹³³ *Id.* at 414.

¹³⁴ See Catholics for a Free Choice, *Complying with the Law? How Catholic Hospitals Respond to State Laws Mandating the Provision of Emergency Contraception to Sexual Assault Patients* (2006), <http://www.catholicsforchoice.org/topics/healthcare/documents/2006complyingwiththelaw.pdf>. See also, Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46(2) ANNALS EMERGENCY MED. 111, __pincite__ (Aug. 2005); Elizabeth Temin et al, *Availability of Emergency Contraception in Massachusetts Emergency Departments*, 12(10) ACAD. EMERGENCY MED. 987, __pincite__ (Oct. 2005).

to prescribe EC or fill prescriptions.¹³⁵ They refer to EC as abortifacients—devices that bring about abortion of an implanted fetus—and object on that basis. In fact, EC does not act to bring about abortion nor can it be used in that way. Particularly for the adolescent population, the major obstacle is knowledge—information concerning what EC is and where to get it—delivered in a timely fashion and in a manner suitable to maturity and the particular needs of this population.

FDA approval of EC was an important step in increasing the knowledge and availability of the product.¹³⁶ Nevertheless, information about the use of EC to consumers, particularly younger women, is still greatly lacking. Many religious hospitals either neglect to inform patients about this option or refuse to provide it, even in cases of rape.¹³⁷ Certain pro-life organizations routinely engage in scare tactics by disseminating false information about the safety, efficacy and public health benefits of EC products.¹³⁸

If EC is used early in a woman's menstrual cycle, it may operate by preventing ovulation.¹³⁹ If used later in the cycle and fertilization of the female egg after intercourse has occurred, it *may* prevent implantation.¹⁴⁰ It is this latter occurrence that inspires EC opponents to refer to it as an abortifacient—a device that brings about abortion of an implanted fetus—because it interferes with the implantation of a fertilized (or “conceived”) egg. Opponents raise the same objections to certain birth control methods, such as the intrauterine device (IUD), that function by generating an environment hostile to sperm, thus preventing implantation of the egg.¹⁴¹ In fact, EC will not abort an implanted embryo, the situation that constitutes pregnancy.¹⁴² Nevertheless, in a 2003 study concerning the knowledge and attitudes of pharmacists about EC, 13 % reportedly believed that EC was an abortifacient and 65 % had negative impressions about the drugs.¹⁴³

Without specific EC legislation, hospital emergency rooms often neglect to inform women about obtaining access to EC, either as a result of

¹³⁵ *Id.*

¹³⁶ Trussel, *supra* note 13, at pincite.

¹³⁷ See, Catholics for a Free Choice, *supra* note 134.

¹³⁸ Elizabeth Bossom, Concerned Women for America, Contraception or Deception?, <http://www.cwfa.org/articledisplay.asp?id=1559&department=CWS&categoryid=life> (last visited Apr. 9, 2008).

¹³⁹ Trussel, *supra* note 69, at #.

¹⁴⁰ *Id.*

¹⁴¹ Susan E. Rubin et al, *Hospital Religious Affiliation and Emergency Contraceptive Prescribing Practices*, 96(8) AM. J. PUB. HEALTH 1398, __pincite__ (Aug. 2006).

¹⁴² Joseph Sanfilippo & Don Downing, *Emergency Contraception: When and How to Use It*, 57(2) supp. 1 FAM. PRAC., S3, __pincite__ (Feb. 2008).

¹⁴³ Bennett et al., 2003.

ignorance, religious affiliation or moral objection.¹⁴⁴ A 2002 study of rape victims treated in an emergency room found that less than 50 % of women and adolescents who were found to be at risk for becoming pregnant received EC.¹⁴⁵ This was not limited to Catholic or religiously-affiliated hospitals, though the Catholic church is the largest provider of health care in the nation.¹⁴⁶ “EC in the ER” laws are gaining a certain level of popularity: in 2007, 18 states and the District of Columbia considered 33 measures to ensure that sexual-assault victims receive access to or information about EC in hospitals.¹⁴⁷ Eleven states have laws on the books that facilitate the availability of emergency contraception to women who have been sexually assaulted.¹⁴⁸

V. EMERGENCY CONTRACEPTION AS AN ABORTIFACIENT

In part, the EC debate is fueled by the absence of a definitive understanding of exactly how EC functions. Pro-life advocates maintain that at least in some instances, EC acts as an abortifacient terminating fetal development after a pregnancy has occurred. Plan B a progestin-only medication, is currently the only product marketed specifically as an emergency contraceptive product.¹⁴⁹ Plan B contains higher levels of hormones than regular birth control pills and is effective at reducing the risk of pregnancy for up to 120 hours, or five days, after unprotected intercourse.¹⁵⁰ Plan B reduces the risk of pregnancy by 89 percent when started within 72 hours — or three days — after unprotected intercourse.¹⁵¹ If a fertilized egg is implanted prior to taking Plan B, it will not function as a contraceptive and it will not harm the pregnancy.¹⁵²

In instances where ovulation has not yet occurred, Plan B is thought to function like other birth control pills: to prevent ovulation, or the release of

¹⁴⁴ NARAL Pro-Choice America, *supra* note 5.

¹⁴⁵ Amey, *supra* note 35, at 636.

¹⁴⁶ Gustav Neibuhr, *The Health Care Debate: The Catholic Church; Catholic Leaders' Dilemma, Abortion v. Universal Care*, N.Y. TIMES, Aug. 25, 1994, at pincite.

¹⁴⁷ AZ, AR, CO, CT, FL, HI, MN, MO, NC, OH, OK, OR, PA, SD, TN, TX, WV, WI. NARAL Pro-Choice America, *supra* note 5.

¹⁴⁸ See note 3 and note 5.

¹⁴⁹ Office of Population Research & Association of Reproductive Health Professionals, Emergency Contraceptive Pills (“Morning After Pills”), <http://ec.princeton.edu/info/ecp.html> (last visited Apr. 14, 2008).

¹⁵⁰ TRUSSELL, *supra* note 20.

