

RUTGERS LAW RECORD

Volume 29

Spring 2005

Number 1

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

By Yuliya Fisher Schaper

I. OUTLINING THE COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES ACT AND ITS SIGNIFICANCE FOR THE VICTIM COMMUNITY.

On July 21, 2003, several Senators, led by Jon S. Corzine of New Jersey, introduced a new bill before the Senate that would guarantee “the provision by hospitals of emergency contraceptives to women who are survivors of sexual assault.”¹ Although rape is a serious and prevalent problem in the United States, the proposed bill is the first attempt by the federal government to ensure that emergency contraception is always available to rape and sexual assault victims in hospital emergency rooms throughout the country. This paper highlights the importance of the availability of emergency contraceptives for rape victims, and analyzes the causes inhibiting the progress of cultural agreement on, and understanding of, the issue of emergency contraception.

A. Pregnancy statistics for victims of sexual assault and the possible risks associated with it.

Based on a 2000 Department of Justice report, an estimated 302,091 women are forcibly raped annually in the United States.² Each year, over 32,000

¹ Compassionate Assistance for Rape Emergencies Act, S. 1564, 108th Cong. (2003). The Act was also introduced in the House of Representatives by Rep. James Greenwood of Pennsylvania on June 19, 2003.

² Patricia Tjaden & Nancy Thoennes, *FULL REPORT OF THE PREVALENCE, INCIDENCE, AND CONSEQUENCES OF VIOLENCE AGAINST WOMEN*, (U.S. Dep't. of Justice, Washington, DC), Nov. 2000 at 13, available at <http://www.ncjrs.org/pdffiles1/nij/183781.pdf>. “Rape was defined as an event that occurred without the victim’s consent, that involved the use or threat of force to

women become pregnant as a result of rape, and approximately 50% of those pregnancies end in abortion.³

B. Current health community treatment of sexual assault victims.

Currently, there is reluctance on the part of emergency rooms nationwide to provide emergency contraception to rape survivors.⁴ “A nationwide study found that fewer than half of all rape survivors eligible for emergency contraception actually received the treatment during a visit to a hospital emergency room.”⁵ The statistics show that although in at least one-third of the rapes and sexual assaults “the victim sustains an injury,”⁶ most rapes are not reported to the police.⁷ Moreover, “most injured rape and sexual assault victims were not treated for their injuries.”⁸ Yet, “81.9 percent of the women who received medical treatment as a result of their most recent rape were treated in a hospital.”⁹ It is notable that one half of those victims who did receive treatment were treated specifically at the emergency room.¹⁰ Studies suggest, however, that even those rape survivors who do request emergency contraception at the hospital are often not provided with it.¹¹ Statistics regarding some states are quite gruesome. In Texas, for example, 37% of hospitals provide emergency contraception to rape victims, while in Wyoming that figure is only 19%.¹²

Percent of hospitals providing emergency contraception to rape survivors:¹³

penetrate the victim’s vagina or anus by penis, tongue, fingers, or object, or the victim’s mouth by penis.” *Id.* at 4.

³ M.M. Holmes et al., Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women, 175 AM. J. OBSTETRICS & GYNECOLOGY 320, 320-325 (1996).

⁴ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, at http://www.naral.org/facts/emergency_contraception.cfm (last visited Nov. 20, 2004).

⁵ *Id.*

⁶ Tjaden et al., *supra* note 2, at 61.

⁷ *RAPE AND SEXUAL ASSAULT: REPORTING TO POLICE AND MEDICAL ATTENTION, 1992 – 2000*, (Bureau of Justice Statistics, Washington, DC), Aug. 2002 at 2.

⁸ *Id.* Only about one-third of the injured victims receive some sort of medical attention. *Supra*, note 2, at 61.

⁹ Tjaden et al., *supra* note, 2 at 54.

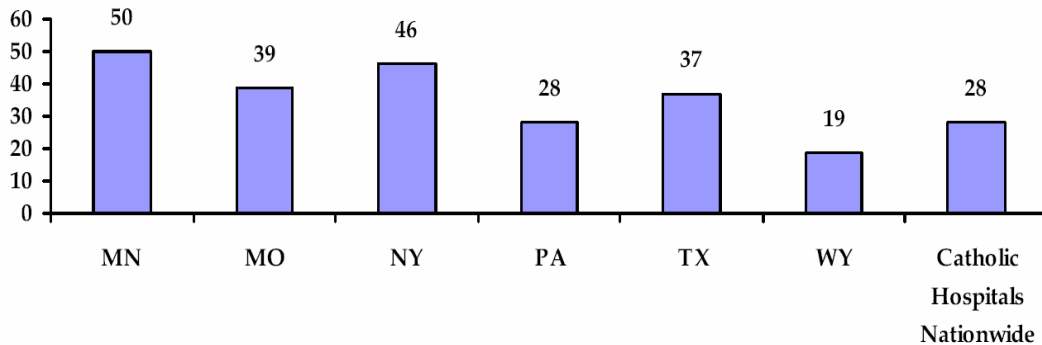
¹⁰ *See supra*, note 7. *See also* Tjaden et al., *supra* note 2, at 54.

¹¹ *Governor Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception*, (Mar. 28, 2003), at

http://www.prochoiceamerica.org/about/newsroom/pressrelease/20030328_ecer.cfm?rend.

¹² *Id.*

¹³ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4. *See also Rape Survivors Deserve the Standard of Care: Emergency Contraception*, (Mar. 21, 2002), available at <http://www.prochoiceminnesotanaral.org/s09issues>.



