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November 15, 2006

Mr. Gerald Radke
Director
Bureau of Facility Licensure and Certification
Department of Health
Room 932
Health and Welfare Building
7th and Forster Streets
Harrisburg, PA 17120

Re: Sexual Assault Victim Emergency Services [36 Pa.B. 6403]

Dear Mr. Radke:

On behalf of the Pennsylvania National Organization for Women (PA NOW), I am submitting our comments regarding the proposed rules for Sexual Assault Victim Emergency Services [36 Pa.B. 6403].

Pennsylvania NOW, Inc. was formed in 1971. Today PA NOW is a grassroots, non-profit, volunteer organization with over 9,000 members and 30 chapters statewide. We are the state organization of the National Organization for Women with headquarters in Washington, DC which has over 500,000 members. NOW members are women and men, young and old, all colors, classes and backgrounds, working together to bring about equal rights for all women.

First of all, we would like to commend the Department of Health for taking the concerns of sexual assault victims seriously and for taking the time to review in depth the needs of victims. In many situations your proposed rules will help assault victims receive a standard of care necessary to help alleviate some of the trauma and concerns they might have (including fear of pregnancy and sexually transmitted diseases). However, in many circumstances, these regulations fall short in meeting the needs of women.

After reviewing these proposed rules, we have some specific, grave concerns, questions, and also some kudos. I will present these by Section, quoting your proposed rule and then presenting the concern/question/kudo we have about that section. If any of these comments are unclear, please do not hesitate to contact me for clarification.

§ 117.52. Minimum requirements for sexual assault emergency services. This section is excellent. Among the requirements listed, we applaud mandating prompt access, with the victim's permission, to "Medical examinations and laboratory or

diagnostic tests (§ 117.52 (a) (1 and 5))," "Oral and written information concerning the possibility of sexually transmitted disease and pregnancy § 117.52 (a) (2))," "Oral and written information concerning accepted medical procedures, medication, and possible contraindications of the medication available for the prevention or treatment of infection or disease § 117.52 (a) (3 and 6)," Medication as deemed appropriate by the attending physician, including HIV and sexually transmitted disease prophylaxis § 117.52 (a) (4)", "Information on the availability of a rape crisis center or sexual assault counselor and the telephone number of a local rape crisis center or sexual assault counselor § 117.52 (a) (7)," and "The opportunity for the victim to consult with the rape crisis center or sexual assault counselor *in person* and *in private* [emphasis added] while at the hospital § 117.52 (a) (8)" are essential in treating a victim of sexual assault.

Sections 117.52 (a) (7) and Sections 117.52 (a) (7) are particularly important in helping the victim of sexual assault to heal emotionally from the trauma (s)he experienced. I emphasized the words "in person" and "in private" from § 117.52 (a) (8) since victims are often leery of talking to someone who might not fully comprehend what they have gone through. By mandating that there is immediate access to a trained sexual assault counselor from the local rape crisis center, you are allowing the woman to speak to someone without fear of being blamed for what happened to her. This is absolutely essential in starting the healing process. Although there are often people at local hospitals trained in counseling, they have usually not received the specialized training needed to assist women who have been sexually assaulted. By mandating access to trained sexual assault counselors, you help the woman and, in many cases, probably also assist the court system in prosecuting the alleged perpetrator(s) of the assault down the road by allowing women to process what has happened to them.

§ 117.53 Emergency Contraception. This section focuses on emergency contraception. Section 117.53 (a) states that "The hospital shall provide the following services to a female sexual assault victim *in addition to* [emphasis added] the minimum requirements in § 117.52" and then goes on to discuss emergency contraception (EC). We are extremely disappointed that EC is not included under § 117.52 (a) (4). Fear of pregnancy is often paramount in the mind of a victim of child-bearing years. Not to include EC as part of the medication provided to victims who desire to prevent a possible pregnancy which results from a sexual assault is — in the words of the mother of the victim in Lebanon County, Pennsylvania, who was refused emergency contraception when she requested EC — a "second" assault on the victim[1].

I will further address our concerns about this exclusion in the 117.57 discussion below.

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1 Statement by Ms. [redacted], PA, received via Fax on Tuesday, October 17, 2006 at 3:47 p.m. Statement focuses on what happened at Good Samaritan Hospital on July 21, 2006 when Ms. [redacted]'s daughter was raped and subsequently denied emergency contraception by both the providing emergency room physician and the hospital upon follow-up request for full EC services.

Even with this exemption, we believe that you must ensure that all women have access AT ALL HOSPITALS which provide sexual assault services *to **immediately** provide information on and either direct access at that hospital or via free transportation to a facility providing Emergency Contraception.* Thus, we believe that Sections 117.53 (a) (1) and 117.53 (1) (4) must be diligently enforced. As you clearly state, hospitals must "Provide the victim with medically and factually accurate written informational materials regarding emergency contraception prepared under § 117.55 (relating to emergency contraception informational materials)" and "Offer emergency contraception to the victim and provide emergency contraception onsite upon the victim's request..." Such medications should be part of the health care regiment offered to all sexual assault victims – the burden should not be placed on the victim to either specifically request it nor should she be required to travel to an alternate location. Such a burden should not be imposed on victims already traumatized by the sexual assault experience. As stated above, I will comment on the "moral" exemption to this mandate below.