¹⁵¹ Planned Parenthood Federation of America, Emergency Contraception (Morning After Pill), <http://www.plannedparenthood.org/health-topics/emergency-contraception-morning-after-pill-4363.htm#effective> (last visited Mar. 14, 2008).

¹⁵² U.S. Food and Drug Administration, *supra* note 60.

an egg from the ovary.¹⁵³ In those cases where ovulation has occurred, Plan B may prevent fertilization by disrupting the union of the sperm and egg.¹⁵⁴ Finally, in those cases where fertilization does occur, Plan B *may* prevent implantation – the fertilized egg attaching to the womb.¹⁵⁵

That Plan B acts as an abortifacient even in the latter group of cases is not at all clear, however. The Society of Adolescent Medicine (SAM) holds that, “[t]here is no evidence that EC prevents implantation, alters sperm or egg transport, inhibits fertilization, or changes cervical mucous,” but instead only prevents ovulation and fertilization.¹⁵⁶ This difference in medical opinion is significant in the debate to increase access to emergency contraception. Those that advocate that life begins at conception or implantation, such as the Catholic Church, contend that taking Plan B is akin to abortion, and therefore oppose the use of EC. The Catholic Church is also the largest provider of healthcare in the nation,¹⁵⁷ yet the majority of non-religiously affiliated medical societies in the U.S. assert that EC is a contraceptive and purely preventative in nature, and thus not an abortifacient.¹⁵⁸

One of the few courts to weigh in on the issue of whether birth control pills constitute an abortifacient was the Seventh Circuit in *Charles v. Carey*.¹⁵⁹ Confronted with a health care provider who objected to dispensing oral contraceptives, the Court said that “use of the term ‘abortifacient’ in describing certain birth control methods forces the physicians to act as the mouthpiece for the State’s theory of life.”¹⁶⁰ The court held that the theory is unproven science and thus cannot be recognized by law.¹⁶¹

The National Institutes of Health (NIH), the American College of Obstetricians and Gynecologists (ACOG), and the American Medical Women’s Association (AMWA) all define pregnancy as beginning with

¹⁵³ *Id.*

¹⁵⁴ Population Council, Emergency Contraception Prevents Fertilization, Not Implantation, Studies Show, <http://www.popcouncil.org/mediacenter/newsreleases/ecdisruptsovulation.html> (last visited Apr. 13, 2008).

¹⁵⁵ *Id.*

¹⁵⁶ Lee Ann E. Conard & Melanie A. Gold, *Emergency Contraceptive Pills: A Review of Recent Literature*, 16 OBSTETRICS & GYNECOLOGY 389, pincite (2004).

¹⁵⁷ Niebuhr, *supra* note 146.

¹⁵⁸ Directive 36 provides, in part: “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.” U.S. Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition, <http://www.usccb.org/bishops/directives.shtml> (last visited Mar. 25, 2008).

¹⁵⁹ 627 F.2d 772, 789–90 (7th Cir. 1980).

¹⁶⁰ *Id.* at 789.

¹⁶¹ *Id.* at 791.

implantation.¹⁶² ACOG, AMWA, and the FDA also agree that EC has no effect once implantation has occurred.¹⁶³ SAM, ACOG, AMWA, the American Medical Association (AMA), U.S. Department of Health & Human Services, and the World Health Organization all support women's access to EC.¹⁶⁴ They also support increased access to EC as essential to women's freedoms in today's political climate.

The use of EC has had a significant impact in preventing unintended pregnancies and abortions worldwide. In the United States, an estimated 51,000 abortions were averted through the use of EC in 2000.¹⁶⁵ EC use accounted for roughly 43 % of the overall decrease in U.S. abortions between 1994 and 2000.¹⁶⁶ It is estimated that widespread use of EC could prevent 800,000 abortions and 1.5 million unintended pregnancies each year in the United States.¹⁶⁷ In a forty year retrospective study, it was found that 86 % of counties had no known abortion provider, and 32 % of women aged 15–44 live in these counties.¹⁶⁸ Of the country's 320 metropolitan areas, eighty-nine had no known abortion provider.¹⁶⁹ Constitutionally-protected restrictions on access to abortion, such as waiting periods, parental consent clauses, and informational requirements, which force women to hear persuasive and often misleading medical information before consenting to abortion, make the process of getting an abortion increasingly difficult, time-consuming, and traumatic.¹⁷⁰

Moreover, recent developments have seen even greater restrictions on a woman's access to abortion. South Dakota's new abortion law represents

¹⁶² AMMIE N. FAJOO, ADVOCATES FOR YOUTH, EMERGENCY CONTRACEPTION: A SAFE & EFFECTIVE CONTRACEPTIVE OPTION FOR TEENS (2005), <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsecp.pdf>; American Medical Women's Association, Position Statement on Emergency Contraception, <http://www.amwa-doc.org/index.cfm?objectId=0EF88909-D567-0B25-531927EE4CC23EFB> (last visited Mar. 27, 2008); THOMAS KING, DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE MEMORANDUM: OPA PROGRAM INSTRUCTION SERIES, OPA 97-2: EMERGENCY CONTRACEPTION (1997), <http://www.hhs.gov/opa/familyplanning/toolsdocs/opa97-2.pdf>.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ Jennifer Brunton & Margaret W. Beal, *Current Issues in Emergency Contraception: An Overview for Providers*, 51(6) J. MIDWIFERY & WOMEN'S HEALTH 457, __pincite_ (Nov. 2006).

¹⁶⁶ Center for Reproductive Rights, *Governments Worldwide Put Emergency Contraception into Women's Hands: A Global Review of Laws and Policies* (2004), http://www.reproductiverights.org/pdf/pub_bp_govtswwec.pdf.

¹⁶⁷ *Id.*

¹⁶⁸ Stanley, K. Henshaw, *Abortion Incidence and Services in the United States, 1995–1996*, 30:6 FAM. PLAN. PERSP. 263, 263 (Nov./Dec. 1998).