Because emergency contraception is most effective if given to a woman within 72 hours of intercourse,¹⁴ hospitals have a paramount responsibility in preventing unwanted pregnancies. The standards of emergency medical care established by the American Medical Association (“AMA”) require that victims of rape be counseled about their risk of pregnancy and offered emergency contraception.¹⁵

Even if given a prescription by a doctor, a woman may be denied the emergency contraception pill by a pharmacist or by her insurance company because many states permit such refusals.¹⁶ In 2002, nine states considered legislation to allow pharmacists to refuse to provide certain medicine, including emergency contraceptive pills.¹⁷ In 1999, North Carolina passed a law that specifically excludes coverage for one of the two emergency contraception brands.¹⁸ Even Wal-Mart, one of the major pharmacies, and often the only one available to people around the country, refused to carry PREVEN, one of the two major emergency contraception regimens.¹⁹

These “so-called conscience clauses” are provisions in state and federal legislation that permit doctors, other medical personnel, and sometimes pharmacists, to refuse to perform any procedure or dispense medication that

¹⁴ *Id.*

¹⁵ *Strategies for Treatment and Prevention of Sexual Assault* (American Medical Association), at <http://www.ama-assn.org/ama1/pub/upload/mm/286/sexualassault.pdf> (Oct. 1995).

¹⁶ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

¹⁷ *Id.*

¹⁸ Belden Russonello & Stewart Research & Communications, *Religion, Reproductive Health and Access to Services: A National Survey of Women Conducted for Catholics for a Free Choice*, (Catholics for a Free Choice, Washington, DC), Apr. 2000 at 2, available at <http://www.cath4choice.org/new/pollreport.htm>.

¹⁹ Dana Canedy, *Wal-Mart Decides Against Selling a Contraceptive*, N.Y. TIMES, May 14, 1999, at C2.

conflicts with the provider's religious or moral beliefs."²⁰ Currently, twelve states have coverage provisions that permit "employers and/or insurers to refuse" coverage based on these grounds.²¹ Additionally, twenty-five states have laws that permit health care facilities and professionals to deny provision of contraception or family planning.²² However, according to a national survey conducted by NARAL Foundation in 2001, "six out of ten respondents (60 percent) oppose denial clauses in contraceptive equity laws."²³

Lack of proper knowledge about emergency contraception is widespread within the healthcare industry itself. "Only 31 percent of obstetrician-gynecologists prescribe [emergency contraception] on a regular basis."²⁴ Moreover, only 20% of doctors discuss emergency contraception options "with their patients most or all of the time as a part of routine contraceptive counseling."²⁵ A survey also found approximately 37% of New York City pharmacists "knew nothing or provided only incorrect information about emergency contraception."²⁶

C. Changes proposed by the bill.

The proposed bill is to ensure for "provision by hospitals of emergency contraceptives to women who are survivors of sexual assault."²⁷ It is aimed at establishing a federal standard for hospitals nationwide that would guarantee prompt provision of information about and availability of emergency contraception. Because lack of awareness about emergency contraception in the United States is very high,²⁸ "women who have been sexually assaulted are unlikely to ask for emergency contraception."²⁹

Emergency contraception is an important resource for victims of rape and sexual assault for many reasons. Foremost, it "does not require an invasive procedure or surgery, requires no anesthesia" and gives women a sense of control

²⁰ *Emergency Contraception (EC): A Safe and Effective Way to Prevent Unplanned Pregnancy*, at http://www.reproductiverights.org/pub_fac_ecdomestic.html (Jul. 2003).

²¹ *The Contraception Report: A State-by-State Review of Access to Contraception 2001: The State of The States*, (NARAL FOUNDATION & NARAL, 2001), available at http://www.prochoiceamerica.org/publications/cont_2001.cfm.

²² *Id.*

²³ *Id.*

²⁴ *Governor Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception*, *supra* note 11.

²⁵ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

²⁶ *Id.*

²⁷ *Compassionate Assistance for Rape Emergencies Act*, *supra* note 1.

²⁸ "Nine out of ten women of reproductive age remain unaware of emergency contraception." *Id.*

²⁹ *Id.*

over their bodies after the trauma of rape.³⁰ Also, of the 32,000 pregnancies that are a consequence of rape every year, about 22,000 “could be prevented if rape survivors had timely access to emergency contraception.”³¹ Unintended pregnancies have serious health effects for both the mother and the child. When women face unplanned pregnancies, not only are the children at more risk, but the women affected by such pregnancies “are more likely to delay prenatal care or not seek it at all and are more likely to smoke and drink.”³²

II. HISTORICAL DEVELOPMENT OF EMERGENCY CONTRACEPTION AS A LEGAL ISSUE IN THE UNITED STATES.

A. Development of the drug and its use throughout the world.

Mifepristone, also called RU-486, was first discovered by “a team of French scientists” in 1980.³³ This discovery was seen as a revolutionary development because for over 100 year prior to this date surgical abortions were seen as “the only safe and legal means of terminating an unwanted pregnancy.”³⁴ The genius of emergency contraception, however, is that technically it is not an abortion. Unlike abortion, “which terminates a pregnancy, emergency contraception *prevents* a pregnancy after sexual intercourse” (italics in original).³⁵ These oral contraceptives stop conception if taken within 72 hours of sexual intercourse by preventing the implantation of a fertilized egg to the lining of a woman’s uterus.³⁶

Emergency contraception has “been available in the United Kingdom since 1984, and in numerous other countries including Germany, Sweden, Switzerland, New Zealand, South Africa, China, Hungary, and Thailand.”³⁷

³⁰ *Scientific Advances in Reproductive Health: Non-Surgical Abortion and Emergency Contraception*, at <http://www.naral.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=1973> (Jan. 20, 2003).

³¹ Compassionate Assistance for Rape Emergencies Act, *supra* note 1, at § 2(1).

³² *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

³³ Jean Reith Schroebel, *Assessing Medical Abortion in the US: One Year After the FDA Approval of Mifepristone*, Vol. 24, No. 3 WOMEN & POLITICS 1,1 (2002), available at <http://www.haworthpressinc.com/store/product.asp?sku=J014>.

³⁴ *Id.*

³⁵ *Scientific Advances in Reproductive Health: Non-Surgical Abortion and Emergency Contraception*, *supra* note 30.

³⁶ See Schroebel, *supra* note 33, at 4. See also *Scientific Advances in Reproductive Health: Non-Surgical Abortion and Emergency Contraception*, *supra* note 30; *Emergency contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

³⁷ Heather M. Field, Note, *Increasing Access to Emergency Contraceptive Pills Through State Law Enabled Dependent Pharmacist Prescribers*, 11 UCLA WOMEN’S L.J. 141, 151 (2000).