These proposed regulations state that victims must receive medically accurate information regarding medications that may be prescribed, including EC medication (§ 117.53 (a) (1) and § 117.53 (a) (2)). We believe that these two sections need to have some clarification. Which, we believe, you have already stated in your background information on emergency contraception. In the "Requirements of Proposed Rulemaking" section, you clearly and accurately state, "Emergency contraception is intended to prevent a pregnancy and will not have an effect on eliminating an already existing pregnancy." This is a medically accurate statement that should be included in the information and efficacy and risk sections on emergency contraception — § 117.53 (a) (1) and § 117.53 (a) (2).

Given that EC has "no effect on eliminating an already existing pregnancy," we are highly concerned with section 117.53 (b). This section states, "Prior to providing emergency contraception to a sexual assault victim as required in subsection (a) (3), a hospital may require the victim to submit to a pregnancy test." This is a form of intimidation and revictimizes the woman. By allowing a hospital to mandate a pregnancy test before providing her with EC and then subsequently allowing the doctor to refuse emergency contraception based on the pregnancy test results, you are allowing hospital personnel to further take personal, healing decision-control away from a woman that she needs to make for herself. It also increases the cost to the hospital, insurance companies, other funding agencies, and possibly even the woman (see comments on payment below).Furthermore, you have failed to demonstrate that a pregnancy test would be effective at this stage, since a pregnancy test immediately following a sexual assault may not reveal whether a women is, in fact, pregnant.

§ 117.54. Prevention of sexually transmitted diseases. This section requires hospitals to be given an STD risk assessment, to discuss risk of transmission, and give information on availability and provide STS prophylactic medication with consent of the victim. We applaud your inclusion of this section in the proposed rules.

I have a question of implementation regarding § 117.54 (d). This section states, "Upon the victim's consent, the hospital shall provide the victim with post exposure prophylactic treatment for sexually transmissible diseases, except that a hospital will not be required to comply with this subsection when risk evaluation, adopted by the United States Department of Health and Human Services Centers for Disease Control and Prevention, clearly recommends against the application of post exposure prophylaxis." Our question relates to the portion of the statement that says, "The hospital shall provide the victim with post exposure prophylactic treatment for sexually transmissible diseases…" As I understand from attending meetings of the Centre County Domestic Violence and Sexual Assault Task Force, STD prophylactic medication is a 30-day series of pills given after possible exposure to HIV or an STD. The medication is very expensive[2] and many hospitals that currently provide the prophylactic treatment give only a 3-5 day supply of the medication to the victim(s) and then either tell them to follow up with their family physician OR give them a prescription for them to fill on their own. Does your statement mean that the hospital is only responsible for the first 3-5 days of medication or are they responsible for providing the entire regimen? And secondly, since it is so expensive, how does a sexual assault victim who has no health care insurance and/or is poor (particularly the working poor who do not qualify for Medicaid or Medical Access) acquire this medication considering it's high cost if the hospital does not provide the full regimen?

§ 117.55. Emergency contraception informational materials. § 117.55 (relating to emergency contraception informational materials) clearly and unequivocally state that "A hospital that provides sexual assault emergency services shall ensure that each member of the hospital personnel that provides the services is furnished with medically and factually accurate and objective written informational materials about emergency contraception developed by the hospital under this section." It further states that these informational materials must be distributed to victims of sexual assault and meet the standards of being "clear," "concise," "readily comprehensible," and "in such varieties and forms as are deemed necessary to inform victims in English and languages other than English (§ 117.55 (b) (1)." These materials must also *accurately* "Explain the nature of emergency contraception, including its use, risks and efficacy (§ 117.55 (b) (2))." As with section 117.54, we applaud your inclusion of these requirements in the proposed rules.

For clarification, the final rules need to clearly insure that victims with disabilities also have access to these materials in an alternative format. Audio tapes, CD's that can be used by screen readers, Braille print, and large-print versions of these materials should also be noted and made available for victims needing the materials in an alternative format. In addition, when you state "languages other than English," hospitals should be prepared to bring in sign language interpreters for the deaf when necessary to not only explain the materials, but also to communicate with the victim from the moment she/he presents

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2 The sexual assault forensic nurses who attend the Centre County Domestic Violence and Sexual Assault Task Force meetings said that these prophylactic medications cost about $4000.00 per regimen cycle and as a result, they are having problems finding the funding to assist low income victims in obtaining this medication if they need it and either do not have health insurance coverage or have inadequate prescription coverage.

herself/himself to the hospital for the exam, treatment, counseling, and other dispensing of medical services.

The third standard of care mentioned in this section (§ 117.55 (b) (3)) states that all hospitals must "provide sexual assault victims with information on finding locations where emergency contraception may be obtained in the event it is not obtained at the hospital." Currently there is no list available that clearly states which hospitals or other facilities provide emergency contraception and which ones don't. We hope that as a result of this rulemaking that you will produce a listing available to the public, all emergency room personnel, and to providers of victim's services by county where EC is available and will be properly dispensed.

Currently the best information on access to Emergency Contraception at hospitals in Pennsylvania is available via a study conducted by the Clara Bell Duval Foundation from January to August 2006 (http://www.aclupa.org/education/clarabellduvallreproductiv/emergencycontraceptionproj/ecservicesforrapevictimsin/2006hospitalsurveyupdate/). I have attached a copy of that survey (See Attachment A). Unfortunately, less than 50% of the hospitals have a clear policy of access to emergency contraception. With these regulations, if properly implemented, we will know where victims should seek care in order to change the conclusion of the Duvall study:

> After years of investigating the practicese (sic) regarding pregnancy prevention for sexual assault victims, the Duvall Project still finds a great lack of clarity surrounding hospitals' procedures regarding EC provision. Consequently, EC remains largely inaccessible to rape victims when they need it--in the emergency room. In addition, this survey highlights the inconsistency of care rape patients receive across hospitals in Pennsylvania. In another part of emergency medicine, Pennsylvanians would not accept this great lack of protocol.

