

University of Pennsylvania
Reproductive Rights Law Project
3400 Chestnut Street
Philadelphia, PA 19104

October 17, 2007

Independent Regulatory Review Commission
Arthur Coccodrilli, Chairman
333 Market Street, 14th Floor
Harrisburg, PA 17101

RE: Regulation #10-182 (#2577), Proposed 28 PA. Code Chs. 101 and 117 – Sexual Assault Victim Emergency Services

Dear Chairman Coccodrilli:

The University of Pennsylvania Reproductive Rights Law Project (RRLP) would like to submit written testimony to the Independent Regulatory Review Committee for its October 17, 2007 meeting. The RRLP is a student-run organization assisting the Women's Law Project, a Pennsylvania-based public interest legal advocacy organization, in its work involving access to reproductive health services. One of the aims of RRLP is to monitor local, state, and federal legislation concerning reproductive rights.

We would like to express our gratitude for the continuing hard work of the IRRC in promoting the interests of women through progressive legislation. Today we would like to thank you specifically for your consideration of the proposed Sexual Assault Victim Emergency Services regulations (28 Pa. Code Chapters 101 and 117) and for soliciting testimony from the public. We appreciate the opportunity to provide you with comments on these regulations.

Legislation concerning emergency services for victims of sexual assault is of great consequence to the success of women's health law reform. The proposed regulations drafted by the Department of Health are critical as they provide much needed protection for women in the Commonwealth who have survived the horrific ordeals of sexual assault. As the Department of Health has recognized, 3,341 forcible rapes were reported in Pennsylvania during 2005, as well as 8,636 other sexual offenses. In light of the U.S. Department of Justice's estimate that only 38% of rapes are reported,¹ these numbers can be expected to be a gross underestimate of the actual number of sexual assaults that occurred during 2005. The regulation of emergency services for sexual assault victims ensures that these women are provided with the immediate medical care they need following this traumatic experience, a range of options to choose from

¹ Shannan M. Catalano, Criminal Victimization 2005, BUREAU OF JUSTICE STATISTICS OF THE U.S. DEPARTMENT OF JUSTICE, Sept. 2006, at 10.

concerning this care, and the necessary resources to make an informed choice. Sexual assault victims deserve the best medical care available and regulations such as this would ensure that they will have the full range of options. More specifically, the proposed regulations are significant as they expand victim access to emergency contraception (“EC”) and information regarding these services. Overall, these regulations would align Pennsylvania with the thirteen other states that currently provide legislation expanding access to EC for victims of sexual assault.²

Although we are generally pleased with the Department of Health’s proposed Sexual Assault Victim Emergency Services regulations, we have a few concerns that we would like to share with you. We hope that you will consider the regulations again in light of these concerns.

- **The definition of “sexual assault” used within § 101.4 should be broadened in order to more realistically encapsulate all forms of sexual assault.**

In its current form, § 101.4 links its definition of “sexual assault” to 18. Pa.C.S. ch. 31, subch. B. Important revisions to this definition should be made in order to adequately protect a varied range of sexual assault victims. First, the PA criminal statute limits its definition to “sexual intercourse” or “deviate sexual intercourse” that occurs without the complainant’s consent. This definition should be expanded in § 101.4 to include “sexual contact” as it is used in the Model Penal Code.³ Without this adjustment, the proposed regulations are underinclusive, as they fail to take into account an entire class sexual assault victims who may also need physical or psychological care and are deserving of redress via the criminal system. We fear that under the current definition, these victims are not adequately protected.

- **The definition of “sexual assault victim” used within § 101.4 should be further expanded to include an individual who *alleges* sexual assault, not merely one who *has been* sexually assaulted.**

Our understanding of the regulations is that the proposal was intended to address *victims*, rather than the *criminality* of a sexual assault. This priority is distorted when a “sexual assault victim” is defined by the criminality or non-criminality of the act by the perpetrator rather than the plight of the victim. We feel that the appropriate interests can be served if § 101.4 defined a “sexual assault victim” as “a person who *alleges* to have been sexually assaulted.” This allows medical interests to be immediately served without a probing and time-consuming inquiry into the