Additionally, many countries provide access to emergency contraception without a prescription. For example, “the major pharmacy associations in Canada, England, and Scotland support [emergency contraceptive pill] access without a prescription, as long as there is some oversight.”³⁸ As of today, emergency contraception is available in as many 101 countries,³⁹ yet it is still often confused with RU-486.⁴⁰

B. Emergency contraception in the United States.

Emergency contraception has often been called the “best-kept secret” in the United States because even though no dedicated emergency contraceptive product was available prior to 1998, “emergency hormonal contraception had been available,” but “only as an ‘off-label’ use of oral contraceptives.”⁴¹ In other words, beginning in the 1960’s, the common practice for many doctors, emergency rooms and family planning clinics was to prescribe a high dose of oral contraceptive pills. In the 1970’s, the method called the “Yuzpe Method” was developed.⁴² It was named after a Canadian physician, Albert Yuzpe, who developed a lower dose regimen of oral hormones to provide women with pregnancy prevention.⁴³ It was not until 1994 that the Center for Reproductive Law and Policy “filed a citizen petition with the [U.S. Food and Drug Administration] on behalf of a coalition of leading medical and public health groups,” in an effort to bring emergency contraceptives “into the medical mainstream”.⁴⁴ Finally, in September 1998, the Food and Drug Administration (“FDA”) approved the first brand of emergency contraceptive called “PREVEN.”⁴⁵ It was a medical and legal breakthrough because “[d]espite decades of safe and effective use of ECP’s (emergency contraceptive pills) around the world, the off-label status of ECP’s made some providers in the U.S. fearful of legal liability.”⁴⁶ These circumstances contributed to the overall low level of

³⁸ *Id.*

³⁹ *Barr Says FDA Extends Plan B Emergency Contraceptive PDUFA Date*, at http://biz.yahoo.com/prnews/040213/nyf091_1.html (Feb. 13, 2004).

⁴⁰ *FDA Approves First Emergency Contraception Kit*, at <http://www.cnn.com/HEALTH/9809/02/morning.after.pill/index.html> (Sept. 2, 1998).

⁴¹ *A Brief History of Emergency Hormonal Contraception*, at <http://www.Plannedparenthood.org/library/facts/echist500done.html> (last modified Jun. 2004).

⁴² Charlotte Ellertson, *History and Efficacy of Emergency Contraception: Beyond Coca-Cola*, Vol. 28, No. 2 FAMILY PLANNING PERSPECTIVES, 44, 44-45 (Mar.-Apr. 1996), available at <http://links.jstor.org/sici?sici=00147354%28199603%2F04%2928%3A2%3C44%3AHAEOEC%3E2.0.CO%3B2-6>.

⁴³ *Id.*

⁴⁴ *A Brief History of Emergency Hormonal Contraception*, *supra* note 41.

⁴⁵ “Plan B”, the other brand of ECP was approved by the FDA in July 1999. *Id.*

⁴⁶ *Id.*

knowledge about availability of emergency contraception by women around the country for decades.

Although emergency contraception has been available in the United States for almost 6 years, it is still underutilized by most medical professionals and facilities. “Despite the safety and efficacy of EC, the low rate of use is of concern. Pediatricians are being confronted with the decision to prescribe EC but do not feel comfortable prescribing it because of inadequate training in its use.”⁴⁷ As for patients, “nearly 9 in 10 women of reproductive age have either not heard of or do not know key facts about emergency contraception.”⁴⁸ There are several factors that hinder the use and distribution of emergency contraception in the United States.

1. The source of the conflict.

The FDA approval of PREVEN brought on a strong wave of opposition from the conservative side of the political spectrum. The main reason for the opposition arose “from a mistaken belief that ECP's cause abortion.”⁴⁹ Shortly after PREVEN was available on the market, various pro-life leaders immediately characterized the drug as an early abortion pill,⁵⁰ despite numerous studies and releases by the FDA to the contrary. To date, ECP's are often seen to be the same as Mifepristone or RU-486, an abortifacient, which terminates an early pregnancy. For years, efforts to bring Mifepristone into the United States were opposed by many anti-abortion groups.⁵¹ It “has been the subject of political debate unlike any other new drug,”⁵² in the U.S. The first Bush Administration “ensured that Mifepristone would not be available in the United States for any purpose.”⁵³ The ban was eventually removed from the bill, and the Food and Drug Administration finally approved the drug on September 29, 2000.⁵⁴ Even

⁴⁷ Neville H. Golden et al., *Emergency Contraception: Pediatricians' Knowledge, Attitudes, and Opinion*, *Pediatrics*, 287, 287 (2001).

⁴⁸ Kaiser Family Foundation, *Emergency Contraception: Is the Secret Getting Out? Summary of Findings*, California: Kaiser Family Foundation, 7-8 (1997).

⁴⁹ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

⁵⁰ See *FDA Approval of the “Morning-After” Pill: Comments from Pro-Life Leader*, at <http://www.cogforlife.org/morningafterpill.html> (last visited Nov. 20, 2004).

⁵¹ Alicia Wallace, *FDA Approval of Mifepristone Immediately Targeted*, *National NOW Times*, at <http://www.now.org/nnt/winter-2001/mifepristone.html> (Winter 2001). See also Schroebel, *supra* note 33, at 2.

⁵² *Id.*

⁵³ *Mifepristone and the Impact of Abortion Politics on Scientific Research & Women's Health*, at http://www.prochoiceamerica.org/facts/mifepristone_research.cfm (Jan. 1, 2004).

⁵⁴ See *The Fight for Mifepristone*, at http://www.prochoiceamerica.org/facts/fight_for_ru486.cfm (Jan. 1, 2004). See also *FDA Approval of Mifepristone Immediately Targeted*, *supra* note 51.

after its approval, Mifepristone remains a target of many legislative and legal debates.