In a related manner, this standard implies that the victim would also be told which pharmacies and alternative medical centers (such as Family Planning Centers, student health services, etc.) stock and provide emergency contraception. At this point, this information is very limited. There is a website entitled "The Emergency Contraception Website" run out of Princeton University (accessible either at http://ec.princeton.edu/emergency-contraception.html or http://www.NOT-2-LATE.com) that allows one to search via zip code, city and state, or area code for places that stock EC. It is only a voluntary listing and thus very limited in its usage, particularly for people who either reside in the rural areas of this state or who do not have access to the Internet. As part of your implementation of these rules, we encourage you to create a listing of all pharmacies and facilities that stock and dispense EC. Once created, this information should be included as part of the informational packet mentioned in the main portion of this standards section ((§ 117.55 (b)).

§ 117.56. Information regarding payment for sexual assault emergency services. This section states that the hospital "shall inform a sexual assault victim receiving sexual assault emergency services at the hospital of the availability of known financial resources for services provided to the victim due to the sexual assault, including payments by the victim's medical insurer, if applicable, the Crime Victim's Compensation Program administered by the Pennsylvania Commission on Crime and Delinquency, and any programs administered by the hospital."

We believe that reassuring the victim that she will not be further victimized by being forced to pay for medical care that resulted from a rape is very important. This is particularly true for low income victims of assault. As such, we believe that you need to clearly state that the Medicaid and Medical Access programs conducted by the Department of Public Welfare also will fully cover the costs of treatment and medications, including the full STD medication regimen as well as emergency contraception. With the use of the Access card however, DPW regulations state that Medicaid will only pay for the medication IF it is prescribed by a doctor. As of December 2006, "Plan B" EC will be available over-the-counter for women ages 18 and older. Therefore, these rules need to clearly state that if a) an adult (or minor) woman is on Medicaid and b) she either decides to or is required to obtain EC at a local pharmacy rather than at the hospital, then the doctor must write out a prescription in order for her to have Medicaid billed for the Emergency Contraception pills.

Similarly, the state just passed and signed into law an upgraded version of the Children's Health Insurance Program (CHIP) to make sure that all children's health care is covered. This new law goes into effect on January 1, 2007. CHIP needs to be part of this mix of health care coverage for victims of sexual assault.

There also needs to be some clarification as to how the Crime Victim's Compensation Program will pay for EC and for the STD prophylactic medication. As we understand, victims can only be compensated for medical costs incurred by submitting proof to the Crime Victim's Compensation Board that they paid for the medication and then ask for reimbursement. For victims without health insurance or with health insurance with either limited or no prescription coverage, this might cause an undue burden and result in refusal to follow through on treatment recommended by the hospital physician and sexual assault team. In the case of STD prophylactic medication, the $4000 cost[2] for the entire regimen would be prohibitive for most victims of sexual assault if they have to initially pay the entire cost for the medication and then request reimbursement. To help resolve this issue, you might want to consider involving the drug companies in funding of these types of drugs for sexual assault victims through their Compassionate Care programs.

The second sentence in this section states that "The hospital shall provide the victim information required to secure the services, including copies of itemized bills and medical records." Does this mean that you assume that the victim will be responsible for any bills

that her insurance or the Crime Victim's Compensation Program does not pay for? If so, that needs to be clearly stated.

However, we do not believe that the victim is legally responsible for any of these bills, including the cost of STD prophylactic or EC medication. In 1995, the legislature passed and the Governor signed into law a bill relating to costs incurred as a result of sexual assault. From my reading of P.L. 1056, Act of Sep. 26, 1995, Special Session, § 1726.1, the cost of medications should never be charged to the victim (see Attachment B). The section reads as follows:

> "The cost of a forensic rape examination or other physical examination conducted for the purpose of gathering evidence in any criminal investigation and prosecution under 18 Pa.C.S. Ch. 31 (relating to sexual offenses) and the cost to provide medications prescribed to the victim therein *shall not be charged* [emphasis added] to the victim. If appropriate insurance is unavailable, reimbursement may be sought pursuant to the provisions of section 477.9 of the act of April 9, 1929 (P.L. 177, No. 175), known as The Administrative Code of 1929."

§ 117.57. Religious and moral exemptions. This section allows a hospital to exempt itself from complying with § 117.53(a) (2) and (3) to offer or supply emergency contraception to a sexual assault victim "if doing so would be contrary to the stated religious or moral beliefs of the hospital." We believe that this exemption denies full and adequate care to a woman who has been sexually assaulted by placing an institution's or an individual health care provider's viewpoint before the critical health care needs of the woman.

We understand that you have carved out the mandate of prescribing EC when appropriate due to your interpretation of Pennsylvania's Religious Freedom Protection Act as stated in Section 902(a) of the act (35 P. S. § 448.902(a)). We draw your attention to the larger public interest issue at stake: women's health and women's right to health care. Not only should the state minimize discrimination, and avoid the "slippery slope" that could easily develop from this loophole exemption you are proposing; in our opinion, the Department should be advocating for good public policy that benefits the health of all of its residents equally and equally effectively. Denying a class of people a medically related service is offensive to the public interest and the traditions, morality and ethics of the State of Pennsylvania. Denial of such services to women could cause additional adverse consequences of pregnancy and childbirth, and a decline in the health of women.