¹⁶⁹ *Id.*

¹⁷⁰ *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), upheld *Roe v. Wade*, 410 U.S. 133 (1973), but created a new “undue burden test,” which will now be applied to restrictions placed on a woman's access to abortion. If the restriction places a “substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability,” it will be considered unconstitutional. The Court found that spousal consent laws placed an undue burden on a woman, but parental consent, twenty-four hour waiting periods, and informational requirements did not pose an undue burden.

the most sweeping abortion ban in the country, making it a felony to perform an abortion on a woman whose life is not in jeopardy and setting up a direct legal challenge to *Roe v. Wade*.¹⁷¹ Other states are considering similar bans.¹⁷² With the current political tide, increased access to and education about EC, as a strategy of prevention, appears to be the most practical path for pro-choice advocates to take.

VI. ACCESS TO EMERGENCY CONTRACEPTION IN PHARMACIES

The FDA approved over-the-counter access to emergency contraception for individuals over 18 with government-issued identification on August 25, 2006.¹⁷³ Those under 18 still need a physician's prescription in most states.¹⁷⁴ However, only nine states, Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Vermont, and Washington allow pharmacists to directly dispense emergency contraception to a patient of any age without a prescription from a provider.¹⁷⁵ Some states permit direct pharmacy access pursuant to legislation, while others have accomplished the same result through regulatory action.¹⁷⁶ Washington was the first state to provide EC without a prescription using a protocol involving physicians.¹⁷⁷ However, no specific legislation was needed because the Pharmacy Practice Act, now in effect for nearly 20 years, allows pharmacists in Washington to initiate drug therapy under standing, signed protocols with a prescribing physician.¹⁷⁸ A two-year pilot program was completed in 1999, in which, in the first 16 months, the program provided EC to nearly 12,000 women, possibly

¹⁷¹ Monica Davey, *South Dakota Bans Abortions, Setting Up a Battle*, N.Y. TIMES, Mar. 7, 2006, at A1.

¹⁷² 15 states have unconstitutional and unenforceable near-total criminal bans on abortion: AL, AZ, AR, CO, DE, LA, MA, MI, MS, NM, OK, UT, VT, WV, WI. In 2007, 13 states considered 26 near-total bans on abortion: AL, CO, GA, MS, MO, ND, OH, OK, SC, SD, TX, UT, VA. 6 states considered 7 measures that would impose near-total criminal bans on abortion if the Supreme Court overturns *Roe v. Wade* (sometimes known as "trigger" bans): MS, ND, OK, TX, UT, VA. NARAL Pro-Choice America, *Who Decides? The Status of Women's Reproductive Rights in America*, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/fast-facts/near-total-abortion-bans.html (last visited March 14, 2008).

¹⁷³ Rob Stein, *FDA Approves Plan B's Over the Counter Sale*, WASH. POST, Aug. 25, 2006, at A04.

¹⁷⁴ Pharmacy Access Partnership, EC Over-the-Counter (OTC) Status, <http://www.pharmacyaccess.org/ECOTCStatus.htm> (last visited Mar. 27, 2008).

¹⁷⁵ ALASKA ADMIN. CODE tit. 12, § 52.240 (yr); CAL. BUS. & PROF. CODE § 4052 (2003–2004); HAW. REV. STAT. § 461-1 (1993); ME. REV. STAT. ANN. tit. 32, §§ 13821–13825 (2003); MASS. GEN. LAWS ch. 94C, § 19a (2005); N.H. REV. STAT. ANN. § 318:47-e (2007); N.M. STAT. § 16-19-26.9 (yr); VT. STAT. ANN. tit. 18, §§ 2077–2079 (2006); WASH. REV. CODE § 18.64.011 (yr).

¹⁷⁶ Pharmacy Access Partnership, *supra* note 174.

¹⁷⁷ NARAL Pro-Choice America, *supra* note 5.

¹⁷⁸ *Id.*

preventing an estimated 700 unplanned pregnancies and 350 abortions.¹⁷⁹ When EC became available, Washington already had the optimal environment to pioneer over-the-counter access.

In the late 1990s, California became the first state to pass legislation specifically permitting pharmacy access to EC, and its demonstrated success may have helped pave the way for other states.¹⁸⁰ By 2008, nine states passed similar bills and three more have measures pending.¹⁸¹ Finally, eight states provide Medicaid coverage for over-the-counter emergency contraception.¹⁸² Medicaid coverage is essential for many women, as Plan B, at a retail price averaging between \$40 and \$50, may be cost-prohibitive.

Most states with pharmacy access laws enacted them pursuant to “EC in the ER” legislation.¹⁸³ Because lawmakers generally avoid appearing unsympathetic to rape victims, they are more likely to support legislation that focuses on the rights of rape victims rather than that which appears to merely increase EC access to women who engage in unprotected intercourse.

Access to EC in pharmacies without prescriptions is often provided through a collaborative therapy agreement between a physician and pharmacist.¹⁸⁴ The physician writes a protocol for administering drug therapy under his or her supervision, and the pharmacist applies that “standing order” to women who request EC in the pharmacy.¹⁸⁵ A standing order is a type of universal prescription from a supervising physician that includes written, standardized procedures and protocols, along with a list of the authorized entities.¹⁸⁶ This protocol, which gives pharmacists

¹⁷⁹ PATH, Increasing Women’s Access to Emergency Contraceptive Pills through Direct Pharmacy Provision (Dec. 1999).

¹⁸⁰ Pharmacy Access Partnership, *supra* note 174.

¹⁸¹ The 3 states with measures pending are: Illinois, New Jersey and New York. *Id.*

¹⁸² Those 8 states are: Hawaii, Illinois, Maryland, New Jersey, New York, Oklahoma, Oregon and Washington. NARAL Pro-Choice America, *supra* note 5.