The line between abortion and emergency contraception is always blurred. Emergency contraceptives do not cause abortion, however, they inhibit ovulation, fertilization, or implantation before a pregnancy occurs.⁵⁵ “In fact, a 2002 study revealed that emergency contraceptive use was likely responsible for up to 43 percent of the decrease in abortions in the U.S. between 1994 and 2000.”⁵⁶ This figure is important because there is a current shortage of abortion providers in the United States. Eighty-seven counties in the nation “have no abortion provider.”⁵⁷ “Despite the potential for ECP’s to reduce unintended pregnancies, efforts to limit access to them has been significant,” because of the mistaken belief that that ECP’s are the same as abortion.⁵⁸ Such misbeliefs crucially undermine the possibility for rape victims to prevent unintended pregnancies and to reduce the need for abortion.

2. Legal points surrounding emergency contraception.

In light of the level of confusion between “the morning-after pill” and abortion, it is quite surprising that the issue has not been addressed by the Supreme Court. No court has ever held that emergency contraceptives constitute abortion.⁵⁹ Several state courts, however, have asserted that emergency contraceptives do not lie within the scope of abortion. In *Margaret S. v. Edwards*, 488 F. Supp. 181, 191 (E.D. La. 1980), the court concluded that, “[a]bortion, as it is commonly understood, does not include IUD’s, the ‘morning-after’ pill, or, for example, birth control pills.” Subsequent to *Edwards*, in a case brought by a rape victim against a Catholic Hospital for a failure to provide information about emergency contraception, the Court of Appeal of California concluded that, “the morning-after pill [i]s a ‘pregnancy prevention’ treatment,” a birth control method rather than a method of terminating a pregnancy.⁶⁰ Overall, “the courts have been

⁵⁵ See *Scientific Advances in Reproductive Health: Non-Surgical Abortion and Emergency Contraception*, *supra* note 30.

⁵⁶ Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, Vol. 34, No. 6 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 284, 300 (Nov.-Dec. 2002).

⁵⁷ See *Mifepristone and the Impact of Abortion Politics on Scientific Research & Women’s Health*, *supra* note 53.

⁵⁸ *Emergency Contraception: An Important and Underutilized Contraceptive Option*, *supra* note 4.

⁵⁹ Bradley Cunningham, Note, *Implications of FDA Approval of RU-486: Regulating Mifepristone Within the Bounds of the Constitution*, 90 KY. L.J. 229, 244 (2002).

⁶⁰ *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405, 413-14 (Cal. Ct. App. 1989).

unwilling, for the most part, to allow post-coital contraception to fall within the laws governing abortion.”⁶¹

In 1972 the United States Supreme Court established that, “if 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 so fundamentally affecting a person as the decision whether to bear or beget a child.”⁶² Therefore, the right of access to contraceptives has been recognized by the Supreme Court for more than thirty years. Yet, the level of controversy surrounding the Supreme Court’s holding has definitely not decreased, and if anything, it has only increased.

In *Brownfield v. Daniel Freeman Marina Hosp.*, the Court determined that a rape victim who was denied information concerning treatment options while at the hospital, may have a cause of action for malpractice damages.⁶³ The Court concluded that such duty “arises from the fact that an adult of sound mind has ‘the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.’”⁶⁴ This case highlighted two vital points. First is the right to privacy that a woman has in her body. Second is a woman’s right to receive necessary medical care from the physician attending to her. Thus, a rape victim, who has been denied the proper access to information on the availability of emergency contraception has suffered, in addition to the harm of rape, “the harm caused by the substandard care following the rape (possibly resulting in an unwanted pregnancy).”⁶⁵ There are physicians who “argue that failure to inform a rape survivor of her options” is equal to medical abandonment, since he “discontinues his services before the need for them is at the end” without giving the patient due notice and an opportunity to secure alternative medical services.⁶⁶

Although there are legal avenues for rape victims as patients, the probability that they will be used is very low. Not only are most women unaware of their rights as victims, but they do not think to question the level of medical services provided to them when they are confronted with such an emergency situation as rape survival. The staggering absence of any education regarding emergency contraception, and specifically, the rights of rape victims, often prevents women from making the well-informed choices that critically affect their lives.

⁶¹ See Cunningham, *supra* note 59, at 244.

⁶² *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

⁶³ *Brownfield*, *supra* note 60, at 405.

⁶⁴ *Id.* at 414.

⁶⁵ Monica Sloboda, Recent Development, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN’S L.J. 140, 152 (2001).

⁶⁶ *Id.*

III. SOME CURRENT ISSUES THAT AFFECT THE AVAILABILITY OF EMERGENCY CONTRACEPTIVES IN THE UNITED STATES.

A. Hospital mergers.

The merging of secular hospitals with religiously affiliated hospitals is a major criterion that reflects the difficulty of the availability of Emergency contraceptives for rape victims. Such mergers often prevent women from receiving necessary reproductive health care because “when a secular hospital merges with a Catholic institution, the secular hospital is typically required to adopt the Ethical and Religious Directives for Health Care Services, which do not allow for the provision of most women’s reproductive services.”⁶⁷ As a result, many women are either left without access to emergency reproductive services, or are forced to travel great distances to gain access to them.

“Most hospital mergers in this country occur between Catholic and non-Catholic hospitals; the Catholic Church is the largest private health care provider in the United States and accounts for about sixteen percent of hospital services nationwide.”⁶⁸ It is because of such vast resources that Catholic hospitals tend to buy less wealthy hospitals around the country. Currently, due to mergers, Catholic hospitals “control about sixty percent of the nation’s healthcare system.”⁶⁹ Though many states now require health care providers to make various reproductive services available, “[t]he Catholic Church manages its health care organizations according to the Ethical and Religious Directives for Catholic Health Care Services, which define church opposition to abortion, sterilization, family planning,” and various other services.⁷⁰

While most medical practitioners see the morning after pill as contraception, Catholic teachings provide that prevention of ovum implantation to the uterine wall is abortion.⁷¹ In fact, about “eighty-two percent of Catholic hospitals do not provide emergency contraception to rape victims,” because of this ambiguity as to whether there has been fertilization or not.⁷² Also, because of

⁶⁷ Alison Manolovici Cody, Note, *Success in New Jersey: Using the Charitable Trust Doctrine to Preserve Women’s Reproductive Services When Hospitals Become Catholic*, 57 N.Y.U. ANN. SURV. AM. L. 323, 323 (2000).

