Emergency Contraception Provision in Hospital Emergency Rooms in the United States

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Introduction

Hormonal emergency contraception (EC) is a safe and effective birth control method used to prevent pregnancy following unprotected intercourse. The most commonly used method in the United States requires taking combined estrogen and progestin or progestin-only oral contraceptive pills. Although these hormonal regimens have been used in the United States for more than two decades, three million unintended pregnancies occur annually in this country, half of which end in abortion[1]. Five percent of rape victims of reproductive age become pregnant as a result of their attacks.[2] Because EC can reduce the risk of pregnancy by at least 75%,[3] many of these unintended pregnancies and abortions that occur each year could be averted.

Since EC is not yet available over the counter in the U.S., women wanting to avoid pregnancy after unprotected intercourse or method failure may seek EC from hospital emergency rooms (ERs), especially during off-hours when clinics and doctor's offices are closed. The American Medical Association, the American College of Obstetricians/Gynecologists and the Food and Drug Administration advocate the use of EC for women who experience unprotected intercourse and want to avoid pregnancy.[4] Four states mandate that hospital ERs provide information about and/or offer EC to women who have been raped, while six other states are strongly encouraged to follow these protocols. Three states have made EC available to all women through pharmacies.

There are several reasons women may have difficulty accessing EC, including lack of information on the part of physicians, healthcare providers substituting moral judgment for appropriate medical care, and religious restrictions. The U.S. Catholic bishops have written directives specifying that EC can only be given to women who have been raped and are also not pregnant, which obviously limits access to the majority of women. Non-Catholic hospitals would be expected to follow the American College of Obstetricians/Gynecologists' standard practice guidelines and administer EC for any woman who requests it.

Methods

To assess the availability of EC in hospital ERs, we conducted two studies, one among Catholic hospitals and the other among a sample of non-Catholic hospitals. Building on a survey of all 597 U.S. Catholic hospital emergency rooms that we conducted in August 2002 with Catholics for a Free Choice,[5] our study staff telephoned 615 non-Catholic hospital emergency rooms in late June 2003. The American Hospital Association generated a list of 3600 hospitals representing all non-Catholic hospitals in the country reporting at least one emergency department visit. We selected an 18% sample, stratified by state. Although the sampling methodology was non-random, we sought a sample with nationwide geographic distribution and a mix of hospital types. Because the non-Catholic sample had slightly different sampling fractions within states, we applied sampling weights to this group to adjust for differential selection probabilities. The differences in results between the unweighted and weighted data were minimal.

In both studies the interviewing methods were identical. Trained female interviewers followed a written script and recorded responses on pre-coded forms. Interviewers made up to three attempts to contact each hospital.

We conducted the surveys during weekend hours to simulate the experience of a woman who has had unprotected intercourse on a Thursday evening. Since most health clinics and physicians' private practices are closed on weekends, and EC should be initiated within 72 hours

of intercourse, weekend hours are likely to represent the most critical time for women seeking EC.

Our studies used a "mystery client" approach by which interviewers spoke with staff fielding calls in the emergency room and asked specifically about the potential of obtaining EC. If the hospital staff indicated that they would not dispense EC under any circumstance, the caller requested the name and telephone number of another facility where she could obtain EC. Callers then pursued up to three referrals whereby they telephoned facilities until they reached a dead end or were told they could obtain EC. Although we employed this interviewing method to reflect the true likelihood that a hospital ER would dispense EC for a woman who recently had unprotected sex, official hospital policy regarding provision of EC may be different from the outcome of the caller's experience.

Results

Overall, the results show that women have limited access to EC through hospital emergency rooms. Table 1 shows that 42% of respondents from non-Catholic hospitals said they do not dispense EC, regardless of circumstance, compared to 55% of staff from Catholic facilities. Staff working in non-Catholic hospitals were three times more likely to dispense EC without any restrictions; however, a significant number said they defer the decision to the physician treating the patient. Nearly one-fourth (23%) of Catholic hospital respondents report that they provide EC to victims of sexual assault compared to only 17% of non-Catholic hospital respondents, with most imposing unnecessary restrictions such as undergoing a pelvic examination.

