Commentaries

Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims

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A B S T R A C T

There is growing concern that rape victims are not provided with emergency contraceptives in many hospital emergency rooms, particularly in Catholic hospitals.

In a small pilot study, we examined policies and practices relating to providing information, prescriptions, and pregnancy prophylaxis in emergency rooms. We held structured telephone interviews with emergency department personnel in 58 large urban hospitals, including 28 Catholic hospitals, from across the United States.

Our results showed that some Catholic hospitals have policies that prohibit the discussion of emergency contraceptives with rape victims, and in some of these hospitals, a victim would learn about the treatment only by asking. Such policies and practices are contrary to Catholic teaching. More seriously, they undermine a victim's right to information about her treatment options and jeopardize physicians' fiduciary responsibility to act in their patients' best interests.

We suggest that institutions must reevaluate their restrictive policies. If they fail to do so, we believe that state legislation requiring hospitals to meet the standard of care for treatment of rape victims is appropriate. (*Am J Public Health.* 2000;90:1372–1376)

Emergency contraception is a Food and Drug Administration–approved method for postcoital pregnancy prophylaxis,[1] the use of which is recommended by the American College of Obstetricians and Gynecologists.[2] Emergency contraceptives are the standard of care for rape victims.[3] Nevertheless, a growing number of surveys have shown that Catholic hospitals throughout the United States are likely to have policies prohibiting emergency room physicians from prescribing emergency contraceptives, even to rape victims.[4–7] Such policies may place a serious burden on rape victims, who are likely to be particularly vulnerable because of postrape trauma and stress. The victim has less than 72 hours to act to protect herself from pregnancy, and she may have delayed seeking care.

Because many women do not know about the treatment,[8,9] we decided to examine whether rape victims are likely to be adequately informed by providers who believe such treatment is immoral.[10,11] In some views, providing information or a referral can make a provider morally culpable for the subsequent acts of the rape victim. This view is supported by abortion-related conscience clause laws enacted by some states. In the broadest, most "permissive" conscience clauses, providers are protected from liability not only for refusing to perform or participate in abortion but also for refusing to discuss abortion and to counsel or refer patients for such a procedure.[12]

To examine whether rape victims are given information about emergency contraceptives, we performed a pilot survey of large hospitals across the United States. In this commentary, we present our results and discuss the moral and ethical implications of our findings.

Pilot Survey

We designed and piloted a telephone questionnaire that addressed (1) whether providers are prevented from discussing or prescribing emergency contraception and whether hospital policies are followed; (2) whether the hospital pharmacy dispenses emergency contraception; (3) if necessary, whether referrals are made; and (4) hospital volume of rape cases. This survey was approved by the University of Pennsylvania institutional review board.

To examine whether conscience clause laws have any bearing on these practices, we chose a set of the largest Catholic[13] and non-Catholic American Hospital Association–member hospitals in large cities in states with "permissive" conscience clause laws and those with either no law or a "standard" law. We identified 8 states (Illinois, Louisiana, Maryland, Missouri, Montana, Oregon, Pennsylvania, South Carolina) in which the law specifically exonerates providers and institutions for refusal to "suggest,"[14] "counsel,"[14,15] "recommend,"[14–16] "advise,"[17–19] "refer for,"[14,20] or "aid, abet, or facilitate" abortion.[21] Although these laws do not necessarily apply to emergency contraception,[22] we hypothesized that the laws may be a proxy for conservative social environments in which withholding information would be more acceptable. Indeed, permissive conscience clause laws are more likely to have been adopted in what Halva-Neubauer called "chal-

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Note. The opinions expressed are those of the authors and do not represent the positions of the Presbyterian Medical Center or the University of Pennsylvania.

This commentary was accepted February 17, 2000.