⁶⁸ Jane Hochberg, Comment, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 Or. L. Rev. 945, 949 (1996).

⁶⁹ *Id.*

⁷⁰ Katherine White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights*, 51 Stan. L. Rev. 1703, 1704 (1999); See Hochberg, *supra* note 68, at 954.

⁷¹ *Id.* at 1715.

⁷² *Id.*

this vagueness, about thirty-one percent of these hospitals would not even “provide a referral to another facility that would offer the service,” even though emergency contraception has been approved by the FDA as a “post-coital pregnancy prophylaxis.”⁷³

Since 1998, several states, starting with California, have passed legislation requiring hospitals to offer emergency contraception to sexual assault victims, yet most still do not have any laws protecting the victims. “The problem posed by elimination of reproductive health services is especially acute in smaller communities” and rural areas that can be more frequently exposed to hospital mergers.⁷⁴ “In 1992, 1,004 rape victims in the Chicago area were denied the pill by fourteen hospitals. Of these women, forty-five percent were low-income women seeking the pill in those hospitals because the hospitals were located in their community.”⁷⁵ ⁷⁶ The monopoly created by the Catholic hospitals has an especially serious impact on women in rural and low-income communities,⁷⁷ as Catholic hospitals may be their only choice in the general hospital health care provision. Yet, “even women in more populated communities are left without any viable” solutions as they may not have access to information about alternate providers or may not feel comfortable enough to seek “services in an unfamiliar location.”⁷⁸ Often, a woman does not even know whether a hospital is affiliated with a religious institution when she arrives to receive a service that she is later refused.⁷⁹

B. Access to the drug by minors.

⁷³ See Sloboda, *supra* note 65, at 151-52.

⁷⁴ Cody, *supra* note 67, at 332-33.

⁷⁵ See Hochberg, *supra* note 68, at 955.

⁷⁶ Alan Guttmacher Institute Report *Demonstrates Need for Policies Promoting Greater Access to Contraception* (October 11, 2002), at http://www.prochoiceamerica.org/Issues/contraception/contraception_facts.cfm. NARAL Pro-Choice America reports that although “overall abortion rate in the United States decreased, rates among economically disadvantaged women increased.” For example, “women with incomes below 200% of poverty made up 30% of all women of reproductive age, but accounted for 57% of all women having abortions in 2000.” Additionally, “[i]n states that do not cover abortion services for women on Medicaid, the abortion rate among Medicaid recipients was twice that of women without Medicaid coverage.”

⁷⁷ US Census Bureau, US Department of Commerce, *Black population in the U.S. March 1999*. <http://www.census.gov/population>.

This also touches upon the issue of access to healthcare specifically for minority women.

Statistically, US Census Bureau reports that about nine percent of white women fall below the federal poverty line, the African American women rate at 25 percent and Latinas at 24 percent.

⁷⁸ See Cody, *supra* note 67, at 333.

⁷⁹ See Sloboda, *supra* note 65, at 147.

Although there are no legal barriers preventing teenagers' access to emergency contraception, many cultural stigmas may negatively affect what actually happens in practical situations when teenagers need ECP's. Statistically, "[c]lose to 900,000 teenagers get pregnant every year."⁸⁰ Also, persons aged 16-19 experience more rapes and sexual assaults than any other age group.⁸¹ Yet, their level of knowledge about emergency contraception is the lowest when compared to other age groups. The major reason behind this is that most teenagers do not know about the availability of emergency contraception or how it works.⁸² In addition, because emergency contraception is so easily confused with abortion, there is a double standard of availability of the drug when it comes to teenagers. Today there are 33 states with parental notification abortion laws in effect, where at least one parent must be notified or give consent to a teen seeking an abortion.⁸³ About thirty-one percent of teenagers who get pregnant have abortions.

Although "[e]mergency contraception provides women with the option to prevent unintended pregnancies"⁸⁴ and could cut the abortion rate by half⁸⁵, there are continuous efforts by state and federal legislators to limit minors' access to reproductive services. One example is the Schoolchildren's Health Protection Act that was introduced in the House of Representatives on February 26, 2003.⁸⁶ If passed, it will "prohibit Federal education funding for elementary or secondary schools that provide access to emergency post-coital contraception."⁸⁷ This Act is an example of a law that will prevent pregnant girls from making life-altering choices and will put them at serious risk of having to have an abortion or continuing with an unwanted pregnancy. Additionally, a bill introduced in the House of Representatives on April 10, 2003, would make it a felony for anyone but a parent to transport a minor across a state line to obtain an abortion if the minor's state of residency requires parental notification for an abortion.⁸⁸ This type of legislation is far from beneficial to any teenager, who may have had an opportunity for a medically safe abortion, but now would be forced into seeking

⁸⁰ Stanley K. Henshaw, U.S. Teenage Pregnancy Statistics With Comparative Statistics For Women Aged 20-24, Alan Guttmacher Institute, 5 (2003), at <http://www.aclu.org/ReproductiveRights/ReproductiveRights>

⁸¹ *National Crime Victimization Survey: Criminal Victimization, 2002*, (U.S. Dept. of Justice, Washington, DC), August 2003 at 8.

⁸² See Kaiser Family Foundation, *supra* note 48.

⁸³ *Fact sheet: Teenagers, Abortion and Government Intrusion Laws*, at <http://www.plannedparenthood.org/library/ABORTION/laws.html>

⁸⁴ See <http://www.stateaction.org>

⁸⁵ *FDA Approves First Emergency Contraceptive Kit*, at <http://www.ccn.com/HEALTH/9809/02/morning.after.pill/index.html>

⁸⁶ Schoolchildren's Health Protection Act, H.R. 926, 108th Cong. (2003).

⁸⁷ *Id.*

⁸⁸ Child Custody Protection Act, H.R. 1755, 108th Cong. (2003).

possibly unsafe and illegal ways to obtain one. Creating such obstacles for teens' access to contraceptives would not lower their sexual activity, but rather would put their lives at risk.⁸⁹

C. FDA's delay of approval of emergency contraceptives for over-the-counter sale.

One of the hottest issues regarding emergency contraception is the ongoing debate of whether the Food and Drug Administration should approve emergency contraception as an over-the-counter medication. This issue fully fleshes out the enormous role that bi-partisan politics play in the issue of contraception.

