Complying with the Law?

How Catholic hospitals respond to state laws mandating the provision of emergency contraception to sexual assault patients

Catholics for a Free Choice

A study conducted by Ibis Reproductive Health for Catholics for a Free Choice

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Catholics for a Free Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well being and respect and affirm the moral capacity of women and men to make sound decisions about their lives. Through discourse, education and advocacy, CFFC works in the United States and internationally to infuse these values into public policy, community life, feminist analysis and Catholic social thinking and teaching.

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This survey was conducted by Ibis Reproductive Health for Catholics for a Free Choice. Ibis Reproductive Health, headquartered in Cambridge, Massachusetts, conducts original research including clinical and social science studies, disseminates relevant new and existing information to women and groups that serve them and mentors others through internships and fellowships.

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Executive Summary

Each year in the United States, three million unintended pregnancies occur, half of which result in abortion.[1] In addition, five percent of women who have been sexually assaulted become pregnant as a result of the attack—with the majority undergoing elective abortion.[2] Women who have experienced sexual assault need comprehensive care and treatment and should have easy access to emergency contraception (EC).

EC—a concentrated dose of regular oral contraceptive pills—can be used to prevent pregnancy after unprotected intercourse, contraceptive failure or sexual assault. EC protects against pregnancy up to 120 hours after intercourse.[3] Research indicates that EC is more effective the sooner it is taken.[4]

Knowledge about EC has increased due to public education efforts and increasing media attention on restrictive hospital EC policies and the continued delay at the US Food and Drug Administration on a decision on over-the-counter access to Plan B®—the brand name for EC in the United States. Several states have taken steps to increase access to EC. As of November 2005, eight states have passed pharmacy access legislation, and nine states have passed "EC in the ER" bills.[5] Pharmacy access legislation allows women to buy EC directly from a trained pharmacist without a prescription; "EC in the ER" legislation requires hospital emergency departments to counsel and/or provide sexual assault patients with EC. Until EC pills are available over-the-counter in the US, states should continue to expand access by passing these two types of legislation.

Expanding access to EC is crucial because hospital emergency departments are often the first point of contact for women who have been sexually assaulted. A potential obstacle to the provision of EC in Catholic hospitals is the *Ethical and Religious Directives for Catholic Health Care Services* developed by the US Conference of Catholic Bishops.[6] These guidelines were designed to ensure that the nation's 611 Catholic hospitals do not violate Catholic teaching which prohibits the use of artificial contraception. Directive 36, however, sets forth circumstances under which Catholic teaching allows for the use of EC for "a female who has been raped to defend herself against a potential conception from the sexual assault…if, after appropriate testing there is no indication that she is pregnant." This guideline is well-intentioned, yet its complexity allows for interpretation and discretion on the part of local bishops, hospital administration and staff.

Catholics for a Free Choice (CFFC) commissioned Ibis Reproductive Health to conduct a survey to determine whether Catholic hospitals in states that have "EC in the ER" legislation are complying with those laws. At the time of this study, California, New Mexico, New York and Washington had explicit "EC in the ER" bills, while South Carolina had a statute specifying that the state will pay for the costs of routine care for sexual assault patients, including emergency contraception. This statute has been interpreted as mandating the provision of EC in the emergency department. No Catholic hospitals were operating in New Mexico at the time of data collection. None of the states' laws exempt Catholic hospitals from providing EC to sexual assault patients.

To gain a general understanding of hospital compliance with EC legislation in the four states, we conducted a two-phase study in mid-2005. First, we anonymously surveyed staff answering the telephone (i.e., mystery client survey) at all of the Catholic hospitals in the four target states to determine responses to an inquiry about the availability of EC at their hospital. Second, we surveyed sexual assault nurse examiners and/or nurse managers to document Catholic hospitals' written policies regarding EC-related services for sexual assault patients.

Our results show that 35% of respondents in the mystery client survey indicated that EC is not available at their hospital for sexual assault patients. Among these respondents, only about half (53%) gave the caller the name and telephone number of another facility where EC might be available; half of those referrals (53%) actually lead to a facility that provides EC. Unfortunately, few respondents in Washington and California took the opportunity to refer callers to a pharmacy where they could obtain EC without a physician's prescription. In addition, callers felt that 20% of respondents displayed a negative attitude towards them, which included being evasive, hanging up on them or scolding them.

We compared these results to a mystery client survey undertaken in 2002, and found that access to EC appears to have improved, particularly at the Catholic hospitals in South Carolina and New York. In 2002, 50% of hospital respondents in South Carolina, 45% in New York, 27% in California and 25% in Washington reported that EC was not available for any patients. In the most recent survey staff at many of the same hospitals reported that EC was now available either upon request or for sexual assault patients. One-fifth of respondents in California and Washington and nine percent in New York indicated EC was <u>not</u> available in 2005 although responses in the 2002 indicated that EC was available. New York's EC legislation was passed in 2004 while laws in California and Washington were passed in 2002, which may partly account for the differences in responses between surveys.

The hospital policy survey revealed that the number of Catholic hospitals that actually treat sexual assault patients was lower than expected. This is particularly true in California, where only 30% of hospitals in the policy survey reported treating sexual assault patients, and in South Carolina, where both participating hospitals reported that they transfer sexual assault patients elsewhere for care. Although there is no exemption for Catholic hospitals, the effectiveness of EC laws may be limited because they only apply to hospitals that treat sexual assault patients. While we must assume that most if not all hospitals will see women who have been sexually assaulted, the laws do not require all hospitals to at least provide EC before transferring the patient to another facility for a forensic examination. Among the Catholic hospitals that do treat sexual assault patients, most had written EC policies (76%) and routinely provided counseling (95%) and EC (86%). Nearly three-fourths of the hospitals that treat sexual assault patients had a full- or part-time sexual assault nurse examiner (SANE) on staff, which may be associated with having a written EC policy and routinely providing the medication.