¹⁸³ *Id.*

¹⁸⁴ ALASKA ADMIN CODE tit. 12, § 52.240 (yr); CAL. BUS. & PROF. CODE § 4052 (2003–2004); HAW. REV. STAT. § 461-1, § 431-10a, § 116-6, § 116-7 (1993); ME. REV. STAT. ANN. tit. 32, §§ 13821-13825 (2003); MASS. GEN. LAWS ch. 94C, § 19a (2005); N.H. REV. STAT. ANN. §§ 318:5-a, 318:47-e (2007); N.M. Stat. § 16-19-26.9 (yr); VT. STAT. ANN. tit. 18, §§ 2077-2079 (2006); VT. STAT. ANN. tit. 33, § 4913 (2006); WASH. REV. CODE § 18.64.011 (yr); WASH. ADMIN. CODE 246-863-100 (yr). Regulations in other states may also permit pharmacists to enter into collaborative therapy agreements.

¹⁸⁵ A sample collaborative agreement, used in California, can be found at <http://www.pharmacyaccess.org/pdfs/ECCollabProtocol.pdf>.

¹⁸⁶ COMMONWEALTH OF MASS., DEP’T OF PUB. HEALTH, JOINT GUIDELINES OF THE BOARD OF REGISTRATION IN PHARMACY, BOARD OF REGISTRATION IN MEDICINE AND DRUG CONTROL PROGRAM, PHARMACY BOARD POLICY 2006-1: PHARMACIST DISPENSING OF EMERGENCY CONTRACEPTION (2006), http://www.mass.gov/Eeohhs2/docs/dph/quality/boards/pharmacy_ec_policy_pharmacist_dispensing.pdf (last visited Mar. 27, 2008).

independent authority to dispense EC, is used in California, Maine, and New Mexico.¹⁸⁷ It requires physicians (and, in some states, nurse practitioners) and pharmacists to establish a collaborative practice agreement detailing the appropriate patient population to receive emergency contraception.¹⁸⁸ Pharmacists evaluate patients who request EC in accordance with the agreement, and provide the medication in appropriate situations.¹⁸⁹ In order to be covered under the collaborative agreement, such pharmacists must undergo required training, typically available as continuing education, either on-line or at a live presentation.¹⁹⁰ They are required to counsel patients on the indication and proper use of EC and refer them to physicians for follow-up testing for sexually transmitted diseases.¹⁹¹ Physicians also provide patients with resources and materials about birth control and EC.

Massachusetts law contains a pharmacy access provision in its EC law that requires a standing order agreement between a physician and a pharmacist.¹⁹² It is completely voluntary in nature: only if a pharmacist chooses to undergo EC training accredited by the Accreditation Council on Pharmacy Education and seeks out a physician who will submit the standing order to the Massachusetts Pharmacy Board, will the pharmacist be able to provide EC directly through the pharmacy.¹⁹³ Because of the voluntary nature of the provision, patients have little hope for obtaining EC over-the-counter unless they have reason to know which pharmacies provide such access. Furthermore, it is reported that the availability of over-the-counter access to EC is actually quite limited.¹⁹⁴ Even in those pharmacies with standing orders, only the individual pharmacist is covered, not the entire pharmacy.¹⁹⁵ Only when the covered pharmacist is available can a patient obtain access to EC in the pharmacy.

A. So-Called “Refusal Clauses”

In all but four states, legislation exists that allows health care providers to refuse to offer medically available and indicated treatment to patients on grounds of the institution’s religious belief. These so-called “refusal

¹⁸⁷ CAL. BUS. & PROF. CODE § 4052 (2003–2004); ME. REV. STAT. ANN. tit. 32, §§ 13821–13825 (2003); N.M. Stat. § 16-19-26.9 (yr).

¹⁸⁸ Pharmacy Access Partnership, Collaborative Practice Agreements, <http://www.go2ec.org/CollabPracticeAgreements.htm> (last visited Mar. 26, 2008).

¹⁸⁹ *Id.*

¹⁹⁰ See, e.g., PHARMACY BOARD POLICY 2006-1, *supra* note 186.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ MASS. GEN. LAWS ch. 94c, § 19A (2005).

¹⁹⁴ For frequently updated information about pharmacists available to dispense EC over-the-counter in Massachusetts, see Massachusetts Emergency Contraception Network, <http://www.masseccnetwork.org/forwomen/> (last visited Mar. 26, 2008).

¹⁹⁵ PHARMACY BOARD POLICY 2006-1, *supra* note 186.

clauses” began appearing in state legislation in 1973 in response to *Roe v. Wade*’s legalization of abortion.¹⁹⁶ On the federal level, Congress passed the “Church Amendment” which paved the way for health care providers to refuse to provide such procedures as abortion or sterilization on grounds of religious objection.¹⁹⁷ In many states, refusal clauses have been expanded over the years and now include such services as in vitro fertilization, emergency contraception, embryonic fetal research and stem cell research.¹⁹⁸

There are numerous varieties of refusal clauses around the country, some more burdensome to women’s rights than others. Many extend not only to physicians but also to pharmacists, nurses, clinics, hospitals and even insurance companies.¹⁹⁹ They can encompass a broad range of family planning and reproductive health services, and can be imposed based upon religion, conscience, or moral values which opens the door for refusal based upon pure bias or political ideology.²⁰⁰ No particular religious affiliation need even be identified when invoking a refusal clause.

There are some limitations to the implementation of refusal clauses. First and foremost, a health care provider who refuses to provide a medically acceptable option to a patient is obligated to refer the patient to another provider within a reasonable distance and without undue delay.²⁰¹ This practice is likely most burdensome to poorer women and adolescents. Furthermore, providers who refuse certain services must do so consistently and must make those refusals known to patients and employees.²⁰² With respect to pharmacists who refuse to dispense medications, they must direct their patients to another pharmacy within a reasonable geographical distance, and if the alternative pharmacy is unable to fill the prescription “in a timely fashion . . . the pharmacist has a duty to the patient to dispense the medication.”²⁰³

¹⁹⁶ Melissa Duvall, *Pharmacy Conscience Clause Statutes: Constitutional Religious “Accommodations” or Unconstitutional “Substantial Burdens” on Women?*, 55 AM. U. L. REV. 1485, 1491 (2006).

¹⁹⁷ 42 U.S.C. § 300a-7 (1973).

¹⁹⁸ Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider “Conscience,” Patient Needs*, THE GUTTMACHER REP. (Aug. 2004). See also, MergerWatch, *Refusals to Provide Care*, available at <http://mergerwatch.org/refusals.html> (last visited Mar. 14, 2008).