² States that provide such legislation as of October 2007 include: Arkansas (ARK. CODE ANN. § 20-13-1403 (2007)), California (CAL. PENAL CODE § 13823.11 (West 2007)), Colorado (COLO. REV. STAT. § 25-3-110 (2007)), Connecticut (2007 CONN. ACTS 24 (Reg. Sess.)), Illinois (410 ILL. COMP. STAT. 70/2.2 (2007) (effective Jan. 1, 2008)), Massachusetts (MASS. GEN. LAWS, ch. 111, § 70E (2007)), Minnesota (MINN. STAT. § 145.4712 (2007)), New Jersey (N.J. STAT. ANN. § 26:2H-12.6c (2007)), New Mexico (N.M. STAT. 24-10D-3 (2007)), New York (N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2005)), Oregon (OR. REV. STAT. § 750.055, 750.333 (2007)), South Carolina (S.C. CODE ANN. § 16-3-1350 (2007)), and Washington (WASH. REV. CODE § 70.41 (2007)). Of these, New York, New Jersey, South Carolina, California, New Mexico, Washington, and Massachusetts require all hospitals providing emergency services to sexual assault victims to dispense emergency contraception upon the request of the victim. NATIONAL CONFERENCE OF STATE LEGISLATURES, 50 STATE SUMMARY OF EMERGENCY CONTRACEPTION LAWS (2007), <http://www.ncsl.org/programs/health/ecleg.htm>.

³ MODEL PENAL CODE § 130.00, 213.4.

criminality of the assault. Further, such an inquiry prior to furnishing medical care would be insensitive and disrespectful to a victim of such a traumatic experience.

The New York Emergency Treatment for Rape Survivors statute has wisely incorporated this language for many of the same considerations.⁴ **Further, such a revised definition would be better equipped to handle the gray areas of rape, such as in cases where it is unclear whether the actions are criminal but there is nonetheless a clear risk of pregnancy, STDs, and other forms of physical or mental injury. This would allow the class of individuals protected by the regulations to be defined based on their reproductive interests and the risk to their health, rather than the criminality of the assault which may be difficult to prove.**

- **§ 117.52(a)(1) should be revised to explicitly provide medical services for *both* the health benefit of the victim *and* to supplement criminal proceedings rather than *either* one or the other or both.**

We have concerns as to the structure of § 117.52(a)(1). As written, § 117.52(a)(1) provides for medical services either for the health benefit of the victim or to supplement criminal proceedings, or possibly both. On its face, the regulation would be satisfied if a hospital provided services geared only to supplement criminal proceedings and refused to take into consideration the health benefit of the victim. We believe that this result is inconsistent with the spirit of the regulations as a whole. **This provision should not be written using the ambiguous “and/or” structure – rather, it should expressly guarantee both options.**

We commend the Department of Health for making § 117.52(a) consent-based. We believe that it is important for all medical procedures to be consent-based, even when those procedures are conducted in the interest of gathering evidence for a criminal proceeding. We also believe that it is important for medical treatment not to be conditioned upon submission to a “rape kit.”

- **Thank you for amending §117.53 to reflect that only *medical* contraindications are acceptable. This regulation would be further strengthened by ensuring that the only acceptable medical contraindications are sourced from authoritative medical guidelines to prevent discretionary abuse.**

We ask that the regulations specify that contraindications are medical and accepted by published medical guidelines. Without this safeguard, it is possible that individuals who have moral objections to EC could refuse to provide EC to a sexual assault victim by fabricating a contraindication that is not medically recognized. We recommend that the regulations cite to the American College of Obstetrics and Gynecology Practice Bulletin, 69, 2005 and World Health Organization Medical Eligibility Criteria for Contraceptive Use, Third edition, 2004 to prevent this type of discretionary abuse. In addition, we ask that the regulations require emergency room staff to document the contraindications that prevented the use of EC. This requirement will also help safeguard the rights of sexual assault victims to proper care and treatment.

⁴ Emergency Treatment for Rape Survivors, N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2005).

- **Thank you for amending § 117.55 such that standard informational materials are to be developed by the Department of Health. We feel that this is the best way to ensure consistency, accuracy, and objectivity.**

If the drafting of informational materials is left up to individual hospitals, there are bound to be differences in the manner in which the information is presented, which points are emphasized over others, and ultimately what sexual assault victims will get out of reading these materials. Thus, the compilation of universal informational materials is instrumental in ensuring that uniform and consistent information is provided to sexual assault victims.

We are concerned about the lack of guidelines given to the Department of Health concerning these materials. At minimum, the regulations should revive the requirement that these materials be “objective” and “medically and factually accurate”.