Even in states with EC legislation, there still appear to be barriers to accessing EC at Catholic hospitals. When comparing hospital-level responses among facilities that reported treating sexual assault patients, only 51% of respondents in both the hospital policy and mystery client survey reported that EC was provided for these patients. Thirty percent of responses to the two surveys were contradictory; the hospital policy respondent indicated that EC was provided, but the mystery client respondent reported differently. Although 34 hospitals did not participate

in the hospital policy survey, nearly half (47%) reported to mystery clients that they provided EC to sexual assault patients.

Catholic hospitals in California, New York and Washington appear to comply with state EC laws for the most part. However, there is room for improvement. First, the number of discrepancies between responses to the mystery client and hospital policy surveys suggests that there is a need to better communicate the hospital's EC policy (or lack thereof) to all staff. Second, the number of hospitals where EC was reportedly available in the 2002 survey but not available in 2005 is a cause for concern. We cannot determine if there was an actual decline in the availability of EC, even after the passage of legislation, or if there has been a continued lack of communication about the status of EC. Third, the poor referral rate indicates the need for hospital staff to keep information on-hand to help ensure that women who have been sexually assaulted are appropriately informed about their rights and are thus able to pursue EC treatment either at another facility or directly from a pharmacist where possible. Lastly, hospital staff addressing sexual assault victims in a hostile manner are not providing a compassionate response and may even dissuade an already distraught woman from seeking care.

The fact that so many of the Catholic hospitals do not treat sexual assault patients raises the question of whether these women have timely access to EC. Are Catholic hospitals choosing not to treat sexual assault patients to circumvent EC legislation? The effectiveness of EC laws appears limited because they only apply to hospitals that treat sexual assault patients and do not require all hospitals to at least provide EC before transferring patients to another facility. Sexual assault patients' access to the full range of hospital services is an area in need of more research. Another area of future research would be to evaluate how certain aspects of EC legislation affect compliance with state law. In the absence of an enforcement mechanism, for example, Catholic hospitals could choose not to comply with EC legislation without the risk of a penalty. Given the gaps in access to EC, it is essential that we seek to expand and enforce laws that serve to protect the religious freedom, conscience and health of women.

Report highlights:

- 35% of mystery client respondents indicated that EC was not available under any circumstances at their hospital.
- 47% refused to provide callers with a referral to another facility for EC and of those who did receive a referral, 47% did not lead to another facility that could provide EC.
- Few respondents in Washington and California (where EC is available directly from pharmacists) referred callers to a pharmacy that provides EC.
- Callers felt that 20% of respondents had a negative attitude towards them, which included being evasive, hanging up on them or scolding them.
- Only 62% of hospitals reported treating sexual assault patients.
- Of these, 76% have a written EC protocol, 95% routinely provided EC counseling and 86% routinely offered EC.
- Among hospitals that reported treating sexual assault patients, only 51% also indicated in the mystery client survey that EC was available; the other half either misinformed callers or didn't know about the availability of EC.

- In almost a third of cases (30%) responses were contradictory; the hospital policy respondent indicated that EC was provided, but the mystery client respondent reported differently.
- 20% of hospital respondents in California, 19% in Washington and nine percent in New York who reported that EC was available during a 2002 survey now report that EC is not available under any circumstance during the 2005 survey.

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Introduction

Why emergency contraception is important

Each year in the United States, three million unintended pregnancies occur, half of which result in abortion.[1] In addition, five percent of women who have been sexually assaulted become pregnant as a result of the attack with the majority undergoing elective abortion.[7] Emergency contraception (EC)—a concentrated dose of regular oral contraceptive pills—can be used to prevent pregnancy after unprotected intercourse, contraceptive failure, or sexual assault. EC is taken within 120 hours of unprotected intercourse and works primarily by inhibiting ovulation.[8] Because EC can reduce the risk of pregnancy by at least 75%,[4] it has the potential to greatly reduce the number of unintended pregnancies and abortions that occur.

Availability of EC

Knowledge and use of EC have increased substantially in the past decade. However, access to EC remains limited because many women still do not know about it and clinicians do not routinely counsel about its use. There are also structural barriers that limit women's ability to access EC in a convenient and timely manner; the US Food and Drug Administration has refused to approve the dedicated EC product Plan B® for over-the-counter sales, despite the recommendations of its advisory committees and professional staff.

A number of states have tried to expand access to EC through two legislative measures. As of November 2005, eight states have passed pharmacy access legislation, while nine states have passed "EC in the ER" bills.[5] Pharmacy access enables women to obtain EC directly from a pharmacist without a physician's prescription under certain condition while "EC in the ER" laws mandate that hospitals must counsel sexual assault patients about EC and/or make it available to them upon request.

"EC in the ER" laws are important because women who have been sexually assaulted deserve immediate and comprehensive attention and a hospital emergency department is often the first point of contact for care following an assault. Women who have been sexually assaulted should be given clear information about the availability of EC, including direct pharmacy access in those states that have it.