As we understand it, the drug at the center of this issue is Plan B, an emergency contraceptive. The efficacy of this drug depends on how soon a woman is able to take it, with the medicine having little medical usefulness after 72 hours. By placing his or her own personal views ahead of the patient, a hospital, physician, pharmacist, or other health care provider is essentially making a decision for the woman when medication is refused. This also holds true for hospital policy that mandates that the health care provider refuse

to provide emergency contraception. This leaves the patient without the immediate treatment she may need. The result of the hospital's decision thus can have a devastating effect on the health and livelihood of that woman, in addition to the fact that she was not allowed to make her own choices.

As stated by the mother of the woman who was sexually assaulted in Lebanon County, PA in July 2006, refusing to provide emergency contraception is a second assault on the victim. In her faxed statement on Tuesday, October 17, 2006 to Pennsylvania NOW[1], the mother of the sexual assault victim, said,

> Medical care should not be about religion. I did not ask Dr. Gish [the emergency room physician at Good Samaritan Hospital in Lebanon County] to take the medication nor did I ask him to force someone to take it. We asked to be taken care of properly, counseled properly on all of our options, and given the legal medication we asked for.
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> His rights are not more important than my child. I understand that religious institutions would like to be exempt from giving rape victims options, counseling, and medication they need. But what if that is the only hospital near by or what if you are unconscious and are taken to a religious hospital?
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> Again I will say religion should have nothing to do with proper expectation and treatment of good medical care for everyone. Everyone should have a choice and a say in their medical decisions, especially someone who was sexually assaulted.
>
> My daughter was assaulted twice. Once by a man who forced her to have sex against her will and once by Dr. Gish who forced his religious beliefs on her and altered her medical care to what he wanted it to be.

It is also Pennsylvania NOW's and National NOW's position that allowing a practice of "refuse and refer" as a means of addressing this issue, allows and perpetuates discriminatory behavior. Informed decisions that cause discrimination against women and others are deemed intentional, so we urge the drafters of these regulations to consider the Pennsylvania NOW arguments, as detailed in this letter. We base our understanding on Pennsylvania State and federal law, health and public policy concerns, and the great risk of costs and liability to the state.

Pennsylvania's anti-discrimination law (Act of 1955, P.L. 744, No. 222, as Amended June 25, 1997 By Act 34 Of 1997, 43 P.S. §§ 951-963) does indeed protect people from discrimination on the basis of creed, which is broader than and includes religion. However, nothing in state or federal law permits religion to be used as a tool to take adverse action against those who profess a different belief. We do not see a clash of protected classes here. One class—women—desires and needs only that lawful medications be made available accurately and promptly. Another class—health care providers who believe that emergency contraception offends their belief structure—seek to impose those views on such women. We make no argument that the health care

providers with these beliefs should not hold those beliefs. However, Pennsylvania NOW wishes to be very clear. We believe that they may not legally impose the adverse effects of their own beliefs on women. In fact, we note that those women—who may be adversely affected should a rule such as the one under discussion be put into place—may have standing to bring complaints and lawsuits against the hospitals and parent corporations, and perhaps this agency that promulgates these proposed regulations.

We would also parenthetically note that Section 5.2 of the PA Human Relations Act does allow medical care personnel to object and refuse to participate in either abortion or sterilization procedures if they do so in writing (§5.2(a) of P.L. 744, No. 222). It also allows health care facilities to not "perform or permit to be performed, participate in, or cooperate in, abortion or sterilization by reason of objection thereto on moral, religious or professional grounds" (§5.2(b)(1) of P.L. 744, No. 222). It then states that neither individuals nor hospitals can be penalized under this act if they refuse to participate in either abortions or sterilizations. As noted, ONLY decisions about participating in ***abortion*** and ***sterilization*** are included in this section. It is therefore our opinion that since emergency contraception is not an abortifacient and thus neither a form of abortion or sterilization, allowing hospitals to exempt themselves from providing this service would further support our argument of sex discrimination as stated above.

We do not accept the Refuse and Refer policies argument as an adequate defense because it illegally segregates women and subjects them to the hardships of travel, time and medical treatment delay, without a basis in law or necessity. We certainly do not want to bring back the bad old days of illegal and dangerous non-medical treatments for women.

In addition to lack of full care, we are concerned about the process for certifying that a hospital meets the guidelines for taking this exemption. Nowhere in these proposed regulations – in either this section or in § 101.4 Definitions – is there a definition of what constitutes a religious hospital. It is unclear as to what a hospital needs to show other than a statement indicating they don't want to offer or provide EC. Can any hospital's board, with a majority vote decide that their hospital falls under this exemption? Even if that hospital's corporate basis is that of a public rather than a religious institution?