TABLE 1—Description of Survey Sample and Respondents

	Catholic Hospitals	Non-Catholic Hospitals	Total
Survey sample			
Permissive conscience clause law	19	18	37
No or "standard" conscience clause law	21	20	41
Total survey sample	40	38	78
Respondents			
Permissive conscience clause law	13	13	26
No or "standard" conscience clause law	15	17	32
Total responses	28	30	58
Role			
Nurse/nurse coordinator	26	25	51
Physician	1	3	4
Clinical educator/rape counselor	1	1	2
Nonresponse		1	1
Average no. of beds	468	663*	
Estimated average no. of rape cases/y	66	108[a,**]	

[a]Linear regression showed no relation between the number of beds in the institution and the number of victims treated ($F_{1,48}=0.00$, $P=.95$).
*Mann-Whitney test ($z=3.1$, $P=.002$).
**Mann-Whitney test ($z=2.0$, $P=.046$).

lenger" states (i.e., those that have enacted more abortion laws restricting the rights created by *Roe v Wade*).[23]

Our control group was drawn from the District of Columbia and 10 states contiguous to the permissive law states. Two of these jurisdictions have no conscience clause law (District of Columbia and Mississippi), and 9 have laws that protect providers who refuse to "perform or participate" in medical procedures that result in abortion (Arkansas, Delaware, Idaho, Indiana, Iowa, New Jersey, North Carolina, Ohio, Washington).[24–32]

All telephone interviews were performed by one of us (B.J.S.) between June and August 1998. The interviewer was blinded to conscience clause law. We called each hospital, were transferred to the emergency department, and held an interview with a person who indicated that he or she knew how rape victims were treated in the emergency department. On average, 2 telephone calls to each hospital were made before completing an interview. Respondents were assured that their identity and that of the institution would be kept confidential. Interviews took approximately 5 minutes.

As shown in Table 1, our final sample included 78 hospitals. Staff at 9 hospitals refused, stated that they were too busy, or told us that an appropriate person was unavailable. Staff at 11 hospitals stated either that they stabilize and transfer or that they do not handle rape cases (e.g., long-term care facility, mental health hospital, or no emergency room). These respondents indicated that emergency medical personnel would not bring rape victims to the hospital except in exigent circumstances. We thus have usable data from 58 interviews (74%).

The results of our survey are presented in Table 2. Staff at 12 of 27 Catholic hospitals reported that their policy prohibits the discussion of emergency contraception with rape victims. Despite these policies, respondents at 8 of the 12 hospitals with restrictive policies indicated that relevant information likely would be provided to victims. In 4 hospitals, providers would discuss contraceptives despite the policy; in 2 hospitals, the victim would be transferred to the gynecology department or to another provider where information would be provided; and in 2 hospitals, rape counselors who come to the emergency room would provide relevant information. Three of these 8 hospitals also tell victims that they have a policy prohibiting discussion of emergency contraception. In the remaining 4 hospitals, a victim would find out about emergency contraception only by asking. One of these 4 provides a pamphlet stating that there may be other services that the hospital does not provide because it is Catholic, but emergency contraception is not specifically mentioned. In all respondent hospitals, providers would discuss emergency contraception if specifically asked.

Regarding the effect of conscience clause laws, 5 of 25 (20%) were in states with permissive conscience clause laws, and 7 of 32 (22%) were in control states; this finding was contrary to the hypothesis that policies restricting the provision of information would be more prevalent in hospitals in permissive law states (2-sided Fisher exact test, $P=1.0$). Given our limited sample size and the 20% average prevalence of restrictive disclosure policies in our sample, we had limited power of less than 60% to detect a difference of about 10%, a medium-size effect, if it exists.[33] Our results nonetheless provide important base rate data that may be useful for future nationwide sampling and study.

Respondents at 7 of the Catholic hospitals in our sample stated that physicians were prohibited from prescribing contraceptives. Five of these 7 also had policies prohibiting discussion. Four respondents indicated that victims would be referred elsewhere, such as to their own physicians, for a prescription. Four respondents noted that victims would be told about their policy prohibiting prescription, and 3 of these 4 also would make a referral. One respondent stated that physicians in that hospital could write prescriptions on their own private prescription pads but not on those bearing the hospital's name. For individual physicians who are uncomfortable prescribing contraceptives, that hospital also had prescriptions presigned by

TABLE 2—Summary of Results

	Catholic Hospitals	Non-Catholic Hospitals
Does hospital policy prohibit discussion of emergency contraception with rape victims?		
Yes	12	0*
No	15	30
Nonresponse	1	0
Does hospital policy prohibit prescription of emergency contraception for rape victims?		
Yes	7	0
No	20	30**
Nonresponse	1	0
Will hospital pharmacy dispense emergency contraception?		
Yes	10	30
No	17	0*
Nonresponse	1	0

*Fisher exact test, $P<.001$.
**Fisher exact test, $P=.03$.

another physician. One respondent stated that physicians might prescribe despite the policy.