Catholic hospital coverage

Catholic hospitals provide a substantial proportion of all care in the US. Of all hospitals that provide emergency care, 13% are Catholic. Of the roughly 107 million emergency department visits in the US in 2000, 15% occurred at Catholic hospitals.[9] In the four states we surveyed for this report, Catholic hospitals constituted a significant proportion of all hospitals with emergency departments: 38% in Washington, 23% in New York, 18% in California and eight percent in South Carolina.

Previous studies have indicated that Catholic hospitals are less likely than secular hospitals to provide EC to sexual assault patients. A 2002 survey of Catholic hospitals conducted by Ibis Reproductive Health for Catholics for a Free Choice found that only five percent of Catholic hospitals provide EC on request to all women, while 23% of hospitals make EC available to victims of sexual assault.[10] In contrast, 17% of non-Catholic hospitals surveyed the following year provide EC for sexual assault patients and 17% provided EC upon a patient's request.[11]

Catholic *Directives*

A number of religious organizations own hospitals in the US, but Catholic facilities observe a specific set of guidelines on how to care for patients. The involvement of the Catholic church in health care provision has important implications for women's health because Catholic hospitals operate under the *Ethical and Religious Directives for Catholic Health Care Services* established by the US Conference of Catholic Bishops. These *Directives* include instructions on certain medical issues that are in conflict with Catholic doctrine. More specifically, the *Directives* prohibit provision of direct abortion and voluntary sterilization in Catholic hospitals. The *Directives* also state that "Catholic health care institutions may not promote or condone contraceptive practices."[6] Directive 36 permits the use of EC for victims of sexual assault if the woman is not pregnant.

As EC became the standard of treatment for sexual assault patients, Catholic ethicists, health care providers and bishops attempted to balance the prohibition of contraception and abortion with an increased demand within the Catholic health community for a compassionate response to women who have been sexually assaulted. Because one possible mechanism of action of EC is the prevention of implantation of a fertilized egg, hardliners within the Catholic community argue that EC could be an abortifacient and should therefore be prohibited in any circumstance. These Catholics consider pregnancy to be fertilization of an ovum, not the medical definition of pregnancy which is implantation of a fertilized ovum; thus, medication that prevents implantation causes an abortion. But Catholic authorities were aware that EC also acted to prevent fertilization, which would be considered contraception not abortion. Although the church forbids contraception, Directive 36 sets forth circumstances under which Catholic teaching allows for the use of EC for "a female who has been raped to defend herself against a potential conception from the sexual assault…if, after appropriate testing there is no indication that she is pregnant."

Implementing Directive 36

This guideline is well-intentioned, yet its complexity allows for interpretation and discretion on the part of local bishops, hospital administration and staff. Each Catholic hospital is free to interpret the Directive and implement either a liberal or a conservative policy. That process is subject to pressure typically from conservative bishops and lay Catholic groups calling for strict application of Catholic teachings in Catholic health facilities. They argue that sexual assault is not an acceptable reason for abortion therefore it should not be an acceptable reason for contraception.

Some aspects of the Directive are meaningless. For example, the Directive suggests that providers administer a pregnancy test to each sexual assault patient. Because EC must be given within five days of intercourse, a pregnancy test will not identify an established pregnancy. A pregnancy test can only tell if a woman was already pregnant prior to the assault. EC does not affect an existing pregnancy,[12] therefore even if a women was unknowingly pregnant, the EC would not cause an abortion. Either way, the pregnancy test satisfies neither the medical need nor Catholic teaching.[13] It only creates a barrier between the sexual assault patient and protection from pregnancy.

Very conservative Catholic ethicists suggest that the Directive requires more than a pregnancy test. Rev. Kevin O'Rourke, director of the Center for Health Care Ethics at St. Louis University, has interpreted the Directive to mean that Catholic hospitals should administer ovulation tests to sexual assault patients before giving EC. In his view, if the ovulation test and the date of the woman's last menstrual period suggest that she has not yet ovulated, then the EC may delay ovulation and avert a pregnancy, a process consistent with Catholic doctrine. If the woman is currently ovulating, he recommends that EC should not be given.[14] This is unworkable for two reasons. First, an ovulation test cannot identify the moment of ovulation as accurately as O'Rourke suggests. Second, an ovulating woman is *most* at risk of pregnancy and in need of EC. To deny a sexual assault patient EC because she is ovulating is to defeat the reason for giving EC. Again, the ovulation test would constitute a useless exercise for sexual assault patients.

Previous studies demonstrating the challenges faced by sexual assault patients at Catholic hospitals have garnered much attention from the public and from several state governments. Reproductive health advocacy groups have petitioned Catholic hospitals to implement EC policies so that sexual assault patients are provided with EC-related services and several states have passed legislation requiring hospital emergency departments to provide sexual assault patients with information about EC and to dispense the medication upon request.

State Laws and Regulations

Leading national medical organizations, including the American College of Obstetricians and Gynecologists, American College of Emergency Physicians and the American Medical Association, recognize EC as a critical part of the standard of care for sexual assault patients in hospital emergency departments. However, in a revised edition of the "National Protocol for Sexual Assault Medical Forensic Examination," the Department of Justice made a glaring omission by failing to include information on counseling about pregnancy prevention and the provision of EC to sexual assault patients. To ensure that sexual assault patients receive compassionate and appropriate treatment, nine states have enacted laws mandating hospitals provide EC-related services to sexual assault patients.