We have researched pamphlets used by other states (New York, California, and Massachusetts) that have been created pursuant to analogous legislation. All of these standardized informational materials are objectively written and outline medically accepted statistics and information. We propose that these pamphlets can be used as a model by the Pennsylvania Department of Health in drafting a similar document.⁵ The Commonwealth may also benefit by incorporating some additional features of these documents. For instance, these informational materials are written in a variety of languages, and are drafted in a comprehensive, useful, and unambiguous manner. To further that end, California mandated that its brochure must be written at a 4th grade level so that the greatest number of people can understand its contents. As a second consideration, Massachusetts includes both a patient and a practitioner fact sheet. Having both in Pennsylvania may prove useful because it will help ensure that all of the hospitals, as well as patients, are functioning with the same base information and statistics. It also recognizes that different information may be important to different parties. Finally, California’s pamphlet emphasizes that Plan B and other forms of EC are *not* the same as RU-486 (the abortion pill), and that EC will not cause an abortion. In fact, all of the states stressed that the use of EC by a pregnant woman will not harm her pregnancy, nor will it affect the chances of getting pregnant for women in general. These facts address common misconceptions among the public concerning EC and it is important that these apprehensions are alleviated.

We urge you to create create guidelines concerning the drafting of the informational materials and what is expected of the Department of Health. This can be achieved in part by making the standard for “objectivity” more clear-cut. For example, a list of what can be considered reputable information might be helpful. Also instrumental would be a list of what must be excluded from these materials, such as overt religious references.

⁵ See, e.g., MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, EMERGENCY CONTRACEPTION AFTER SEXUAL ASSAULT: KEY FACTS FOR SURVIVORS (2006); Massachusetts Department of Public Health, Key Facts about Emergency Contraception for Emergency Department Staff Who Provide Care to Sexual Assault and Rape Survivors (2006), both available at http://www.mass.gov/?pageID=eohhs2terminal&&L=6&L0=Home&L1=Provider&L2=Certification,+Licensure,+and+Registration&L3=Facilities&L4=Health+Care+Facilities+and+Programs&L5=Hospitals&sid=Eeohhs2&b=terminalcontent&f=dph_quality_healthcare_p_emergency_contraception&csid=Eeohhs2; STATE OF NEW YORK DEPARTMENT OF HEALTH, EMERGENCY CONTRACEPTION FOR RAPE SURVIVORS (2006), available at http://www.health.state.ny.us/nysdoh/consumer/women/emergency_contr.htm.

- **Thank you for providing the provisions of § 117.56 as a safeguard to sexual assault victims.**

RRLP would like to thank the Department of Health for taking into account the potential financial constraints of sexual assault victims. Financial considerations are oftentimes a key concern of sexual assault victims who are worried about paying for their treatment. The inclusion of § 117.56 will help diminish the psychological burden on the victims of sexual assault.

- **§ 117.57's allowance of a moral or religious exception to providing emergency contraception is problematic, and will unduly limit the access of sexual assault victims to emergency contraception.**

We strongly encourage you to reconsider including a moral or religious belief exception in this legislation. We believe that its inclusion will severely limit the opportunity of many sexual assault victims to receive appropriate care.

This exception is unusual, and has been found unnecessary by many states that have drafted similar legislation including New York, California, and Massachusetts. Instead, these states require *all* hospitals providing emergency services to dispense EC upon the victim's request. This is a policy reflection of the states' belief that sexual assault victims should be provided with the option of emergency room EC regardless of where they present. This policy also reflects the reality that sexual assault victims often do not choose which hospital they are transported to – such considerations are governed by convenience and a hospital's proximity to the assault. **If a woman is being transported by ambulance she may have no choice at all. The option of EC should be available in any hospital these victims are taken to.** This is in contrast to women who use EC for reasons other than a sexual assault, who have the ability to choose their medical provider and to select a hospital that reflects their religious beliefs. **We urge you to reflect these same considerations by taking this exception out of the regulations. However, if this is not possible, we recommend changing the exception from allowing hospitals to opt out due to their "stated" beliefs to specifying that these beliefs must be "documented".** This would make the exception somewhat stronger, and allow for more sexual assault victims to have adequate access to EC.

- (A) **If a religious or moral exemption is offered as currently drafted, there is no way the Commonwealth can guarantee that there is a hospital in close proximity that provides emergency contraception services.**

§ 117.57(2) states that a hospital not providing EC services must, at the request of the victim, arrange for the immediate transfer of the victim to a facility that does provide the services. However, this safeguard is not always possible.

Given the geographic distribution of hospitals in Pennsylvania, there is strong chance that some sexual assault victims will be faced with a situation in which *no* hospitals in their county provide EC. For example, Berks County has only two hospitals, one of which, St. Joseph's Medical Center, is Catholic. What will happen to sexual assault victims if the other hospital, Reading

Hospital and Medical Center, self-evaluates and decides not to provide EC to sexual assault victims? The same thing could be said of Cumberland County, and a few others. Additionally, there is Union County, where the only hospital is Evangelical Community Hospital, which could realistically also opt out due to moral or religious beliefs. Additionally, many pharmacies and other facilities that may dispense EC in the area have limited evening hours – few operate at all hours of the day, especially in less urban communities. **In each of these cases, sexual assault victims would be left without a facility in their county to turn to that could provide EC services.** In these cases, the moral judgment of religious hospitals would override the victims’s moral and religious choices.