We raise this question because we fear that any hospital, regardless of ownership, could deny emergency contraception with this loophole. In the Lebanon County case mentioned above, could Good Samaritan Hospital use this exemption to deny emergency contraception to a sexual assault victim? Good Samaritan's mission statement says, "The Good Samaritan Health System (GSHS) is a ***non-sectarian*** [emphasis added] health system whose purpose is to provide high quality health services for the entire community.[3]" Yet they denied EC last summer to a sexual assault victim who clearly requested access to this legal medication. Would these rules allow them to continue that policy since they do not define themselves as a religious hospital? Because there is no clear definition as to what type of hospital qualifies under these proposed rules, you might be opening up a huge loophole that will deny access to women across the state. And in

3 http://www.gshleb.org/aboutus.cfm?id=16, retrieved November 1, 2006.

the rural counties where there is none or only one hospital in the county (27 of the 67 counties in PA according to the Duval Emergency Contraception Survey), this loophole could make it even harder for victims to receive complete medical services when they have been assaulted.

Given this limitation for full services in your proposed ruling, your provision that requires the hospital to provide full, medically accurate information on emergency contraception under § 117.56 (a) (1) as well as the mandate that hospitals using this exemption must give "oral and written notice to the sexual assault victim that those services are not provided at the hospital due to the services being contrary to the stated religious or moral beliefs of the hospital (§ 117.57 (1)) and then arrange for an immediate, no cost, transfer of the victim upon her request to a facility that provides full services ((§ 117.57 (2))" is a minimal compensation to this loophole. To ensure that this transportation is *actually offered and provided*, we believe that both the written and oral notice required of hospitals as described in Section 117.57 (1) must include this statement; hospitals also need to show how they will meet this requirement.

§ 117.58 Hospitals not providing sexual assault emergency services. This section appropriately recognizes that some hospitals are not equipped to provide sexual assault emergency services. This includes hospitals that do not provide emergency services or are specialized hospitals (e.g., rehabilitation hospitals). We agree with you that "ideally it would be of greater benefit to this Commonwealth to have sexual assault emergency services provided in as many locations as possible." And that it is appropriate for a hospital to determine that it is inappropriate to provide these services when "there is a greater risk to the victim and the integrity of future criminal prosecution if a sexual assault victim is treated at a hospital without the appropriate staff and equipment." We are especially pleased that you have created a mechanism whereby these hospitals must notify you as well as local emergency responders (law enforcement and ambulance and emergency medical care and transport services) within 30 days of the hospital's decision to opt out of providing these services. Since the trained sexual assault counselors usually work for local rape crisis centers, we would also recommend that the rules state that hospitals must also notify the local rape crisis centers when they make their decision to not provide sexual assault emergency services.

We are additionally appreciative that if a victim presents her/himself at one to these hospitals that they will immediately inform the victim that they do not provide the emergency services and IMMEDIATELY arrange for transportation to another nearby facility that services victims of sexual assault.

Privacy Issues. In reviewing these proposed rules, Pennsylvania NOW a noticed lack of ruling on two issues of concern for victims of sexual assaults. The first issue surrounds privacy for victims who are younger than 18 years of age. The second issue deals with the privacy of the records relating to any pregnancy testing or HIV/STD risk assessment.

Minor Victims of Sexual Assault. Minors may be the victims of familial sexual assault as well as victims of acquaintance/date rape and stranger rape. These victims, regardless of

the perpetrator, may be fearful of having parental involvement. This may be due to fear of retribution/violence by their parents or guardians. It could also be a result of embarrassment or guilt. In most cases, parental involvement would be helpful to the adolescent victim; your rules, however, need to ensure that minors have the absolute right given to them by medical privacy laws and regulations to make their own medical decisions without parental notification or consent if that is what they want. As part of this decision, the minor should not be required to provide parental insurance information if that information would result in informing the parents of treatment against the wishes of the victim.

According to the 2000 report from the Alan Guttmacher Institute on "Minors and the Right to Consent to Health Care," minors do have the capacity to make their own health care decision. The report also says, "[I]ndeed, the right to make important decisions about health care has been well established in federal and state policy. Many states specifically authorize minors to consent to contraceptive services, testing and treatment for HIV and other sexually transmitted diseases, prenatal care and delivery services, treatment for alcohol and drug abuse, and outpatient mental health care." You can read more of their analyses at http://www.agi-usa.org/index.html.

These concerns for privacy and confidentiality are backed up by a broad spectrum of the medical community. Access to confidentiality needs to be specifically adhered to for these young victims of sexual assault as stated below.

> **American Academy of Family Physicians:** "Concerns about confidentiality may discourage adolescents from seeking necessary medical care and counseling, and may create barriers to open communication between patient and physician. Protection of confidentiality is needed to appropriately address issues such as...unintended pregnancy." (Adolescent Health Care, 2001)
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> **American Academy of Pediatrics:** "Health care professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients...This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis....At the time providers establish an independent relationship with adolescents as patients, the provider should make...clear to parents and adolescents [that]...confidentiality will be preserved between the adolescent patient and the provider. (Confidentiality in Adolescent Health Care, 2004)
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> **American College of Obstetricians and Gynecologists**: "The potential health risks to adolescents if they are unable to obtain reproductive health services are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care for patients who request confidentiality. Therefore, laws and regulations that are unduly restrictive of adolescents' confidential access to reproductive health care should be revised." (Access to Reproductive Health Care for Adolescents, 2003)

American College of Physicians: "In the care of the adolescent patient, family support is important. However, this support must be balanced with confidentiality and respect for the adolescent's autonomy in health care decisions and in relationships with health care providers. Physicians should be knowledgeable about state laws governing the right of adolescent patients to confidentiality and the adolescent's legal right to consent to treatment." (Ethics Manual: Fourth Edition, 1998)

American Medical Association: "Our AMA...reaffirms that confidential care for adolescents is critical to improving their health....When in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care." (Confidential Health Services for Adolescents, 2004)

Society for Adolescent Medicine: "Confidentiality protection is an essential component of health care for adolescents because it is consistent with their development of maturity and autonomy and without it, some adolescents will forgo care....Health care professionals should support effective communication between adolescents and their parents or other caretakers. Participation of parents in the health care of their adolescents should usually be encouraged, but should not be mandated....Laws that allow minors to give their own consent for all or some types of health care and that protect the confidentiality of adolescents' health care information are fundamentally necessary to allow health care professionals to provide appropriate health care to adolescents and should be maintained." (Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine, 2004).