¹⁹⁹ As many as 21 states have laws that could be construed to permit pharmacists to refuse to fill women’s prescriptions for contraception, including EC. NARAL Pro-Choice America, *supra* note 5.

²⁰⁰ American Civil Liberties Union, Reproductive Freedom Project, *Religious Refusals and Reproductive Rights: Accessing Birth Control at the Pharmacy* (2007) available at <http://www.aclu.org/reproductiverights/religion/29402pub20070417.html> (last visited Mar. 14, 2008) (hereinafter, “ACLU, Religious Refusals”).

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ In 1998, the American Pharmacy Association House of Delegates adopted an official policy regarding pharmacists’ right to refuse to dispense certain products: “[The] American Pharmacy Association] recognizes the individual pharmacist’s right to exercise conscientious refusal and supports

The argument has been made, of course, that the failure to provide women with reproductive health care and family planning services is discriminatory. Planned Parenthood Federation of America has long argued that every individual is entitled to reasonable access to prescribed medication and devices, and that informed consent demands that patients be advised about all medically available alternatives.²⁰⁴ Nevertheless, without widespread knowledge and information, women who need EC services do not know that they can ask for it. Regrettably, health care providers do not always fulfill their obligations of providing information about alternatives that conflict with their personal, moral, religious or ideological beliefs or making timely referrals.

While there is no case law directly on point, the Equal Employment Opportunity Commission (pursuant to its enforcement of Title VII of the Federal Civil Rights Act of 1964) and the U.S. Supreme Court have acknowledged that employers are obligated to “make reasonable accommodations to the religious needs of employees . . . where such accommodations can be made without undue hardship” to the employer’s business.²⁰⁵ In the pharmacy context, the employer’s challenge would be to demonstrate the loss of revenue from the refusal to dispense EC and an inability to make a reasonable accommodation for the objecting pharmacist.

In *Hellinger v. Eckerd Corp.*, a pharmacist in Florida brought an action against a prospective employer for an alleged violation of Title VII when it refused to hire him because selling condoms violated his Orthodox Jewish beliefs.²⁰⁶ The plaintiff argued that his religious beliefs could have been accommodated by asking condom purchasers to check out at a different register or by hiring a second pharmacist.²⁰⁷ Although the pharmacy claimed undue hardship on the basis of the potential loss of customers, goodwill, or revenue, the Florida court denied the pharmacy’s motion for summary judgment, finding that evidence of actual hardship was lacking. It was not enough to “rely merely on speculation” that no reasonable accommodation could be made.²⁰⁸

Public pressure on large pharmacy chains has yielded policy change. According to an ACLU poll, 85 percent of consumers agreed that pharmacists owe a professional obligation to provide their patients with

the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.”

²⁰⁴ Planned Parenthood Affiliates of New Jersey, Talking Points, About Planned Parenthood, available at http://www.plannedparenthoodnj.org/advocate/talking_points.php.

²⁰⁵ Title VII of the Civil Rights Act of 1964, Pub. L. No. 88-352, §§ 701 *et seq.*, 78 Stat. 253 (1964).

²⁰⁶ *Hellinger v. Eckerd Corp.*, 67 F. Supp. 2d 1359 (S.D. Fla. 1999).

²⁰⁷ *Id.* at 1361.

²⁰⁸ *Id.* at 1365.

any medication that has been legally prescribed, including contraception.²⁰⁹ In 2006, facing national pressure from several consumer advocacy and women's health groups, Wal-Mart reversed its national policy of banning the sale of EC in its stores.²¹⁰ This move greatly improves access to EC for women, particularly in rural areas, where Wal-Mart may be the only accessible pharmacy.

B. Emergency Contraception in Massachusetts and Connecticut

"EC in the ER" statutes exist in eleven jurisdictions²¹¹ and typically take one of three forms: (1) hospitals must provide information about EC to rape survivors; (2) hospitals are required to provide a rape victim with a referral to another hospital that provides EC; or (3) hospitals are required to provide information about EC and furnish EC treatment on-site if the victim requests it.²¹²

In 2005, the Massachusetts legislature overwhelmingly passed a law requiring hospitals to provide EC to suitable candidates who are treated in hospital emergency rooms.²¹³ The governor vetoed the bill, but the Massachusetts legislature overrode the veto, making the EC bill a Massachusetts' law.²¹⁴ In 2007, Connecticut passed a similar law, but allowed emergency rooms to administer pregnancy tests, and to refuse to provide EC if the test was positive.²¹⁵ Both the Massachusetts and Connecticut laws require access to EC in both pharmacies and emergency rooms.²¹⁶ An integral provision of the laws requires that all hospital emergency room providers discuss with rape victims the option of EC in

²⁰⁹ ACLU, Religious Refusals, *supra* note 200.

²¹⁰ Press Statement, Wal-Mart Stores, Inc., Wal-Mart to Carry Plan B Emergency Contraception (Mar. 3, 2006), available at <http://www.walmartfacts.com/articles/1704.aspx>. In response to pressure from activists across the country, on April 4, 2007, Wal-Mart adopted a refusal policy that ensures that women can access contraception in the same store without added delay if an individual pharmacist refuses to fill a prescription. Press Release, Am. Civil Liberties Union of Fla., ACLU of Florida Applauds New Wal-Mart Policy Requiring its Pharmacies to Fill Valid Requests for Birth Control (Apr. 4, 2007), available at

<http://www.aclu.org/reproductiverights/contraception/29275prs20070404.html>.

²¹¹ CA, IL, MA, NJ, NM, NY, OH, OR, SC, TX, WA. Center for Policy Alternatives, Policy Brief: Emergency Contraception for Sexual Assault Victims, available at <http://www.stateaction.org/issues/issue.cfm/issue/EC-SexualAssault.xml> (last visited Mar. 14, 2008).

²¹² Heather Rae Skeeles, *Patient Autonomy Versus Religious Freedom: Should State Legislatures Require Catholic Hospitals to Provide Emergency Contraception to Rape Victims?*, 60 WASH. & LEE L. REV. 1007, 1016 (2003).