At the time that this study was undertaken, California, New Mexico, New York and Washington had legislation requiring hospital emergency departments to provide sexual assault patients with information about EC and to dispense the medication upon request. In addition, South Carolina enacted a statute pertaining to emergency contraception for sexual assault victims as part of South Carolina's Victims' Rights Amendment. This statute has been

interpreted as requiring the provision of EC in hospitals that treat sexual assault patients, although it only explicitly sets forth what the state will pay for in order to ensure that sexual assault patients are not denied treatment if they are unable to pay.

Appendix 1 provides an overview of "EC in the ER" legislation in the five states. Each state's law varies with respect to the types of hospitals to which the statute applies, the types of restrictions on EC provision and the existence of an enforcement mechanism. None of the states' laws exempt Catholic hospitals from the requirement that they provide EC to sexual assault patients.

As indicated in the appendix, all of the state laws apply only to hospitals that provide emergency care for sexual assault patients. If a hospital stabilizes a sexual assault patient then transfers her to another facility for a forensic sexual assault examination, the hospital could be classified as not treating sexual assault patients, and clearly some hospitals have taken this option. Further research needs to be done to determine how often this occurs and how it affects the standard of care for women who are transferred. It is unclear whether laws requiring the dispensation of EC have any impact on the decision to treat sexual assault patients.

Sexual assault nurse examiner programs have been established throughout the country to provide sexual assault examinations and to collect forensic evidence. These programs were designed to reduce treatment delays, to provide a coordinated approach to treatment and care and to decrease the chance of inadequate examination. Establishing a sexual assault nurse examiner program requires significant financial investments for staff training, materials and equipment, as well as accreditation by a state department of health or forensic nurse association.[15] For hospitals that have few sexual assault patients, it may be difficult for specially-trained staff to remain highly skilled and the hospitals may not deem it affordable to invest in the resources necessary to adequately treat these patients.[15] Regardless of whether hospitals treat sexual assault patients, they have the opportunity to provide EC prior to transferring patients for further care and treatment.

The laws in California and South Carolina state that a hospital must provide EC "if indicated," for example, if the patient experienced unprotected sexual contact. In California, law enforcement authorities are supposed to be notified when a woman has been sexually assaulted and requests a forensic examination. In practice, this means that if a woman chooses not to report the assault to law enforcement and does not have a forensic examination, she may not have routine access to EC. The laws in Washington and New York specify that hospitals may provide EC to sexual assault patients who are not already pregnant. This language may have been added to the statutes in order to satisfy Catholic hospitals' interpretation of Directive 36. However, there are no contraindications to using EC, the pills are not harmful to a pregnant woman or her fetus, and the dedicated EC product, Plan B®, has very few side effects. Therefore, the potential benefit of taking EC, even unnecessarily, outweighs the delay of a hospital requiring a pregnancy test prior to providing EC.

New York, Washington and New Mexico have enforcement mechanisms that direct complaints of violations to the state department of health for investigation. In addition, a hospital in New Mexico may be fined $1,000 or have its license revoked in the case of numerous unresolved complaints. Hospitals in California and South Carolina, however, are not subject to any penalties for not complying with the legislation, potentially limiting the effectiveness of these laws.

This study explores compliance with state "EC in the ER" laws and highlights the differences between Catholic hospitals' policies and the experiences of callers inquiring about the availability of EC.

Methodology

In September 2004, we identified 100 Catholic hospitals operating in California, New York, South Carolina and Washington State.[16] We compiled the hospital list using the Catholic Health Association website. We excluded one hospital because it had ceased operations and two hospitals because they are currently controlled by a non-Catholic entity. Another three hospitals were excluded because they only treat specific populations (e.g., hospice, psychiatric cases). The final analysis included 94 Catholic hospitals: 41 in California, 33 in New York, four in South Carolina and 16 in Washington. Researchers entered and analyzed data using SPSS version 11.5 statistical software.

Mystery client survey

In April 2005, study staff telephoned 94 Catholic hospital emergency departments to assess the likelihood that a female client calling to inquire about EC would have access to either the pills or a prescription. Trained female interviewers followed a written script and recorded responses on pre-coded forms. Interviewers made up to three attempts to contact each hospital.

We conducted the survey during weekend hours to simulate the experience of a woman who had unprotected intercourse on a Thursday evening and was seeking EC outside of regular clinic hours. The study used a "mystery client" approach whereby female interviewers anonymously spoke with staff fielding calls in the emergency room and began by asking "Do you give out emergency contraception?" If the hospital staff indicated that they do not dispense EC under any circumstances, the caller asked specifically about the provision of EC for sexual assault patients and the need for a pregnancy test. If EC was not available even in the case of sexual assault, the caller requested the name and telephone number of another facility where she could obtain EC. Callers then pursued referrals until they reached a dead end (i.e., were not offered EC, nor a prescription, nor a referral to another facility) or were told they could obtain EC.

Hospital policy survey

We conducted the research for this portion of the project in May and June 2005 to document official hospital policy regarding provision of EC for victims of sexual assault and to assess compliance with state law. Trained female interviewers called each hospital, asked to speak to the sexual assault forensic examiner, the sexual assault nurse examiner or the nurse manager in the emergency department. The interviewers then followed a written script and recorded responses on pre-coded forms. Interviewers made up to three attempts to contact an appropriate respondent at each hospital.

Once the appropriate person was reached, the interviewer described the project and invited the respondent to participate. If the respondent agreed to participate but stated that their hospital refers all sexual assault patients to another facility, these hospitals were classified as not treating sexual assault patients and the interviewer did not continue with the survey.

