2022 Council Resolution 27: Equitable Access to Emergency Contraception in the ED

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **In Progress**

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Purpose:

That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and, that ACEP advocate for universal access to emergency contraception in the emergency department.

Fiscal Impact:

Budgeted committee and staff resources for development of a policy statement and advocacy initiatives.

Background:

WHEREAS, Emergency medicine upholds the basic human rights principle of non-discrimination including providing medical care without bias to race, color, sex, language, religion, political, or other opinions, national or social origin, property, birth, or other status such as disability, age, marital, and family status, sexual orientation and gender identity, health status, place of residence, economic, and social situation1;; and

WHEREAS, 55% of patient visits to the ER are women or 72,352,000 out of 129,974,000 visits recorded most recently by the Centers for Disease Control and Prevention2; and

WHEREAS, This obligation includes the right to ensure availability, accessibility, acceptability, and quality of contraceptive services without discrimination1; and

WHEREAS, In the United States, 76.2% of women aged 18–49 years are considered to be at risk for unintended pregnancy, and the risk for unintended pregnancy varies significantly by age group, race/ethnicity, and urban-rural status3; and

WHEREAS, Emergency contraception should be available for populations at most risk for unintended pregnancy including when no contraceptive was used, sexual assault, concern for possible contraceptive failure, or improper or incorrect use4,5,6; and

WHEREAS, Emergency contraception can prevent up to 95% of pregnancies when taken within 5 days of intercourse,4 but is most effective when taken within 24 hours6; and

WHEREAS, Many patients in the United States do not have access to primary care or gynecologic services within 24 hours9,10; and

WHEREAS, There are many misconceptions about emergency contraceptives including confusion with abortifacients and termination of pregnancy, rather than an understanding that these medications only work prior to establishing pregnancy4,8; and

WHEREAS, The American Medical Association (AMA):

1. Recognizes healthcare, including reproductive health services like contraception and abortion, is a human right11
2. Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion11; and

WHEREAS, The American College of Obstetricians and Gynecologists (ACOG) expert consensus and practice bulletins recommend:

1. Health care providers integrate copper IUD emergency contraception into their practice with same-day availability.8
2. Write advance prescriptions for emergency contraception to increase awareness and reduce barriers to access.8; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) has an existing policy stating that:

Section III-IV Protecting Access to Women's Health, Reproductive Health, and Organizations That Provide Increased Health Access to Women: EMRA will advocate for policies that protect access to women's health care including reproductive health care. Support increased funding for organizations that provide access to reproductive care.12

Section IV-VIII. Healthcare as a Human Right: EMRA firmly believes that all individuals should have access to quality, affordable primary and emergency healthcare services for all people (especially vulnerable and disabled populations, including rural, elderly, and pediatric patients) as a basic human right.12; and

WHEREAS, The American College of Emergency Physicians (ACEP) has an existing policy "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" stating that ACEP supports the availability of non-prescription emergency contraception13; and

WHEREAS These misconceptions can lead to further inaccessibility of medical treatment to a vulnerable population during a critical time5; therefore be it

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

The resolution directs ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments (EDs) nationwide, and would also direct ACEP to advocate for universal access to emergency contraception in the ED.

Existing ACEP policy regarding emergency contraception is succinct and narrow in scope. As noted in the resolution, the ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

"A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion."

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal

access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these "conscience clauses" also prohibit discrimination against health care providers who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is also in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

However, some maintain concerns that access to contraception may also potentially be at risk given Justice Clarence Thomas' concurring opinion in *Dobbs*. While Justice Thomas reiterates that *Dobbs* itself does not address any right beyond abortion, he does suggest that the Court should reconsider "…all of this Court's substantive due process precedents, including *Griswold*, *Lawrence*, and *Obergefell*," adding that "Because any substantive due process decision is 'demonstrably erroneous,'…we have a duty to 'correct the error' established in those precedents." These comments have led some to conclude that access to contraception may also be under threat should the Supreme Court be presented with and opt to consider a similar case that could effectively overturn *Griswold* or other related precedent.

As the resolution notes, while contraceptives and abortion/abortifacients are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy), there are often common misconceptions conflating the two. The American College of Obstetricians and Gynecologists (ACOG) states that "Intrauterine pregnancy begins when a fertilized egg implants itself in the uterus," and, that "Emergency contraception prevents a pregnancy from occurring after sexual activity. It is not an abortifacient; it does not end a pregnancy." Despite this distinction, much of the debate around the broader issue centers around the more fundamental disagreement of when life begins or whether pregnancy begins at conception or at implantation. Those who believe life begins at the moment of conception or fertilization oppose emergency contraception that prevents the implantation of a fertilized egg, arguing that action constitutes an abortion.

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the "morning-after pill"), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is "a hypothetical that has never been proven."

Given wide variation in state regulation of abortion and reproductive health procedures, including "trigger" laws, newly-passed laws in several states (some of which include prohibitions on abortions even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger), and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine, including the provision of emergency contraception. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception out of an abundance of caution to avoid potential legal exposure.

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

Stragegic Plan Reference:

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Prior Council Action:

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) "Sexual Assault" adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action:

January 2021, reaffirmed the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy;" reaffirmed October 2015 and June 2010; originally approved October 2004.

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed the "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient"

handbook prepared by the Sexual Assault Grant Task Force.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Council Action:

Reference Committee B recommended that Resolution 27(22) be adopted.

The Council adopted Resolution 27(22) on September 30, 2022.

Testimony:

Testimony was largely in support of the resolution. During asynchronous testimony several comments noted the importance of advocating for emergency contraception in the emergency department (ED). One comment noted that the resolution appears to reiterate existing ACEP policy. During live testimony, there was unanimous support of addressing access to lifesaving care. Several members noted challenges with various state laws being separate from or in conflict with ACEP policy and how emergency physicians could potentially find themselves in legal jeopardy. Other testimony included reiteration that it is the role of emergency physicians to provide treatment and counsel to patients, that the resolution is specific to emergent conditions, and additionally, that it is within ACEP's mission and purview to set guiding principles with respect to the delivery of emergency care. Other testimony included comments about the necessity of protecting women's rights.

Board Action:

The Board adopted Resolution 27(22) on October 3, 3022.

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Implementation Action:

Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care.

Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

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