²¹³ MASS. GEN. LAWS ch. 91 § 3(o) (2005).

²¹⁴ Scott Greenberger, *Lawmakers override Governor's Contraception Veto*, BOSTON GLOBE (Sept. 16, 2005), available at http://www.boston.com/yourlife/health/women/articles/2005/09/16/lawmakers_override_governors_contraception_veto/ (last visited April 18, 2008).

²¹⁵ S.B. 1343, 2007 Gen. Assem., Jan. Sess. (Conn. 2007).

²¹⁶ MASS. GEN. LAWS ch. 94C, § 19A; MASS. GEN. LAWS ch. 41, § 97B; MASS. GEN. LAWS ch. 111, § 70E(o); S.B. 1343, 2007 Gen. Assem., Jan. Sess. (Conn. 2007).

medically and factually accurate terms.²¹⁷ Hospital service providers are also required to furnish EC on-site if the rape victim elects to take it.²¹⁸

Emergency rooms are often the first, and sometimes only, option for women who have been raped and seek medical treatment. Rape survivors turn up at hospital emergency rooms for many reasons. Some do not have health insurance, and therefore have no primary care physician. Other survivors seek treatment outside of normal business hours. Still others do not want to involve their primary care physician due to privacy concerns, embarrassment, shame or fear. For other victims, emergency rooms provide the fastest and easiest way to receive treatment. Indeed, hospitals are usually the best-equipped and have the most experienced medical service providers for treating rape victims and conducting a rape kit exam that preserves the collection of evidence.²¹⁹ It is essential for rape survivors to receive comprehensive and compassionate treatment. Informed consent demands that all patients be advised of all available and appropriate options, one of which is immediate access to EC. Because the effectiveness of EC decreases with time,²²⁰ the longer it takes for a woman to access EC after unprotected intercourse, the less likely she is to benefit from it.

More than 300,000 women reportedly are sexually assaulted in the U.S. each year.²²¹ Of these women, it is estimated that 25,000 become pregnant as a result.²²² It is estimated that approximately 22,000 such pregnancies would be prevented if all rape victims were offered EC.²²³ Of course, not all women, even rape victims, will choose to take advantage of EC. But the absence of timely and accurate information exponentially multiplies the number of women who never receive the option. The failure of medical care in these circumstances leaves women often feeling that they were victimized again.

The importance of providing EC to women who show up in Massachusetts emergency rooms after being sexually assaulted is not mitigated by the FDA's decision to make EC available over the counter to women over 18, nor by Massachusetts' law providing access to EC in pharmacies by specially trained pharmacists. Emergency rooms still have the obligation to provide the proper comprehensive care of rape victims. They are usually the first point of contact because they provide

²¹⁷ MASS. GEN. LAWS ch. 111, § 70E(o); S.B. 1343, 2007 Gen. Assem., Jan. Sess. (Conn. 2007).

²¹⁸ MASS. GEN. LAWS ch. 91 § 3(o) (2005).

²¹⁹ Temin, *supra* note 134, at 987–93.

²²⁰ G. Piaggio et al., Timing of Emergency Contraception with Levonorgestrel or the Yuzpe Regimen, 353 LANCET 721 (1999).

²²¹ U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS NATIONAL CRIME VICTIMIZATION SURVEY (September 2005).

²²² F. Stewart & J. Trussell, *Prevention of Pregnancy Resulting from Rape: A Neglected Preventive Health Measure*, 19 AM. J. PREV. MED. 228, 228 (2000).

²²³ *Id.*

indispensable treatment around the clock and on an emergency basis. Furthermore, in light of the emergency nature of treatment for sexual assault, her most likely point of treatment is an acute care facility, a hospital, and requiring her to search elsewhere for medication is unduly burdensome. It is for this reason that the AMA declared EC to be part of the basic standard of care for rape victims.²²⁴

The AMA issued its *Strategies for the Treatment and Prevention of Sexual Assault* in 1995, three years before the FDA approved prescription use of EC.²²⁵ The document unequivocally supports the use of pregnancy prophylaxis, stating: “Patients should be informed that Prophylactic regimens are 97–98 % effective if started within twenty-four hours of the sexual attack and are generally only recommended within seventy-two hours. There is a 1 % failure rate for any pregnancy prophylaxis, with potential teratogenicity effects if the patient does become pregnant.”²²⁶ Furthermore, the AMA principles provide that a physician’s personal beliefs cannot supersede the proper care of a patient.²²⁷

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.²²⁸ 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.²²⁹

VI. EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITALS

Implementation of EC laws are most frequently challenged by Catholic hospitals, many of which had never offered EC, who would be required to adhere to the new law. Such hospitals previously took the position that to provide EC without any restrictions would violate tenets of the Catholic faith.²³⁰ Catholic hospitals constitute the largest group of health care providers in the United States.²³¹ In Massachusetts, for example, twelve of

²²⁴ AM. MED. ASS’N, STRATEGIES FOR THE TREATMENT AND PREVENTION OF SEXUAL ASSAULT 16 (1995).

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* See also Report to Congress, Agency for Healthcare Research and Quality, U.S. Dep’t of Health and Human Servs., Medical Examination and Treatment for Victims of Sexual Assault. Evidence-based Clinical Practice and Provider Training (Sept. 2003), available at <http://www.ahrq.gov/RESEARCH/victsexual/victsexual.pdf>.

²²⁸ *Id.*, *supra* at note 239.

²²⁹ *Id.* at 15.

²³⁰ Directive 36 of the U.S. Bishops’ *Ethical and Religious Directives for Catholic Healthcare Services*, *supra* note 41.