Making emergency contraception available without a prescription would make a stark difference, especially for those women who are victims of rape or sexual assault. If a woman would not want to report the rape or get an examination in an emergency room she would be able to make a quick and private decision by going into a pharmacy and picking up the medication as soon as she needed to. There are many instances when it is hard to find a doctor to write a prescription within the first seventy-two hours after intercourse,⁹⁰ especially on the weekends or holidays. Additionally, if a woman were denied emergency contraception treatment while at the hospital,⁹¹ she would be able to buy it later over the counter. Both of these aspects could significantly reduce the trauma that rape victims already experience and would immediately alleviate the fear of pregnancy after a rape has occurred.⁹²

In December 2003, the Food and Drug Administration was approached by a myriad of organizations and groups that urged its' approval of emergency contraception to a non-prescription status as one that would benefit the American society greatly by reducing the number of unplanned pregnancies and abortions.⁹³ As of today, "[m]ore than 50 health organizations, including the American Medical Association, the American Medical Women's Association, and the

⁸⁹ *Preventing Teenagers from Getting Contraceptives Unless They Tell a Parent Puts Teens at Risk* (July 18, 2003), at <http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=9035&c=223>.

⁹⁰ *Rape Survivors Deserve the Standard of Care: Emergency Contraception*, at <http://www.naral.org>. The chances of becoming pregnant are reduced by up to eighty-nine percent when the ECP's are "taken within seventy-two hours of unprotected sex."

⁹¹ See White, *supra* note 70.

⁹² *ACLU Letter Urging President George W. Bush to Support the Food and Drug Administration's Petition to Allow the Emergency Contraceptive "Plan B" to Be Sold Over-the-Counter* (January 20, 2004), at <http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=14778&c=225>.

⁹³ See <http://www.fda.gov> Docket Number: 2001P-0075.

American College of Obstetrics and Gynecology (ACOG), support over-the-counter status for oral emergency contraception.”⁹⁴

In spite of all of the support for ECP's as an easy-access over-the-counter medication, “the Food and Drug Administration is under intense political pressure to reject the move.”⁹⁵ “A coalition of conservative lawmakers, led by Rep. Dave Weldon, R-Fla., is urging the Bush administration to reject the approval.”⁹⁶ The opposition was formed not because the pill is deemed to be medically unsafe, but because of the argument that approval of the sale of Plan B as a non-prescription drug is inconsistent for an administration that advocates sexual abstinence amongst teenagers.⁹⁷ This argument relies heavily on the idea that the ability to buy the morning-after pill freely will encourage teenagers to have unsafe sex. This belief is not supported by any evidence gathered in the United States nor in any other country where the ECP has been available for many years. First of all, it is highly unlikely that a teenager will find it affordable to buy a thirty-five dollar medication on a regular basis.⁹⁸ Additionally, “there is no evidence that morning-after birth control lulls women into complacency about regular birth control or sexually transmitted diseases or encourages sexual activity in general.”⁹⁹ A study showed that women who had easy access to emergency contraception “were not more likely to use emergency contraception repeatedly.”¹⁰⁰ These women’s “use of other methods of contraception was no different from that of the women in the control group” who first needed to get a prescription for the medication.

Professor Sherry Colb argues that the reasoning behind the right-wing coalition belief closely resembles the claims that are always used when women seek abortions – “that is, that they use it as a form of birth control” and use it on

⁹⁴ Salynn Boyles, *Easy Access to Morning-After Pill Backed* (December 16, 2003), at <http://content.health.msn.com>.

⁹⁵ *FDA Postpones Decision on Morning-After Pill Sales. Government Ponders Whether To Make Pill Available Over-The-Counter* (February 13, 2004), at <http://www.channel3000.com/health/2846952>.

⁹⁶ *FDA Delays Decision on OTC Emergency Contraception* (February 14, 2004), at http://www.usatoday.com/news/health/2004-02-14-plan-b_x.htm; See Sherry F. Colb, *The Night Before the Morning After: Why Has the FDA Delayed Approval of Over-The-Counter Emergency Contraception?* (February 25, 2004), at <http://writ.findlaw.com/colb/20040225.html>.

⁹⁷ Colb, *supra* note 96.

⁹⁸ *Barr Plan B Emergency Contraceptive OTC CARE Program Adequate, Committee Says*, at <http://www.fdaadvisorycommittee.com>. Barr Pharmaceuticals estimate that the drug will cost between thirty and forty dollars per dose packet. “Barr said that the cost would discourage women from using the emergency contraception for regular contraceptive use.”

⁹⁹ *FDA Delays Decision on OTC Emergency Contraception*, *supra* note 96.

¹⁰⁰ See Field, *supra* note 37, at 177.

demand, after irresponsible sex.^{101 102} The truth is, even someone with deep religious beliefs against premarital sex could find themselves in a situation, like rape or failed contraception, where the morning-after pill is the most viable and safe way to prevent an unwanted pregnancy. In fact, over-the-counter availability of ECP is the one method that allows many groups of people, “who may be the very religious Christians whose life choices find approval among conservative Republicans – to go to a drug store and buy what they need, without having to try to schedule an appointment with a doctor within 72 hours of intercourse.”¹⁰³

Although the FDA review panel of doctors and scientists has agreed that Plan B should be sold without a prescription, in December 2003, the decision that was to be made in February has been postponed until May.¹⁰⁴ Unfortunately, the political pressure on the FDA is high and the chances of the decision being positive are very low. One thing is clear, however – there is a certain hypocrisy in the current Administration’s position on the issue – with every day that someone does not have access to ECP’s, “is another day when someone’s going to be pregnant when they don’t need to be and don’t wish to be.”¹⁰⁵

IV. IMPORTANCE OF THE DRUG TO THE SEXUAL ASSAULT VICTIMS.

Although availability of emergency contraception is an issue that may concern any woman, it is especially crucial to those women who have been raped or sexually assaulted. In general, statistics show that there is a lack of reporting of rape and sexual assault cases to the police and of seeking of medical treatment by victims. “Most rapes and sexual assaults against females were not reported to the police.”¹⁰⁶ This has to do with the fact that 3 out of 4 women, who have been raped or sexually assaulted, were victimized by a current or former boyfriend or

¹⁰¹ Sherry F. Colb, *The Night Before the Morning After: Why Has the FDA Delayed Approval of Over-The-Counter Emergency Contraception?* (February 25, 2004), at <http://writ.findlaw.com/colb/20040225.html>.