Privacy of Records. The Pennsylvania Crimes Code contains a Rape Shield Law[4] protecting victims of sexual assault from use of prior history of sexual conduct in the prosecution of an alleged perpetrator of sexual violence. Evidence collected during a sexual assault forensic exam and risk assessments for STD and pregnancy falls into this category of prior sexual behavior.

Despite this law, many victims of sexual assault as well as Sexual Assault Forensic Examiners may be reluctant to fully do a risk assessment for HIV/STD's and pregnancy for fear that the results of the exams, lab work, and risk assessment could be used against the victim in a court of law. We therefore believe that you may need to craft special

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4 Title 18 of the Crimes and Offenses Statute, Chapter 31, Subchapter A, § 3104 (a), contains a "General Rule" on admissible evidence. It states, "specific instances of the alleged victim's past sexual conduct, opinion evidence of the alleged victim's past sexual conduct, and reputation evidence of the alleged victim's past sexual conduct shall not be admissible in prosecutions under this chapter except evidence of the alleged victim's past sexual conduct with the defendant where consent of the alleged victim is at issue and such evidence is otherwise admissible pursuant to the rules of evidence." Retrieved from http://members.aol.com/StatutesP8/18PA3104.html on November 5, 2006.

protections of these records from the sexual assault exam to assure the victim and service providers of the confidentiality of these records so that the victim will feel comfortable enough to allow for a full assessment of these risks.

Overall we are pleased that you have crafted proposed rules for Sexual Assault Victim Emergency Services. We would like to see them revised to fully – and without discrimination – provide full access to the entire breadth of emergency services. We hope that you will carefully review our comments and improve the ruling where needed so that all victims of sexual assault receive compassionate quality care when they present themselves at a hospital here in Pennsylvania for treatment.

If you have any questions regarding our comments, please do not hesitate to call me. Thank you for your concern and commitment to quality care of our citizenry who have had to experience these types of traumatic events.

Sincerely,

Joanne L Tosti-Vasey

Joanne L. Tosti-Vasey, Ph.D.
President, Pennsylvania NOW, Inc.

Enc. 2

Attachments

Attachment A: 2006 Survey of Pennsylvania Hospitals About Their Provision of EC for Rape Victims

Attachment B: Act 20 of September 26, 1995, Special Session 1, P.L. 1056, No. 20, CL 18 Crimes Code

Attachment A: 2006 Survey of Pennsylvania Hospitals About Their Provision of EC for Rape Victims

2006 Survey of Pennsylvania Hospitals About Their Provision of EC for Rape Victims

Counties A-D Hospitals in Counties E-O Hospitals in Counties P-Z

Click on the links above to read about whether or not hospitals in your county provide emergency contraception to rape victims.

Background

Healthcare providers in emergency departments rely on strict protocols for treating heart attacks, brain injuries, and a multitude of other health situations requiring urgent care. Doctors and nurses follow a process--that's how emergency departments work. Yet, when it comes to offering and providing emergency contraception (EC) to rape victims as part of their emergency care, many hospitals fail to establish and act in accordance with a protocol. The Duvall Project's survey of emergency departments in Pennsylvania hospitals in 2002 revealed that 46% of hospitals routinely offered and provided EC to victims of sexual assault. The remaining 54% of hospitals surveyed did not have an established protocol for the provision of EC to rape victims. Many of these hospitals had informal procedures where EC provision was dependent upon the physician, EC was only offered by prescription, or EC nor any information about EC was offered to the patient. The number of hospitals routinely offering and providing EC to rape victims increased as some hospital information was updated, raising the percentage to 50%.

Nearly four years later and with an "EC in the ER" bill introduced into the Pennsylvania legislature (the Compassionate Assistance for Rape Emergencies Act was introduced in October 2005), the Duvall Project undertook the task of surveying Pennsylvania hospital emergency departments once again.

Methods

In January 2006, the Pennsylvania Coalition Against Rape (PCAR) sent a letter and survey to the CEOs of the 173 hospitals in our database from previous surveys. The letter explained the survey and its relevance to Pennsylvania's proposed Compassionate Assistance for Rape Emergencies (CARE) Act. Hospital personnel were asked to complete the survey and fax their responses to the Duvall Project of the ACLU of Pennsylvania. A low response rate prompted another mailing in May to the directors of hospital emergency departments. After a second mailing attempt, PCAR and the Duvall Project still had less than a 50% response rate.

During the months of July and August 2006, the Duvall Project and PCAR made additional attempts to reach hospital personnel via phone. Interviewers called each of the non-responding hospitals and asked to speak with a Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner (if the hospital had such a program), a nurse manager, the Director of the Emergency Department, or someone who would be most knowledgeable about the treatment of sexual assault patients. Hospital personnel were asked a series of questions related to the treatment of sexual assault patients with a particular focus on prophylaxis for pregnancy or emergency contraception (EC). The Duvall Project also contacted hospitals who had previously faxed survey responses but provided confusing or unclear answers.