To further explore whether EC policies were being followed at a subset of Catholic hospitals, we interviewed 13 rape crisis advocates. Although this is a small sample and thus not generalizable to all hospitals in this study, the results provide supplemental information for certain stakeholders. (See Appendix 4.)

Results

Mystery client survey

Respondents to the mystery client survey indicated that access to EC was limited for sexual assault patients. Only one-third of respondents (37%) said that EC was available for sexual assault patients at their hospital, and many of these hospitals would require a pregnancy test, physical examination and/or notification of police (Table 1). Other key findings include:

- 35% of respondents said that EC was not available under any circumstance.
- only 7% reported that EC was available upon request for all women.
- 14% of respondents indicated that provision of EC was at the discretion of the physician treating the patient.
- 6% of respondents did not know, were unclear or did not respond to the inquiry.

**Table 1:
Number and Percent of Respondents Who Said EC is Available at Their Facility, by Circumstance and State**

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	94	41	33	4	16
No, regardless of circumstance	33 35%	19 46%	7 21%	2 50%	5 31%
Sexual assault and pregnancy test/exam	17 18%	2 5%	8 24%	1 25%	6 38%
Doctor's discretion	13 14%	5 12%	6 18%	1 25%	1 6%
Sexual assault (no other restriction)	10 11%	3 7%	5 15%	0 0%	2 13%
Yes, on request	7 7%	5 12%	2 6%	0%	0 0%
No response/don't know/unclear	6 6%	3 7%	2 6%	0 0%	1 6%
Sexual assault and doesn't know about pregnancy test	4 4%	2 5%	1 3%	0 0%	1 6%
Sexual assault and report to police*	4 4%	2 5%	2 6%	0 0%	0 0%

*Includes responses where examination and pregnancy test may also be required.

Hospital-level results are included as Appendix 2.

We compared the results of the mystery client survey conducted among the same hospitals in 2005 and 2002. Generally, about half of respondents in California (44%), Washington (44%) and South Carolina (50%) reported the availability of EC to be the same in both surveys (Table 2). In 2002, 50% of hospital respondents in South Carolina, 45% in New York, 27% in California and 25% in Washington reported that EC was not available for any patients; however, in the most recent survey, staff at these hospitals were more likely to report that EC was available either upon request or for sexual assault patients. But, 20% of hospital respondents in California, 19% in Washington and nine percent in New York who reported that EC was available in 2002, reported that EC was not available under any circumstance in the 2005 survey. New York's EC legislation was passed in 2004 while laws in California and Washington were passed in 2002, which may partly account for the differences in responses between surveys, at least where availability stayed the same or improved.

Table 2:
A Comparison of Results from the 2002 and 2005 Mystery Client Surveys on the Availability of EC in 2002 and 2005, by State

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	94	41	33	4	16
Availability unchanged	35	18	8	2	7
	37%	4%	24%	50%	44%
Availability no longer restricted	32	11	15	2	4
	34%	27%	45%	50%	25%
Availability more restricted	14	8	3	0	3
	15%	20%	9%	0%	19%
Unclear response*	13	4	7	0	2
	14%	10%	21%	0%	13%

*An unclear response was given to the question in one of the two surveys; therefore the results cannot be compared.

When hospital staff indicated that EC was not available under any circumstance or they gave an unclear response, only about half (53%) then provided callers with a name and telephone number of another facility where EC might be available (Table 3). Respondents most frequently referred callers to another hospital (79%). EC is available directly from pharmacists in Washington and California without a prescription, however, one-half of respondents in Washington and only 10% of respondents in California referred callers to a pharmacy where EC is available.

Most of the referrals that were provided by hospital staff were not effective. About one-half (53%) of the referrals led directly to EC, while 42% led to a dead end, including wrong telephone numbers and places that did not offer EC or an additional referral for it.

Table 3:
Among Hospitals that Do Not Provide EC for Any Circumstance, Number and Percent of Respondents Who Gave a Referral and the Outcome of the Referral Process

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	36*	20	8	2	6
Referrals to another facility					
Referral given	19 53%	10 50%	3 38%	2 100%	4 67%
Outcome of referral					
Led to EC	10 53%	5 50%	3 100%	0 0%	2 50%
Dead end	8 42%	4 40%	0 0%	2 100%	2 50%
Doctor's discretion	1 5%	1 10%	0 0%	0 0%	0 0%

*Includes three respondents that provided unclear responses.

Overall, hospital staff responded to inquiries about EC in a neutral or positive manner, although callers felt that 20% of respondents displayed a negative attitude towards them. Respondents in New York were most likely to express a negative attitude toward callers.

Table 4:
Number and Percent of Respondents by Attitude toward Callers

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	94	41	33	4	16
Neutral	43 46%	20 49%	12 36%	2 50%	9 56%
Positive	32 34%	15 37%	10 30%	1 25%	6 38%
Negative	19 20%	6 15%	11 33%	1 25%	1 6%

Among those respondents with a negative attitude:

- 39% were perceived as being somewhat evasive
- 28% hung up on callers
- 22% were considered to be unhelpful
- 12% either were either completely disinterested in the issue or scolded the caller.

