Michigan Emergency Department Responses to Callers Requesting Emergency Contraception

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Introduction

Sexual assault remains a significant public health concern in the United States, with approximately 300,000 women assaulted annually[1]. Emergency department care following sexual assault should include evaluation of physical trauma, sexually transmitted infection prophylaxis, psychological support, and pregnancy prevention[1]. The American College of Obstetricians and Gynecologists recommends that emergency contraception (EC) be offered to all individuals capable of becoming pregnant after sexual assault[2], and in 2022 the American College of Emergency Physicians adopted Resolution 27 affirming equitable access to EC regardless of institutional affiliation[3]. Earlier mystery-caller studies conducted between 2002 and 2005 demonstrated that more than half of emergency departments declined to provide EC, with notable differences between Catholic and non-Catholic institutions[4]. Catholic hospitals operate under the United States Conference of Catholic Bishops' Ethical and Religious Directives, which restrict interventions perceived to interfere with implantation and require "appropriate testing," a term interpreted variably across dioceses[4]. In the post-Dobbs era and following the FDA's removal of "impeding implantation" language from Plan B labeling, updated data evaluating first-contact access to EC are necessary[5].

Aims and Objectives

The aim of this study was to determine the prevalence of refusal to provide emergency contraception to sexual assault survivors among Michigan emergency departments. We sought to compare EC availability between Catholic and non-Catholic EDs, assess the presence of institutional restrictions, evaluate referral practices and referral validity, and characterize communication barriers encountered at first contact.

Methods

Using the 2002 Catholics for a Free Choice study as a methodological model, a statewide mystery-client approach was employed to contact all Michigan emergency departments. Ninety-four EDs were included, consisting of 69 non-Catholic and 25 Catholic institutions. Female callers in their mid-20s conducted standardized phone inquiries over a weekend, asking general questions such as "Do you provide emergency contraception?" and "I'm calling to get the morning-after pill."

Methods (cont.)

If EC was reported as unavailable, callers specifically inquired about availability for a sexual assault victim and requested a referral if necessary. Referrals were followed until EC was obtained or a "dead end" was reached. A referral was considered valid if it led directly or indirectly to a facility that provided EC. Calls were not recorded in accordance with Michigan law, and staff roles were not probed in order to preserve ecological validity. Hospital demographic data, including urban versus rural status and trauma designation, were collected when available.

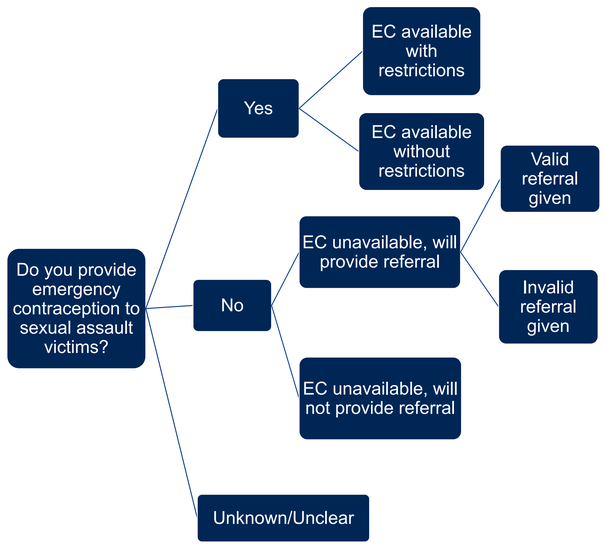

Figure 1: Telephone encounter flowchart

Results

Table 1: Availability of EC at Michigan EDs. EC = Emergency contraception; ED = Emergency department.

	Non-Catholic (n=69), No. (%) [95% CI]	Catholic (n=25), No. (%) [95% CI]
EC Available	34 (49.3) [37-61]	6 (24) [7-40]
EC Unavailable	32 (46.4) [34-58]	18 (72) [54-89]
Unknown/unclear	3 (4.3) [0-9]	1 (4) [0-11]

Table 2: Restrictions placed upon EC. EC = Emergency Contraception; ED = Emergency department.

	Non-Catholic (n=34), No. (%) [95% CI]	Catholic (n=6), No. (%) [95% CI]
Unrestricted	19 (55.9) [39-72]	2 (33.3) [0-71]
Restrictions present	11 (32.4) [16-48]	4 (66.7) [28-100]
Unknown/unclear	4 (11.7) [0-22]	0 (0) [0-0]

Table 3: Referral provision for EC when unavailable. ED = Emergency Department; EC = Emergency contraception.

	Non-Catholic (n=32), No. (%) [95% CI]	Catholic (n=18), No. (%) [95% CI]
Referral provided	30 (93.8) [85-100]	13 (72.2) [51-92]
No referral provided	2 (6.2) [0-14]	5 (27.8) [7-48]

Table 4: Referral validity when provided.

	Non-Catholic (n=30), No. (%) [95% CI]	Catholic (n=13), No. (%) [95% CI]
Valid	30 (100) [1-1]	11 (84.6) [65-100]
Invalid	0 (0) [0-0]	2 (15.4) [0-34]

When asked about EC provision, several Catholic and non-Catholic ED staff members responded with various comments, such as:

- "We're a Catholic hospital and according to our values we don't do that here."
- "No, we don't have Plan B, and if you were assaulted or something that should be reported and then go talk to your PCP."
- "No, it doesn't work like that, you can't just come in and get the medication."
- "I've never been asked that in my 10 years of working here."

In some cases, the provision of EC was uncertain, with 4.3% (n=3, 95% CI [0-9]) of non-Catholic EDs and 4% (n=1, 95% CI [0-11]) of Catholic EDs providing vague responses such as:

- "We don't give medical advice over the phone."
- "It's a policy that I can't give out that kind of information."

Conclusions

This statewide mystery-client study demonstrates that individuals seeking EC after sexual assault in Michigan may encounter substantial first-contact barriers when contacting emergency departments. Catholic EDs reported lower EC availability, more frequent institutional restrictions, and less reliable referral pathways compared with non-Catholic EDs. However, nearly half of non-Catholic EDs also reported EC as unavailable, indicating that access barriers extend beyond religious affiliation and reflect broader systemic inconsistencies in emergency care delivery. Differences in the interpretation of "appropriate testing," institutional policy variability, and inconsistent frontline communication contribute to these disparities. Because initial phone communication often determines whether a survivor presents for care, inaccurate, vague, or dismissive responses may delay time-sensitive treatment, reduce medication efficacy, and increase the risk of unintended pregnancy and additional trauma. These findings are particularly relevant in the evolving reproductive health landscape following the Dobbs decision and the FDA's updated labeling of levonorgestrel, where clarity in institutional policy and staff education is essential. This study has important limitations. Each hospital was contacted only once, responses may vary by individual staff member or shift, and phone interactions may not reflect actual in-person clinical practice. Nevertheless, the methodology intentionally captures the real-world experience of a first-contact inquiry, which itself functions as a critical gatekeeping step in access to care. Improving equitable access to EC in emergency departments will likely require standardized communication protocols, mandatory trauma-informed education for all frontline staff, and accountability mechanisms such as periodic mystery-caller audits. Ensuring consistent and accurate first-contact communication represents an essential component of trauma-informed emergency care and a meaningful opportunity to reduce disparities in reproductive health access.

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