Findings

Of the 173 hospitals surveyed, **82 (or 47.4%) indicated that they always offer to provide both doses of EC to rape victims in their emergency departments. These hospitals were designated with the color "green."** Some of these hospitals admitted to not having an established procedure in place for another physician to provide EC to the patient in cases where the attending physician refuses to provide it. These hospitals were coded as "green" with an asterisk, indicating that there is a possibility that a patient's care may be affected by this lacking protocol. Other hospitals, particularly in Philadelphia County, refer rape victims to neighboring hospitals that specialize in treating sexual assault patients. These hospitals were coded as "green" with an asterisk, noting what hospital patients are referred to.

Fifty-two (or 30.1%) of the hospitals were coded as "yellow." These hospitals varied in their responses and their practices regarding EC provision encompassed one or more of the following: EC is sometimes offered, a prescription for one or both doses of EC is/are offered (sometimes depending on the time of day), and/or it depends upon the doctor on duty whether or not EC is offered/provided. Some hospitals indicated that they were in the process of improving their services. This is noted with an asterisk next to the color designation. **Four (or 2.3%) of the hospitals were coded as "red."** These hospitals do not offer EC, do not provide EC on-site or by prescription, and do not provide information about EC to rape patients. **Five (or 2.9%) of the hospitals presented procedures surrounding the provision of EC that were "unclear."** This designation specifies that the hospital participated in the survey but interviewers were unable to color-code their confusing responses.

Thirty (or 17.3%) of the hospitals were categorized as "non-participating." These hospitals were unresponsive to both written and phone survey attempts, declined to participate when contacted by phone, hung-up on the interviewer, ended the call in the middle of the survey, referred the interviewer to the "risk management" department of their hospital, or were temporarily closed. Before hospitals were categorized as non-participating due to a lack of response, interviewers made three to six phone call attempts, leaving voice messages for the person identified as most knowledgeable about the treatment of sexual assault patients.

The phone surveys allowed interviewers to gain additional insight into the hospital personnel's knowledge of emergency contraception and their attitudes surrounding its provision. The nurse manager at one hospital stated, "We don't really see that many sexual assault patients here. In my seven years here, no one ever really asked for EC and I'm pretty sure we have never given it. Maybe we'd give a prescription . . . if asked." At another hospital, the Director of Emergency Medicine confused emergency contraception with the "abortion pill" RU-486. He also told the interviewer that if a doctor has a "moral or ethical objection" to providing patients with a prescription for EC, the patient is referred to the Department of Health.

Discussion

There was no marked change between the survey results of 2002 and 2006. After four years have passed, there still seems to be a great barrier to rape victims accessing EC in emergency departments across the state. While the 2006 survey categorized responses a bit differently, hospitals designated as "appropriate" in 2002 would be categorized as "green" in 2006. Therefore, a comparison of the percentages from each year serves useful in understanding how services have changed (or not changed) over a four year time period.

Conclusions

After years of investigating the practices regarding pregnancy prevention for sexual assault victims, the Duvall Project still finds a great lack of clarity surrounding hospitals' procedures regarding EC provision. Consequently, EC remains largely inaccessible to rape victims when they need it--in the emergency room. In addition, this survey highlights the inconsistency of care rape patients receive across hospitals in Pennsylvania. In another part of emergency medicine, Pennsylvanians would not accept this great lack of protocol.

A standardization of care is required to ensure that all rape victims are not being harmed by hospitals failing to provide comprehensive care. The CARE Act would guarantee that rape victims receive comprehensive care at whichever hospital they go to. With the FDA's recent approval of emergency contraceptive Plan B for individuals 18 and older, hospitals should be assured that this medication is a safe and effective means to prevent pregnancy and should still be made available to rape victims in emergency rooms. Regardless of whether this medication is available behind pharmacists' counters, EC is a critical component of a rape victim's care in emergency departments in Pennsylvania and nationwide.

Attachment B: Act 20 of September 26, 1995, Special Session 1, P.L. 1056, No. 20, CL 18 Crimes Code

CRIMES CODE (18 PA.C.S.) AND JUDICIAL CODE (42 PA.C.S.) - AMEND
Act of Sep. 26, 1995, Special Session 1, P.L. 1056, No. 20 Cl. 18
Special Session No. 1 of 1995
No. 1995-20

HB 127

AN ACT

Amending Titles 18 (Crimes and Offenses) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, authorizing the court to order an offender to pay the cost of a reward; further providing for exceptions to the interception and disclosure of communications by inmates of correctional institutions; and providing for costs for forensic examination for sexual offenses and criminal prosecution involving domestic violence.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Title 18 of the Pennsylvania Consolidated Statutes is amended by adding a section to read:

§ 1109. Costs.

In addition to any other sentence imposed, the court may order an offender to pay the cost of any reward paid for the apprehension and conviction of the offender.

Section 2. Section 5704 of Title 18 is amended by adding a paragraph to read:

§ 5704. Exceptions to prohibition of interception and disclosure of communications.