Hospital policy survey

The hospital policy survey results revealed a series of interesting findings. Sixty hospitals agreed to participate in this portion of the study, for a response rate of 64%. Among those who agreed to participate, 38% of respondents reported that their hospital does not treat sexual

assault patients and instead refers them to another facility for treatment (Table 5). Among the remaining 37 hospitals, 33 were able to provide an estimate of the number of sexual assault patients treated at their hospital in the 12 months prior to the survey. On average, 61 sexual assault patients were treated (range: 0-550; median=25). A state-by-state analysis shows that:

- Both participating hospitals in South Carolina reported that they transferred sexual assault patients elsewhere for care.
- 70% of Catholic hospitals in California referred sexual assault patients to another site.
- All of the hospitals in New York and 83% of the hospitals in Washington reported treating sexual assault patients.

Table 5:
Number and Percent of Hospitals that Treat Sexual Assault Patients*

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	60	27	19	2	12
Treats sexual assault patients	37	8	19	0	10
	62%	30%	100%	0%	83%
Refers sexual assault patients	23	19	0	2	2
	38%	70%	0%	100%	17%

*Among hospitals that agreed to participate in the survey.

Among the hospitals that treated sexual assault patients, 76% have a written protocol for providing EC to sexual assault patients (Table 6): 88% in California, 79% in New York, and 60% in Washington.

The vast majority of hospitals (95%) reported that they always or sometimes counseled sexual assault patients about EC. All hospitals in New York and California, and 80% in Washington, reported that they routinely counseled sexual assault patients about EC.

While the vast majority of hospitals reported counseling sexual assault patients about EC, fewer hospitals routinely offered EC to their patients. Eighty-six percent of hospitals reported that they always or sometimes offered EC to their sexual assault patients, while 14% of respondents did not know whether their hospital routinely made EC available to sexual assault patients. Among the six hospitals that only sometimes offered EC, five indicated that provision was based on the results of a pregnancy test while one reported that the decision was at a doctor's discretion. Hospital-level results are included in Appendix 3.

Table 6:
Characteristics of Hospitals that Treat Sexual Assault Patients, by Number and Percent of Respondents

		State		
	Total	**CA**	**NY**	**WA**
N	37	8	19	10
EC in written protocol				
Yes	28 76%	7 88%	15 79%	6 60%
No	3 8%	0 0%	2 11%	1 10%
Don't know	6 16%	1 12%	2 11%	3 30%
Routinely counseled about EC				
Always	30 81%	7 88%	16 84%	7 70%
Sometimes	5 14%	1 13%	3 16%	1 10%
Never	0 0%	0 0%	0 0%	0 0%
Don't know	2 5%	0 0%	0 0%	2 20%
Routinely offered EC				
Always	26 70%	5 63%	13 68%	8 80%
Sometimes	6 16%	1 13%	4 21%	1 10%
Never	0 0%	0 0%	0 0%	0 0%
Don't know	5 14%	2 25%	2 11%	1 10%

The majority of hospitals that provided EC (74%) gave EC to their patients on-site with most providing Plan B®. The remaining hospitals provided patients with a prescription, or the respondent did not know how EC was provided at their hospital.

Table 7:
EC Provision Practices among Hospitals that Always or Sometimes Offer EC to Sexual Assault Patients*

		State		
	Total	**CA**	**NY**	**WA**
N	31*	5	17	9
How is EC provided				
On-site	23 74%	4 80%	14 82%	5 56%
By prescription	6 19%	0 0%	2 12%	4 44%
Don't know	2 6%	1 20%	1 6%	0 0%
Type of EC offered				
Plan B	14 45%	4 80%	4 24%	6 67%
Preven	3 10%	0 0%	3 18%	0 0%
Oral contraceptives	4 13%	1 20%	3 18%	0 0%
Don't know	10 32%	0 0%	7 41%	3 33%

*One response is missing for these two questions.

Most respondents indicated that their hospital had a sexual assault nurse examiner (SANE) program on a full- or part-time basis, with California and New York having a higher proportion of hospitals employing this program. Among hospitals that have a full- or part-time sexual assault nurse examiner program, 48% always and 22% sometimes (i.e., based on the result of pregnancy test) provided EC (data not shown).

Table 8:
Number and Percent of Respondents Who Report Having a SANE Program

		State		
	Total	**CA**	**NY**	**WA**
N	37	8	19	10
SANE on duty				
Full-time	13 35%	3 38%	6 32%	4 40%
Part-time/On-call	14 38%	4 50%	9 47%	1 10%
No on-site SANE program	9 24%	1 13%	3 16%	5 50%
Don't know	1 3%	0 0%	1 5%	0 0%

In some cases, there were discrepancies between what the hospital policy respondent reported about hospital practice and what the mystery-client callers were told when they called the emergency department. When comparing hospital-level responses among those that treat sexual assault patients, only 51% of responses to the mystery client survey matched the response given in the policy survey regarding provision of EC (Table 9). Thirty percent of responses to the two surveys were discordant, while responses for 19% of hospitals were unable to be compared because of unclear responses to the question of EC provision in one of the two surveys.

Table 9:
Number and Percent of Policy Responses that Correspond to Mystery Client Responses Regarding the Availability of EC*

		State		
	Total	**CA**	**NY**	**WA**
N	37	8	19	10
Concordant responses	19	5	11	3
	51%	63%	58%	30%
Discordant responses	11	1	5	
	30%	12%	26%	50%
Don't know	7	2	3	2
	19%	25%	16%	20%

*Responses were to the question of whether the hospital provides EC "for sexual assault patients" or "upon request."

Table 10 shows that 26% of hospitals reported not treating sexual assault patients during the hospital policy survey, yet the mystery client callers were told that EC was available at these same hospitals. This discrepancy makes it difficult to know how sexual assault patients would be treated if they went to these hospitals.