Respondents at 17 Catholic hospitals stated that their pharmacies are prohibited from dispensing emergency contraceptives. In one hospital, the inpatient pharmacy could not dispense contraceptives, but the outpatient pharmacy located down the hall would. In another, the pharmacy would dispense contraceptives only to rape victims.

Although many of the Catholic hospitals in our study have no emergency contraceptive restrictions, respondents were quite candid about the controversy over emergency contraceptives. Two individuals commented that the treatment is a "big deal" or a "big issue" and that even though it is provided, the hospitals "don't like it." Two others indicated that physicians may discuss emergency contraceptives but that the use of such contraceptives "is not promoted." One respondent hinted that prescriptions are written, but this respondent "officially abstained" from answering our question. Another respondent from a Catholic hospital that recently merged with a non-Catholic one stated that "contraceptive issues are currently uncharted waters, and for the time being, contraceptive discussion is allowed but not encouraged."

According to our respondents, hospital policies were followed much of the time, but there are various ways of providing treatment for victims while upholding the policies. Clearly, some Catholic hospitals (and their staff) are willing to compromise on the issue of emergency contraceptives, generating "creative solutions" to meet the standard of care.[34]

Ethical Considerations in the Treatment of Rape Victims

This pilot study confirmed that the nationwide standard of care for treatment of rape victims in large urban hospital emergency rooms includes emergency contraception. Nonetheless, we found that some Catholic hospitals prohibit the discussion, prescription, and distribution of emergency contraception in the care of rape victims.

The variability in treatment policies reflects the local control that diocesan bishops have over medical services.[35–37] The general principles to be applied in keeping with the Church's religious beliefs are stated in the *Ethical and Religious Directives for Catholic Health Care Services.*[38] Directive 36 provides the following:

> A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[38]

In Catholic moral theology, contraception is viewed as an illicit interference with the procreative purpose of the conjugal act of a married couple. However, as stated by Pope Paul VI, "a conjugal act imposed upon one's partner without regard for his or her condition and lawful desires is not a true act of love, and therefore denies an exigency of right moral order in the relationships between husband and wife."[39] Simply, the proscription on contraception does not apply in cases of rape. Indeed, Catholic nuns working in the Congo in the early 1960s were permitted to take contraceptives because of the high chance of rape.[40]

Emergency contraception generally refers to high-dose estrogen or estrogen–progestin combination pills, or a progestin mini-pill, which inhibits or disrupts ovulation, interferes with fertilization or the transport of the embryo to the uterus, and possibly inhibits embryo implantation in the endometrium.[41] The mechanism by which emergency contraception prevents pregnancy thus encompasses both permissible and nonpermissible actions. However, the directive only enjoins acts performed with the specific intent of "removal, destruction, or interference with the implantation" of an embryo regardless of whether they in fact do so. Testing a rape victim to determine whether conception has occurred as a result of the rape is not feasible, and the most that can be accomplished is an extremely rough judgment of probabilities.[42] Thus, a provider cannot tell whether giving the victim an emergency contraceptive will prevent ovulation and conception or may instead interfere with implantation of a fertilized ovum. Under the principle of double effect, as long as the provider has the intent of preventing ovulation or conception, prescribing or giving a victim an emergency contraceptive is permissible even with the foreknowledge that it might instead cause rejection of a fertilized ovum.[43]

Some Catholic organizations have adopted more dogmatic positions. The Pennsylvania Catholic Conference, for example, stated that although conception may be avoided, use of any "medical procedure, the purpose and/or effect of which is abortive, is never permissible."[44] By sidestepping the intentionality of an act, the true effect of which act can never be assessed with certainty, they reject both the gross uncertainty surrounding the processes of fertilization and implantation and the principle of double effect.