¹⁰² There are a few reasons that women will not assume more risk and be less responsible about contraception if ECP’s become available over-the-counter. “First, ECP’s are less effective than almost any pre-coital method of contraception.” Second, such side-effects as vomiting and nausea will discourage women from using ECP’s frequently. “Third, the high cost of ECP’s when compared to the cost of ongoing pre-coital contraception may be a barrier to overly frequent use.” Field, *supra* note 39, at 179-180.

¹⁰³ Colb, *Supra* note 101.

¹⁰⁴ See *Id.*; see *FDA Delays Decision on OTC Emergency Contraception*, *supra* note 96.

¹⁰⁵ *FDA Delays Decision on OTC Emergency Contraception*, *supra* note 96.

¹⁰⁶ Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992 – 2000, *supra* note 7, at 1. Thirty-six percent of rapes, 34% of attempted rapes, and 26% of sexual assaults were reported to police, 1992 -2000.

husband.¹⁰⁷ Fear of coming forward because of possible retaliation and shame for what happened are the two biggest reasons domestic violence victims do not report their injuries to the authorities. In fact, the report “Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000” report states that “[t]he closer the relationship between the female victim and the offender, the greater the likelihood that the police would be told about the rape or sexual assault.”¹⁰⁸ Furthermore, victims of intimate violence have a high level of distrust in the judicial system available to them. Many victims do not want the police or courts to be involved - about 61.5 percent of women who chose not to report their victimization, did so because they did not think that the police would do anything about it.¹⁰⁹

In addition, the fact that many women in the United States do not know about emergency contraception leads to a gap in knowledge about an effective tool in avoiding further the trauma of an unwanted pregnancy. Nearly 75% of women aged 18-44 used in a national survey have not heard of emergency contraception, and only 2 percent have ever used them.¹¹⁰ Because women do not know about ECP’s, they tend to think that there is no immediate help available. “Most injured rape and sexual assault victims were not treated for their injuries.”¹¹¹ Unless emergency room personnel will be obligated to offer emergency contraception to victims of sexual assault and rape, most women who do not have any other access to education about their contraceptive options will be deprived of making safe choices that will affect their lives.

V. CURRENT STATE LEGISLATION IS A POSITIVE REINFORCEMENT TOOL FOR THE FEDERAL LEGISLATION TO BE PASSED.

A. State Hospital Emergency Contraception Provisions.

Although emergency contraception has been a controversial debate for a few years now, the majority of the public supports increased availability of emergency contraception.¹¹²

¹⁰⁷ *Id.* at 3.

¹⁰⁸ *Id.* The report also states that “about three-fourths of all victimizations were not reported to the police” when the offender was a current or former boyfriend or husband.

¹⁰⁹ *Extent, Nature and Consequences of Intimate Partner Violence. Findings from the National Violence Against Women Survey* (National Institute of Justice, Washington, DC), July 2001, at 51.

¹¹⁰ Kaiser Family Foundation, *supra* note 48.

¹¹¹ *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992 – 2000*, *supra* note 7, at 2.

¹¹² “A vast majority of Americans – over 80% - believe hospitals should not deny EC to women who are survivors of sexual assault, regardless of the hospital’s religious affiliation.” *Governor*

Unfortunately, as of now, there are only four states in the United States that have legislation covering emergency contraception in the emergency room.¹¹³

¹¹⁴ In March 2003, New Mexico became the third state “to sign a bill requiring hospitals to offer emergency contraception to rape survivors.”¹¹⁵ In June, New York State followed.¹¹⁶ To date, there are nearly a dozen states that have this type of legislation pending.¹¹⁷ Additionally, in Illinois, for example, a law that was enacted in 2001, “ensures that sexual assault victims receive information about [emergency contraception]”, though it does not make it a requirement for “hospitals to provide the treatment.”¹¹⁸ A law in South Carolina requires that the victims receive pregnancy prevention information, though it “does not explicitly mention [emergency contraception].”¹¹⁹ Although many states enact various anti-choice measures yearly,¹²⁰ overall, the states have shown a much firmer commitment to the issue of access to emergency contraception to sexual assault and rape victims in hospitals than their federal counterpart.

B. Pharmacy Access to Emergency Contraception.

There are currently six states that allow women to buy emergency oral contraceptives directly from pharmacists without a prescription.¹²¹ Typically these pharmacists have collaborative therapy agreements with certain doctors, through which they “delegate the authority to prescribe ECP’s” to the pharmacists

Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception, *supra* note 11.

¹¹³ The four states are: California, New Mexico, New York and Washington. *See* The Contraception Report, *supra* note 21.

¹¹⁴ *Proactive State policies: Improving Access to Emergency Contraception (EC)* at http://www.prochoiceamerica.org/facts/ec_state_policies.cfm.

Additionally, the state of Oregon has adopted a non-conventional legislation establishing “Sexual Assault Victims’ Emergency Medical Response Fund”. “Funded by gifts, grants and donations, this fund ... will pay the costs of complete medical assessments for the victims of sexual assault, including the offering and provision of emergency contraception.”

¹¹⁵ *Governor Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception*, *supra* note 11.

¹¹⁶ N.Y. Pub. Health Law § 2805-P (2004).

¹¹⁷ *Governor Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception*, *supra* note 11.

¹¹⁸ *Proactive State policies: Improving Access to Emergency Contraception (EC)*, *supra* note 114.

¹¹⁹ *Id.*

¹²⁰ Emergency contraception for rape survivors is a huge step forward for the pro-choice movement, “considering states have enacted 335 anti-choice measures” from 1995 to 2003. *Governor Richardson Signs Bill Ensuring Sexual Assault Survivors Receive Emergency Contraception*, *supra* note 11.