Table 10:
Number and Percent of Mystery Client Respondents Reporting that EC is *Not* Available Among Hospitals That Do *Not* Treat Sexual Assault Patients

		State		
	Total	**CA**	**NY**	**WA**
N	23	19	2	2
Concordant responses	14	11	1	2
	61%	58%	50%	100%
Discordant responses	6	5	1	0
	26%	26%	50%	0%
Don't know	3	3	0	0
	13%	16%	0%	0%

Although 34 hospitals did not respond to the hospital policy survey, responses during the mystery-client portion help shed light on how these hospitals may treat sexual assault patients. As Table 11 shows, nearly one-half of hospitals that did not respond to the policy survey indicated during the mystery client survey that they provide EC to sexual assault patients, while approximately one-third reported that EC was not available under any circumstance.

Table 11:
Number and Percent of Responses to the Mystery Client Survey among Hospitals that Did Not Respond to Policy Survey, Number and Percent of Responses to the Mystery Client Survey

		State			
	Total	**CA**	**NY**	**SC**	**WA**
N	34	14	14	2	4
Sexual assault (with or without restrictions)	16	5	6	1	4
	47%	36%	42%	50%	100%
No, regardless of circumstance	11	6	4	1	0
	32%	43%	29%	50%	0%
Doctor's discretion	6	2	4	0	0
	18%	14%	29%	0%	0%
Yes, upon request	1	1	0	0	0
	3%	7%	0%	0%	0%

Individual-level comparisons for all hospitals are presented in the last two columns of Appendix 3.

Summary

The results from this study show that most Catholic hospitals that treat sexual assault patients in California, New York and Washington have written EC policies and routinely provide EC-related services. Nearly three-fourths of the hospitals that treat sexual assault patients had a full or part-time sexual assault nurse examiner on staff, which may be positively associated with having a written EC policy and routinely providing EC-related services.

However, even in the states with EC legislation there still appear to be barriers to EC at Catholic hospitals. First, there were discrepancies between what some hospitals reported as policy and the information mystery clients were given by hospital staff. If a hospital does not treat sexual assault patients, staff should be able to provide EC or refer the patient to the closest facility that offers the necessary services. In states where pharmacy access is available, hospital staff should inform callers about the availability of EC at community pharmacies. Second, the number of hospitals where EC was reportedly available in the 2002 survey but restricted in 2005 is a cause for concern. It is impossible to determine whether there was an actual decline in availability or if consistent and concrete information continues to be elusive.

Women who have been sexually assaulted and are given misinformation about the availability of EC face unnecessary delays and perhaps an unintended pregnancy. Communicating a hospital's EC policy to all staff and having accurate referral information on-hand can help ensure that women who have been sexually assaulted are appropriately informed about their rights and are thus able to pursue EC treatment. In addition to being aware of hospital policy, staff should be sensitive to the needs of prospective patients. Callers during the mystery client survey felt that a fair number of respondents were hostile towards them. Staff addressing sexual assault victims in such a manner are not providing compassionate care and may even dissuade an already distraught woman from seeking services.

The number of Catholic hospitals treating sexual assault patients was lower than expected. This is particularly true in California, where 70% of hospitals that responded to the policy survey did not treat sexual assault patients. These hospitals are not violating state law because the EC legislation only applies to hospitals that provide emergency care, services or examinations to sexual assault patients. However, the fact that so many Catholic hospitals do not treat sexual assault patients raises the question of whether all women have access to needed health services. Hospitals that do not already have an EC policy should consider developing guidelines for EC provision regardless of whether they conduct sexual assault forensic examinations. Furthermore, assessing sexual assault patients' access to a range of hospital services is an area in need of more research. Another area of future research would be to evaluate how certain aspects of EC legislation, such as an enforcement mechanism, affect compliance with state law. In the absence of an enforcement mechanism, for example, Catholic hospitals could choose not to comply with EC legislation without the risk of a penalty. Given the gaps in access to EC, states should continue to expand access through legislative means, including a viable enforcement mechanism.

There are possible limitations to our findings. The Catholic hospitals that provided EC-related services may have been more likely to agree to participate than those that do not give information or provide EC. However, the majority of hospitals that did not participate in the policy survey were actually failed contact attempts rather than outright refusals. Hospital staff who refused to participate or did not return our phone calls may work in a facility that does not treat sexual assault patients; therefore, they may have felt that the survey was not applicable to their hospital. Because we are not able to confirm reasons for non-participation, we can not assess whether the non-participating hospitals are complying with state legislation.

Conclusion and Recommendations

It is important that states continue to pass EC legislation mandating that women who have experienced sexual assault are provided with appropriate treatment. Although legislation does not guarantee compliance by hospitals, it does raise awareness about the rights of patients to prevent pregnancies resulting from sexual assault, and it puts pressure on hospitals to provide comprehensive and compassionate care. Hospitals also must ensure that staff are trained to provide EC or a referral to another facility or a pharmacist.

It is somewhat heartening to find that among the Catholic hospitals that do treat sexual assault patients, most have written EC policies (76%) and routinely provided counseling (95%) and EC (86%). We would prefer these figures to be 100%, but they are a significant improvement on a nationwide survey we carried out in 2002 when only 28% of Catholic emergency departments provided EC to women who had been sexually assaulted.