²³¹ Niebuhr, Gustav, NY Times, *supra* n.

the seventy-one acute care facilities are Catholic-owned,²³² and Caritas Christi Health Care, a facility of the Roman Catholic Archdiocese of Boston, was an outspoken opponent of the EC legislation.²³³ Similar opposition was mounted in Connecticut, where the law was crafted to allow hospitals to contract with “independent providers” (which the law defines as a physician, physician-assistant or nurse-midwife) in order to comply with the new legislation.²³⁴

An informal study conducted in 2004 by the reproductive rights advocacy organization NARAL Pro-Choice Massachusetts found that prior to implementation of the Massachusetts EC legislation, one in six Massachusetts hospitals, or 16.9 %, did not offer EC in cases of rape.²³⁵ Thirty-two percent of those hospitals did not provide a referral for EC when asked, and many reportedly provided misinformation about EC.²³⁶ Moreover, none of the twelve Catholic hospitals in Massachusetts provided EC to rape survivors.²³⁷

In the week preceding the EC law’s implementation in Massachusetts, the governor announced that Catholic hospitals would not be forced to comply, citing a 1975 Massachusetts provision that prevented the state from forcing private hospitals to dispense contraceptive devices.²³⁸ After generating much opposition from constituents in his Democratically-led state government, the governor and the Massachusetts Department of Public Health reversed their position just a few days later, declaring that no hospitals were exempt from the new law.²³⁹ Many believe the political flip-flop was a calculated maneuver to create enough confusion over the interpretation of the EC law so that Catholic hospitals could defend their position of non-compliance.²⁴⁰ Daniel Avila, associate director for policy and research for the Massachusetts Catholic Conference, the public policy arm of the Boston Archdiocese, stated that, despite the administration’s new position Catholic hospitals will continue to have a basis for not handing out the morning-after pill.²⁴¹ Avila stated “As long as that statute was left standing, I think those who want to rely on that [1971] statute for

²³² Skeeles, *supra* note 212, at 1010.

²³³ Steve LeBlanc, *Confusion over new emergency contraception law deepens*, THE ASSOCIATED PRESS, Dec. 9, 2005.

²³⁴ See S.B. 1343, 2007 Gen. Assem., Jan. Sess. (Conn. 2007).

²³⁵ NARAL Pro-Choice Massachusetts, Comparison of EC Survey Results: 2004 and 2006, available at <http://www.prochoicemass.org/news/ecreport.shtml> (last visited March 14, 2008).

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ LeBlanc, *supra* note 233.

²³⁹ *Id.*

²⁴⁰ Scott Helman, *Romney Says No Hospitals are Exempt from Pill Law*, BOSTON GLOBE, Dec. 9, 2005.

²⁴¹ *Id.*

protection for what they're doing have legal grounds."²⁴² In Connecticut, the Catholic Bishops Conference dropped its opposition to dispensing EC in Catholic hospitals for victims of rape.²⁴³ However, because the law does not require a pregnancy test, the Bishops conference maintains its opposition in other cases.²⁴⁴

The Massachusetts Department of Public Health is charged with promulgating the regulations of the new law, and sent a letter in December, 2005 to the Chief Executive Officers of all seventy-one acute care facilities in Massachusetts describing the new EC protocol and their obligation to comply with the law.²⁴⁵ Pro-choice advocates were seeking strict adherence to the law, while anti-choice proponents and Catholic hospitals were seeking to construe the language more broadly. For example, the letter provides: "Facilities that provide emergency care must promptly offer emergency contraception at the facility to each female rape victim of childbearing age, and must initiate emergency contraception upon her request."²⁴⁶ One plausible way of construing this requirement is that hospitals may provide prescriptions for EC to be filled at a nearby pharmacy. Another alternate construction is that the EC law is a mandate to provide EC directly to the rape victim. Moreover, many hospitals, uncomfortable with dispensing EC to minors, are unprotected by the regulation as it contains no language explicitly excluding minors from obtaining access to EC without parental consent. Much of the new law is arguably open for interpretation, and the conflicting interests of the states' acute care providers will doubtless lead to varying interpretations of the new regulations.

Because the Connecticut EC law is new and untested, it is unclear how Catholic hospitals will deal with its essential provisions. Some Catholic hospitals have taken the position that they will only provide EC after it is proven that ovulation has not occurred and thus the patient requesting EC is not "at-risk" for conceiving a pregnancy.²⁴⁷ The argument is that such a patient is less likely to effectively terminate a potential pregnancy.²⁴⁸ In

²⁴² *Id.*

²⁴³ Kaiser Family Foundation, *Connecticut Catholic Bishops Agree To Comply With Law Requiring Hospitals To Dispense EC to Rape Survivors* (October 1, 2007), available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=47863 (last visited March 14, 2008).

²⁴⁴ The bishops based their opposition on their interpretation of the U.S. Conference of Catholic Bishops document entitled, "Ethical and Religious Directives for Catholic Health Care Services," provision no. 36., available at www.usccb.org/bishops/directives.shtml.

²⁴⁵ PAUL I. DREYER, PH.D., ASSOCIATE COMMISSIONER, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., COMMONWEALTH OF MASSACHUSETTS, CIRCULAR LETTER: DHCQ 05-12-456, (Dec. 12, 2005).

²⁴⁶ *Id.*

²⁴⁷ Christopher Keating, *Bishops Accept Contraceptive Law*, HARTFORD COURANT, Sept. 28, 2007 at A1.

²⁴⁸ *Id.*

Massachusetts, the Sisters of Providence Health System, another Catholic-affiliated healthcare provider, has taken the position that it will provide EC to patients who, “after appropriate medical testing,” are determined not to have conceived.²⁴⁹ The “appropriate medical testing” language comes directly from Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services* which sets forth circumstances under which Catholic teaching allows for the use of EC.²⁵⁰ It provides that EC is acceptable for “a female who has been raped to defend herself against a potential conception from the sexual assault...if, after appropriate testing there is no indication that she is pregnant.”²⁵¹

It is unclear what type of medical testing is deemed adequate, but the very requirement of “appropriate medical testing” seemingly violates the Massachusetts and Connecticut laws mandating the provision of EC to any rape survivor who requests it. Some argue even a simple, urine-determinative pregnancy test, often administered in non-religiously affiliated hospitals before providing EC, creates an unnecessary impediment to obtaining the medication. Since a pregnancy test only indicates whether a woman was already pregnant prior to the assault, and since EC does not abort an existing pregnancy, the pregnancy test “creates a barrier between the sexual assault patient and protection from pregnancy.”²⁵²

Some very conservative Catholic ethicists argue that Directive 36 requires more than a pregnancy test. For example, Rev. Kevin O’Rourke, Director of the Center for Health Care Ethics at St. Louis University, has publicly interpreted the Directive as requiring Catholic hospitals to administer ovulation tests to sexual assault patients before giving EC.²⁵³ If the ovulation test and the date of woman’s last menstrual period predict that she has not yet ovulated, EC may delay ovulation and avert a pregnancy.²⁵⁴ If, however, the woman is currently ovulating, EC should not be given to her.²⁵⁵ This policy sits in stark contrast with accepted medical practice of administering only a pregnancy test or no test at all before dispensing EC. More importantly, such a policy would deny access to EC by an ovulating woman, who is most at risk for pregnancy and thus most in need of it.