It shall not be unlawful under this chapter for:

* * *

(13) An investigative officer, a law enforcement officer or employees of the Department of Corrections for State correctional facilities to intercept, record, monitor or divulge any telephone calls from or to an inmate in a facility under the following conditions:

(i) The Department of Corrections shall adhere to the following procedures and restrictions when intercepting, recording, monitoring or divulging any telephone calls from or to an inmate in a State correctional facility as provided for by this paragraph:

(A) Before the implementation of this paragraph, all inmates of the facility shall be notified in writing that, as of the effective date of this paragraph, their telephone conversations may be intercepted, recorded, monitored or divulged.

(B) Unless otherwise provided for in this paragraph, after intercepting or recording a telephone conversation, only the superintendent, warden or a designee of the superintendent or warden or other chief administrative official or his or her designee shall have access to that recording.

(C) The contents of an intercepted and recorded telephone conversation shall be divulged only as is necessary to safeguard the orderly operation of the facility, in response to a court order or in the prosecution or investigation of any crime.

(ii) So as to safeguard the attorney-client privilege, the Department of Corrections shall not intercept, record, monitor or divulge any conversation between an inmate and an attorney.

(iii) Persons who are calling in to a facility to speak to an inmate shall be notified that the call may be recorded or monitored.

(iv) The Department of Corrections shall promulgate guidelines to implement the provisions of this paragraph for State correctional facilities.

Section 3. Title 42 is amended by adding sections to read:

§ 1726.1. Forensic examination costs for sexual offenses.

The cost of a forensic rape examination or other physical examination conducted for the purpose of gathering evidence in any criminal investigation and prosecution under 18 Pa.C.S. Ch. 31 (relating to sexual offenses) and the cost to provide medications prescribed to the victim therein shall not be charged to the victim. If appropriate insurance is unavailable, reimbursement may be sought pursuant to the provisions of section 477.9 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

§ 1726.2. Criminal prosecutions involving domestic violence.

(a) General rule.--In any criminal prosecution of an offense related to an incident involving domestic violence, of any type or grade, whether the charges were filed by private criminal complaint, by the police or by the district attorney, no fees, costs or fines associated with the filing of the criminal charges, the issuance or service of a warrant, protection order or subpoena and other generated costs shall be charged to the victim.

(b) Definition.--For purposes of this section, an offense related to an incident involving domestic violence shall be defined as any of the offenses or crimes set forth in Title 18 (relating to crimes and offenses), where the alleged perpetrator and victim have one of the relationships set forth in the definition of "family or household member" in 23 Pa.C.S. § 6102 (relating to definitions) or are persons who reside or resided temporarily or permanently in the same dwelling.

Section 4. The addition of 18 Pa.C.S. § 1109 shall apply to sentences imposed on or after the effective date of this act.

Section 5. This act shall take effect in 60 days.

APPROVED--The 26th day of September, A. D. 1995.

THOMAS J. RIDGE

House Bill 127 History

HB 127 By Representatives YOUNGBLOOD, COY, NICKOL, VANCE, VAN HORNE, ROBINSON, CHADWICK, DURHAM, BUXTON, GORDNER, MERRY, GANNON, FICHTER, STERN, LEVDANSKY, STEELMAN, BARLEY, RAYMOND, KENNEY, BUNT, CLYMER, M. COHEN, SEMMEL, MILLER, COLAIZZO, FARMER, S. H. SMITH, FARGO, STRITTMATTER, STABACK, WOGAN, E. Z. TAYLOR, NYCE, BARD, WALKO, LYNCH, JOSEPHS, STISH, TRELLO, SATHER, CLARK, DEMPSEY, FEESE, HERMAN, BELARDI, McGILL, STEIL, OLIVER, GLADECK, HERSHEY, PLATTS, CORNELL, B. SMITH, STAIRS, DiGIROLAMO, RYAN, PERZEL, TANGRETTI, D. W. SNYDER, PITTS, RAMOS, HORSEY and FLICK.

Prior Printer's Nos. 164, 172, 181. Printer's No. 183.

An Act amending Titles 18 (Crimes and Offenses) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, authorizing the court to order an offender to pay the cost of a reward; further providing for exceptions to the interception and disclosure of communications by inmates of correctional institutions; and providing for costs for forensic examination for sexual offenses and criminal prosecution involving domestic violence.

Referred to JUDICIARY, May 19, 1995
Reported as amended, June 6, 1995
First consideration, June 6, 1995
Re-committed to RULES, June 6, 1995
Re-reported as committed, June 12, 1995
Second consideration, June 12, 1995
Re-referred to APPROPRIATIONS, June 13, 1995
Re-reported as committed, June 14, 1995
Third consideration and final passage, June 15, 1995 (202-0)

In the Senate

Referred to JUDICIARY, June 19, 1995
Reported as amended, June 20, 1995
First consideration, June 21, 1995
Re-referred to APPROPRIATIONS, June 21, 1995
Re-reported as committed, June 26, 1995
Second consideration, June 26, 1995
Amended on third consideration, June 27, 1995
Third consideration and final passage, June 28, 1995 (49-0)

In the House

Referred to RULES, June 29, 1995
Reported as committed, Sept. 18, 1995
House concurred in Senate amendments, Sept. 19, 1995 (199-0)
(Remarks see House Journal Page 372-373), Sept. 19, 1995
Signed in House, Sept. 19, 1995
Signed in Senate, Sept. 19, 1995
In hands of the Governor, Sept. 20, 1995
Last day for action, Sept. 30, 1995
Approved by the Governor, Sept. 26, 1995
Act No. 20