Restrictive policies leave providers sailing between Scylla and Charybdis: if they provide emergency contraception, they may contribute to an act that they view to be immoral, but if they fail to inform about or offer emergency contraception, they may contribute to the (perhaps morally more repugnant) later-term abortion resulting from an avoidable pregnancy. Indeed, pregnancy occurs in up to 5% of rapes, and victims often abort.[45]

A physician who does not inform a rape victim of her options to help avoid pregnancy violates the obligation to act in her best interest and violates her right to give an informed consent to treatment.[46,47] Providers may justify the failure to disclose by asserting that there is not 1 patient but 2—the rape victim and an embryo. This is precisely the point over which rape victims and providers may disagree. This disagreement can be discovered and resolved only through open discussion about the provider's conflicting personal morals or institutional policies that prevent the discussion or prescription of emergency contraceptives.[48–50]

In our view, the failure to discuss emergency contraception is tantamount to abandonment.[51–53] If a physician "discontinues his services before the need for them is at an end, he is bound first to give due notice to the patient and afford the latter ample opportunity to secure other medical attendance of his own choice."[54] Clearly, the uninformed rape victim may think she has received all possible and appropriate medical care.

This analysis suggests that hospitals with restrictive practices or policies regarding discussion or prescription of, or referral for, emergency contraceptives should reevaluate the theological, medical, and social justifications for those policies. One of our respondents summarized the dilemma and her hospital's solution: "Being able to give the pill is a big deal, but it is given to rape victims as a standard part of care." If hospitals continue to fail to meet the standard of care for treatment of rape victims, we believe that state legislation is called for that will require providers to meet the standard.[55] Simply requiring a referral is inadequate, because the effectiveness of the treatment decreases with time lapsed from coitus.[56,57]

We examined hospitals in larger metropolitan areas. Our results thus may not be applicable to rural or even suburban hospitals and need to be confirmed in larger studies. Because victims' options may be quite limited in areas with few providers or hospitals, restrictive policies (or laws that permit pharmacists to refuse to fill contraceptive prescriptions) could have particularly harsh effects. This may be exacerbated by the expansion of the Catholic health system, particularly because of the growth in the number of Catholic sole providers (where the closest similar facility is more than 35 road miles away), and because mergers often lead to

restriction of reproductive services.[4,34,58] These issues need to be examined in greater detail.

Conclusion

The use of emergency contraceptives at Catholic hospitals is clearly a divisive issue. This study confirms that no consensus exists across Catholic hospitals regarding compliance with the medical standard of care or, for that matter, with the Church's own health directives. These hospitals should reevaluate their policies and practices in light of the directives, which we believe adopt a compassionate and reasoned approach, within the Catholic moral framework, to the treatment of rape victims.

What seems to be missing is a clear moral analysis of culpability and duty that would help Catholic and other health care providers resolve the dilemmas posed by a conflict of their own beliefs and values with the beliefs, values, and, perhaps most important, treatment needs of their patients, including rape victims. The permissive conscience clause laws enacted by several states appear to resolve this conflict purely in favor of the provider. These laws are unreasonable because they create unique, dangerous, and insidious exceptions both to the quasi-fiduciary role of physicians and to the obligation of providers to secure informed consent to medical care and, most significantly, because they are inconsistent with patients' reasonable expectations that their physicians will act in their best interest. A better resolution would be to strike a balance between the interests of providers in their moral integrity and their fidelity to patients' well-being and trust: to require not performance or participation in acts the provider believes to be immoral, but communication and discussion fully respectful of patients' status as independent moral agents. □

Contributors

S. S. Smugar and J. F. Merz together initiated the study, developed the survey sample, and drafted the survey instrument. S. S. Smugar checked the data and wrote the first draft of the paper. J. F. Merz performed the statistical analyses and assisted with the writing of the paper. B. J. Spina piloted the questionnaire, helped modify the instrument after piloting, ran the survey, performed data entry and cleaning, and assisted with the writing of the paper.

Acknowledgments

The authors thank the Greenwall Foundation for partial support.

The authors also thank the emergency department staff who responded to the survey for taking the time out of their hectic schedules to talk; Rev Dr James McCartney for helpful discussions; and Arthur Caplan, Kathryn Kolbert, Aimée Kahan, Marcie Merz, and several anonymous reviewers for comments on a draft of the manuscript.

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