Table 2 shows that among hospital staff in both groups who indicated that their facility does not dispense EC for any reason, only about half provided callers with a name and telephone number of another facility. When specifically asked if the referral facility provides EC, 84% of non-Catholic and 80% of Catholic hospital staff did not know (data not shown). The majority of respondents in each group referred callers to another hospital (Table 3). The remainder were directed to call clinics, rape crisis hotlines and other facilities such as the local Department of Health and nurse hotlines. When callers pursued the referrals, significantly more given by non-Catholic hospital staff proved to be ineffective (80% versus 65%), leading to wrong numbers, clinics closed on weekends and facilities that did not provide EC or additional referrals (Table 4).

Discussion

Given the potential to significantly reduce the high rates of unintended pregnancy and abortion in the United States, women seeking to prevent pregnancy should have unhindered access to emergency contraception in hospital emergency rooms. Although EC has been endorsed by leading medical authorities, our data show that few women are able to obtain a prescription for this safe and effective method of birth control. Although Catholic hospital staff were generally more restrictive than those working in non-Catholic facilities, the number of women who would have been given EC without restrictions is dismally low regardless of the religious affiliation of hospitals.

There are several ways to increase access to EC for women. First, states can pass legislation mandating that hospitals offer EC to rape survivors. Less than ten states currently have enacted such laws. Second, hospitals can train all emergency room staff (especially those answering the telephone) about the availability and benefits of emergency contraception, and educate physicians and nurses on the mechanism by which EC prevents pregnancy. Health care

providers holding religious or ethical beliefs that compromise provision of EC should refer patients to practitioners who dispense this treatment. Third, practitioners should be encouraged to provide women with an advance prescription of EC. Furthermore, the FDA can change the status of EC from a prescription to an over-the-counter product therefore allowing women to bypass the constraints of the health care system.

Table 1. Respondents willing to provide EC, by circumstance.

Circumstance	**Non-Catholic**	**Catholics**
n (%, [CI])	(n=3425)†	(n=597)
No, regardless of circumstance	1447 (42.2, [37.0-47.3])**	328 (54.9)
Yes, on request	595 (17.4 [13.5-21.3])**	30 (5.0)
Doctor's discretion	567 (16.5, [12.6-20.4])**	33 (5.5)
Negative pregnancy test/exam required	138 (4.0, [2.0-6.0])**	3 (0.5)
Rape alone	35 (1.0, [0.0-2.0])**	16 (2.7)
Rape and not pregnant	264 (7.7, [4.9-10.5])**	77 (12.9)
Rape, don't know about pregnancy test	246 (7.2, [4.5-9.9])	40 (6.7)
Rape, not pregnant, and report to police	29 (0.8, [-0.1-1.7])	3 (0.5)
No response/don't know/unclear	105 (3.1, [1.3-4.9])**	67 (11.2)

† Weighted *n*.

** p<0.01.

Table 2. Percent of respondents who gave a valid referral.

	Non-Catholic	**Catholics**
N (%, [CI])	(n=1442)†	(n=328)
Referral given	752 (52.1, [44.0-60.2])	154 (47.0)

† Weighted *n*.

Table 3. Type of referral facility.

Facility type	**Non-Catholic**	**Catholics**
N (%, [CI])	(n=752)†	(n=154)
Hospital	526 (69.9, [59.6-80.2])	119 (77.3)
Rape hotline	45 (6.0 [0.7-11.3])	10 (6.5)
Clinic	103 (13.7 [6.0-21.4])	10 (6.5)
Other	78 (10.4, [3.6-17.2])	15 (9.7)

† Weighted *n*.

Table 4. Final outcome of referrals.

	Non-Catholic	**Catholics**
n (%, [CI])	(n=752)†	(n=149)
Dead end	598 (79.6, [78.3-80.9])**	96 (64.4)
Led directly to EC	131 (17.4 [8.9-25.9])**	44 (29.5)
Led eventually to EC	23 (3.0 [-0.8-6.8])	9 (6.0)

† Weighted *n*.

** p<0.01.

Overall chi-square p<0.05.

References

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