²⁴⁹ Stephanie Barry, *Hospital Limits Morning-After Pill*, THE REPUBLICAN (Springfield, Mass.), Dec. 16, 2005.

²⁵⁰ See Catholics for a Free Choice, *supra* note 134, at .

²⁵¹ *Id.*

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ Joseph Sanfilippo, & Don Downing, *Emergency Contraception: When and How to Use It*, 57(2) FAMILY PRACTICE (Supplement 1) S3–S10 (Feb. 2008).

²⁵⁵ *Id.*

Other Catholic hospitals may choose to only dispense EC as part of the rape kit examination, usually conducted by a Sexual Assault Nurse Examiner (SANE), who acts as a service provider unaffiliated with the hospital. This would allow the hospital to avoid having to dispense EC directly by shifting the burden of doing so to the SANE. However, a hospital with such a procedure still violates the law by requiring a rape kit examination in order to access EC. This is particularly troublesome because not all hospitals have a SANE program, and even in those that do there is no guarantee a rape survivor will have timely access to EC.²⁵⁶ Thus in addition to violating the EC law, relying on the SANE program to provide EC would often be ineffective. In an informal study conducted by NARAL Pro-Choice Massachusetts two months after the EC law went into effect, it appeared that all hospitals in Massachusetts were either offering EC medication or providing EC prescriptions when requested by a sexual assault victim.²⁵⁷ This represents a markedly different response from what was reported in NARAL's 2004 study. At that time, before the Massachusetts EC legislation came into effect, one in six hospitals did not provide EC to rape victims.²⁵⁸

It does not appear, however, that hospitals are yet providing unencumbered access to EC. Rather, many Massachusetts and Connecticut hospitals are establishing internal protocols for determining the circumstances where EC is appropriate. For example, 12.9 % of Massachusetts hospitals reportedly leave the provision of EC to the physician's discretion, even if the physician's religious beliefs conflict with the hospital's protocol on dispensing EC.²⁵⁹ In addition, 8.6 % of hospitals reportedly require a rape kit examination to justify the use of EC.²⁶⁰

Despite the ability of hospitals to find creative ways to remain non-compliant, the 2006 NARAL survey results are relatively encouraging. More hospitals reportedly are providing EC, or prescriptions for EC, than

²⁵⁶ Only 23 of the 71 acute care facilities in Massachusetts are designated SANE sites. However, even designated SANE sites are not guaranteed a sexual assault nurse examiner for every rape case. It merely means that a SANE may be paged to conduct a rape kit examination, but if she is already conducting another rape kit exam at another SANE site, a member of the hospital staff must conduct the rape kit examination. See Sexual Assault Nurse Examiner Program (SANE), <http://www.mass.gov/dph/fch/sane/index.htm>.

²⁵⁷ NARAL Pro-Choice Massachusetts, Comparison of EC Survey Results: 2004 and 2006, available at <http://www.prochoicemass.org/news/ecreport.shtml> (last visited March 14, 2008).

²⁵⁸ *Id.*

²⁵⁹ NARAL Pro-Choice Massachusetts, EC Accessibility to Rape Survivors in Massachusetts Hospitals (2006), available at <http://www.prochoicemass.org/news/ecreport.shtml> (last visited March 14, 2008).

²⁶⁰ *Id.*

in 2004.²⁶¹ While the law prohibits obstacles to accessing “EC in the ER” for rape victims, it is yet unclear how Massachusetts and Connecticut plan to enforce adherence to the letter of these new laws.

VII. CONCLUSION

Avoidance and non-compliance with EC statutes abound in many jurisdictions, even for treatment of rape victims.²⁶² Non-complying hospitals are notoriously reticent to change their ways.²⁶³ In a 2002 study analyzing access to emergency contraception in emergency rooms across the U.S., researchers report that a large proportion of hospital staff working in states with “EC in the ER” statutes indicate that EC was still unavailable in the emergency room.²⁶⁴ These findings suggest that legislative mandates do not necessarily ensure the availability of EC. In Massachusetts and Connecticut, the new laws will likely require time for policy changes and for new regulations to be implemented.²⁶⁵ A 2004 study conducted in states with “EC in the ER” statutes, focusing exclusively on Catholic hospitals, found that among Catholic hospitals that treat sexual assault patients, 86 % of them have EC but may only dispense it under specific circumstances.²⁶⁶ While still short of 100 %, this represents a large number of Catholic hospitals that have chosen to comply, in a somewhat limited nature, with local EC laws. The findings are encouraging as they represent a significant improvement nationally as compared to a study conducted in 2002 that found only 28 % of Catholic emergency departments providing EC to women who were sexually assaulted in states without EC statutes.²⁶⁷ Thus, although compliance is not guaranteed, it would appear that “EC in the ER” laws are having an important impact on Catholic hospitals’ protocols.

²⁶¹ NARAL Pro-Choice Massachusetts, Comparison of EC Survey Results: 2004 and 2006, available at <http://www.prochoicemass.org/news/ecreport.shtml> (last visited March 14, 2008).

²⁶² Harrison, *supra* note 134, at 109.

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ See Catholics for a Free Choice, *supra* note 134, at 23.

²⁶⁷ *Id.*