There is a great deal of evidence suggesting that, given the opportunity this exception provides, Catholic hospitals will opt out of providing EC to sexual assault victims. For example, a 2002 survey of emergency rooms in Catholic hospitals in the US showed that only 28% will provide a rape victim with EC.⁶ Additionally, a 2005 “mystery client” telephone survey of hospital found similar results. In this survey, a client was calling simply to inquire about the availability of EC in hospitals and found that 55% of Catholic hospitals did *not* dispense EC to sexual assault victims.⁷ **These data suggest that Catholic hospitals are likely to take advantage of the exception, if provided with the opportunity, leaving women in their area with less access to EC in the case of sexual assault.**

(B) Allowing hospitals to unilaterally self-evaluate and decide whether or not to provide emergency contraception services is problematic.

§ 117.57 allows hospitals to unilaterally decide whether or not to provide EC to sexual assault victims. This practice is problematic in that it leaves a large loophole for hospitals. Hypothetically, every hospital in the state could opt out of providing EC services, leaving sexual assault victims throughout the Commonwealth without access to EC. **We recommend that, if such an exception must be provided, an external agency should be charged with determining whether a hospital should be allowed to opt-out.** The agency can accomplish this by balancing the hospital’s religious interests with the needs of the community for comprehensive emergency room services. **Alternatively, a hospital can “apply” to be exempt from providing EC in the emergency room.** In order to be approved for an exemption, the hospital must make a showing that there are other hospitals in the area that are able to accommodate the EC needs of rape victims and there are procedures in place for transporting victims to those alternative facilities. However, if the hospital fails to make such a showing, the interest of community health should outweigh the hospital’s religious or moral objection to providing EC for sexual assault victims.

⁶ CATHOLICS FOR A FREE CHOICE, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC EMERGENCY HOSPITAL ROOMS (2003), available at <http://www.cath4choice.org>.

⁷ T. Harrison, *Availability of emergency contraception: A survey of hospital emergency department staff*. 46 ANNALS OF EMERGENCY MEDICINE 105 (2005).

- **If a hospital takes advantage of the exception provided in § 117.57 and discontinues providing emergency contraception to sexual assault victims in its emergency room, it should be obligated to continue providing emergency contraception services until notice is received and published as per § 117.58.**

We urge you to adopt this modification in order to ensure fairness. Otherwise, sexual assault victims, having been promised the availability of EC at a certain hospital by law enforcement, may have to face the extra strain of having hospital staff unexpectedly refuse to provide them with EC upon their request in time sensitive circumstances.⁸

Finally, we would like to add that in addition to our own support, many medical associations such as the American Public Health Association,⁹ the American Medical Association,¹⁰ and the American College of Obstetricians and Gynecologists¹¹ are in support of the uniform availability of EC for all sexual assault victims.

Thank you very much for your hard work on women's health law reform implementation and your consideration of our comments and concerns. RRLP would be happy to discuss this issue further at any point.

Sincerely,

University of Pennsylvania
Reproductive Rights Law Project

Cc: Sandra Knoble, Acting Director
Bureau of Facility Licensure and Certification
Department of Health
Room 932, Health and Welfare Building
7th and Forster Streets
Harrisburg, PA 17120

⁸ Research demonstrates that the effectiveness of EC decreases as the time since the sexual contact increases. The treatment is most effective when taken immediately. G. Piaggio, H. von Hertzen, D.A. Grimes & P.F.A. Van Look, *Timing of emergency contraception with levonorgestrel or the Yuzpe regimen*, 353 LANCET 721 (1999).

⁹ AMERICAN PUBLIC HEALTH ASSOCIATION, ENSURING ACCESS TO EMERGENCY CONTRACEPTION FOR SURVIVORS OF RAPE: OFFICIAL POSITION PAPER. Adopted November 18, 2003.

¹⁰ AMERICAN MEDICAL ASSOCIATION, ACCESS TO EMERGENCY CONTRACEPTION. POLICY OF THE HOUSE OF DELEGATES, H-75,985 (2002), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-75.985.HTM.

¹¹ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ACOG PRACTICE PATTERN NUMBER 3: EMERGENCY CONTRACEPTION. Washington, DC: American College of Obstetricians and Gynecologists (1996).