¹²¹ The six states are: Alaska, California, Hawaii, Maine, New Mexico, and Washington. *See* The Contraception Report, *supra* note 21.

without the patient actually going to the doctor.¹²² Four of the states “have adopted measures to explicitly allow pharmacists to provide EC without a prescription. The California law was enacted in 2001, the Hawaii law and New Mexico regulations were adopted in 2003, and the Maine law was enacted in 2004.”¹²³ Additionally, “two states allow pharmacists to enter into collaborative therapy agreements that apply to any prescription drug, including EC.”¹²⁴

Presently, states appear to be more responsive in enacting legislation that increases the overall access to emergency contraception when compared to the efforts made on the federal level. Some states’ proactive approaches prove to be a good model for an avenue of adopting the necessary measures that would ensure access of emergency contraception for rape and sexual assault victims nationwide.

VI. PROBABILITY OF THE BILL PASSING THROUGH CONGRESS.

Although the Compassionate Assistance for Rape Emergencies Act¹²⁵ was introduced in the Senate in late July, 2003, no legislative action has taken place in regards to its’ passage.¹²⁶ The Bill was referred to the Senate Committee on Health, Education, Labor and Pensions on the same day, but has not been mentioned ever since.¹²⁷ What happened? In the opinion of some of the sponsors of the Bill, there are several ongoing issues that may negatively affect the probability of success of this Act ever passing as a law.

First is the passage of the Unborn Victims of Violence Act of 2004 that was signed into law by President Bush on April 6, 2004. The Act is also known as “Laci and Connor’s Law”, named after the deceased Laci Peterson who was pregnant with her son Connor at the time of her murder.¹²⁸ This Act makes it a crime to injure or kill any “child in utero” during the commission of any federal or military crime of violence.¹²⁹ Although the Act is only related to federal and military crimes that only affect attacks on pregnant women, it accords full legal status to a fetus and could eventually open doors to altering laws that grant a

¹²² See Field, *supra* note 37, at 147-148.

¹²³ See *Proactive State policies: Improving Access to Emergency Contraception (EC)*, *supra* note 114.

¹²⁴ *Id.*

¹²⁵ *Supra* note 1.

¹²⁶ See <http://thomas.loc.gov/cgi-bin/bdquerytr/z?d108:SN01564>; (last visited March 1, 2005).

¹²⁷ Although the same Act that was introduced in the House of Representatives had 82 co-sponsors, unlike 7 for the Senate side, its’ legislative path has not been any different. After the introduction on June 19, 2003 it was referred to several committees for further consideration and has not made any further progress since then. See <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:HR02527> (last visited March 1, 2005).

¹²⁸ See http://www.nrlc.org/Unborn_Victims/BushsignsUVVA.html.

¹²⁹ See Unborn Victims of Violence Act of 2004, H.R. 1997, 108th Cong. (2004)(enacted).

woman the right to choose. Senator John Kerry, one of the co-sponsors of the Compassionate Assistance for Rape Emergencies Act, has expressed his strong opposition on the passage of the Unborn Victims of Violence Act, by pointing out that he has “serious concerns about this legislation because the law cannot simultaneously provide that a fetus is a human being and protect the right of the mother to choose to terminate her pregnancy.”¹³⁰ Although this law does not directly affect the issue of emergency contraception, it closely relates to the stance of the current Congressional majority on the issue of a woman’s right to choose.¹³¹

Furthermore, as mentioned previously in this paper, one of the most vital questions with regard to emergency contraception currently is whether the FDA will approve the Plan-B regimen for over-the-counter use.¹³² That this debate has been masked under the blanket of further medical research portrays the strongest available example of bi-partisan politics on the issue of the woman’s right to choose. Unfortunately, the absence of any ongoing feedback from the FDA is not a promising sign when estimating the chances of approval to be announced in May of 2004.

Additionally, the congressional community’s inactivity and lack of interest in the issue of emergency contraception for rape and sexual assault victims is obvious. Perhaps it may be explained by the sharp division in the political views between the bi-partisan sides of the American political society that has been intensified even further after the current administration assumed office in January 2001. The change in the political face of the majority in both the House and the Senate from liberal to conservative has drastically overturned the priorities in discussions on the floor of the current Congress.

VII. CONCLUSION - THE ACT PRESENTS A NEW FACE TO THE OLD DEBATE.

From afar, the topic of emergency contraception within the American society may seem relatively new, but taking a closer insight shows that the political and ethical aspects involved in the debate are surprisingly familiar to anyone who has followed the development of the pro-choice movement in the United States. The question of whether a woman has the right to her own body

¹³⁰ Email from Senator John Kerry on the Unborn Victims of Violence Act, at http://www.nrlc.org/Unborn_Victims/kerryemail_UVVA.html.

¹³¹ The Bill passed both the House of Representatives and the Senate with the lead on the Republican side. The Bill passed the House of Representatives with the tally of 254 to 163. *See* <http://clerk.house.gov/evs/2004/roll031.xml>. The Bill passed the Senate with a vote of 61 to 38. *See* http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=108&session=2&vote=00063.

¹³² *See FDA Delays Decision on OTC Emergency Contraception, supra* note 96.

seems to have the same answer to the conservative wing of the political spectrum, whether it is related to easier access to abortion, better sex education, or availability of emergency contraception.

Lack of progress on the passage of the Compassionate Assistance for Rape Emergencies Act serves as a sharp reminder of the need to increase availability of resources and support for rape and sexual assault victims in the United States. At this time, the level of knowledge about emergency contraception is not well-developed, even within the medical community. Recognition of the need to open doors for access to emergency contraception will also open several other doors to such legal rights as the right to privacy and the right to receive proper medical care. This note was a highlight to the fact that presently, there are many inhibiting factors that prevent rape and sexual assault victims from receiving proper care in hospital rooms nationwide, and that in order to reduce the number of abortions in the United States, there needs to be a serious improvement of interrelationship, and strengthening of the trust level, between victims of rape and sexual assault, and members of the legal and medical communities.