Hospitals, especially nonprofit hospitals, are community assets and have a duty to provide the health care that the community needs. Women who have been sexually assaulted need to be offered a comprehensive regimen of care. The provision of emergency contraception in these circumstances has become a standard of medical care endorsed by the country's leading medical associations, including American Medical Association and the American College of Obstetricians and Gynecologists. All health care institutions that counsel or treat women who have been sexually assaulted should inform, provide or meaningfully refer women for emergency contraception.

The fact that several state legislatures and health authorities now require that emergency contraception be offered to women who have been sexually assaulted is a welcome development. These laws are an important advance in ensuring women's health and well being. However, the fact that many Catholic hospitals in this study deny the moral decision-making right of women to seek and use emergency contraception is a serious concern. A Catholic hospital that does not put the conscience and religious freedom of individuals first is not living up to its claim that it provides "compassionate and understanding care…to a person who has is the victim of sexual assault." As this is clearly not understood by Catholic health care providers, it is essential that we seek to expand and enforce laws that serve to protect the religious freedom, conscience and health of women.

Recommendations

In order to improve services for sexual assault patients at Catholic hospitals, we recommend several next steps:

- Inform hospital administrators of these findings and advocate for the communication of existing hospital policy to all staff; the need to be sensitive to issues of sexual assault and pregnancy prevention should be emphasized.
- Encourage hospitals to develop guidelines for EC provision and pharmacy referrals regardless of whether they conduct sexual assault forensic examinations; follow up by evaluating whether hospitals that do not treat sexual assault patients provide EC before transferring the patient to another facility.
- Inform policymakers about the gaps in EC legislation, e.g., the lack of an enforcement mechanism, and the importance of making EC accessible at all hospitals regardless of whether or not they treat sexual assault patients.
- Educate policymakers about the urgent need for expanded access to EC in states where legislation and pharmacy access do not exist.

Appendices

Appendix 1:
State-by-State Legislation for EC in Emergency Departments

State	Type of Hospitals	Enforcement	Indication(s)	Religious Exemption
CA	Emergency departments that provide services to sexual assault patients	No	Provide "postcoital contraception" if indicated by history of contact; law enforcement shall be notified	No
NM	Hospitals that provide emergency care for sexual assault patients	Department of Health investigate complaints of violations. If failure to comply is found, DoH may 1) issue a written warning, 2) fine the facility $1,000, or 3) impose intermediate sanction, suspend or revoke facility's license	None	No
NY	Hospitals providing emergency treatment to sexual assault patients	Commissioner shall promulgateall such rules and regulations as may be necessary and proper to implement provisions of this section	Not required to provide EC to a sexual assault patient who is pregnant	No
SC	Licensed health care facility providing sexual assault exams	No	Medication for pregnancy prevention, if indicated	No
WA	Hospitals providing emergency care to sexual assault patients	Department of Health must respond to complaints of violations	Provide EC if not medically contraindicated	No

Appendix 2:
Hospital Level Mystery Client Survey Results

Hospital	City, State	Provides EC, by circumstance								Provides referral	Referral led to EC
		On request	Dr. discretion	SA*	SA, exam preg. test req.	SA, doesn't know if exam/ preg. test req.	SA, police report	Doesn't know/unclear	No		
Citrus Valley Med Ctr-Queen of the Valley	West Covina, CA				X						
Dominican Hospital	Santa Cruz, CA			X							
Little Company of Mary Hospital	Torrance, CA								X	No	
\Little Company of Mary-San Pedro Hospital	San Pedro, CA								X	Yes	Yes
Marian Med Ctr	Santa Maria, CA	X									
Mercy General Hospital	Sacramento, CA								X	No	
Mercy Hospital	Bakersfield, CA								X	Yes	No
Mercy Hospital of Folsom	Folsom, CA		X								
Mercy Med Ctr	Redding, CA			X							
Mercy Med Ctr Merced	Merced, CA					X					
Mercy Med Ctr Mount Shasta	Mount Shasta, CA						X				
Mercy San Juan Med Ctr	Carmichael, CA		X								
Mercy Southwest Hospital	Bakersfield, CA								X	Yes	No
Mission Hospital Regional Med Ctr	Mission Viejo, CA	X									
O'Connor Hospital	San Jose, CA	X									
Petaluma Valley Hospital	Petaluma, CA		X								
Providence Holy Cross Med Ctr	Mission Hills, CA								X	No	
Providence Saint Joseph Med Ctr	Burbank, CA								X	Yes	No
Queen of the Valley Hospital	Napa, CA	X									

*SA=Sexual assault

Appendix 2:
Hospital Level Mystery Client Survey Results (continued)

Hospital	City, State	Provides EC, by circumstance								Provides referral	Referral led to EC
		On request	Dr. discretion	SA*	SA, exam preg. test req.	SA, doesn't know if exam/ preg. test req.	SA, police report	Doesn't know/unclear	No		
Redwood Memorial Hospital	Fortuna, CA								X	Yes	Yes
Saint Agnes Med Ctr	Fresno, CA				X						
Saint John's Health Ctr X	Santa Monica, CA	X									
Saint Louise Regional Hospital	Gilroy, CA								X	Yes	Yes
Santa Rosa Memorial Hospital	Santa Rosa, CA				X						
Scripps Mercy Hospital	San Diego, CA								X	No	
Seton Med Ctr	Daly City, CA							X			
Seton Med Ctr Coastside	Moss Beach, CA								X	Yes	Yes
St. Bernardine Med Ctr	San Bernardino, CA								X	Yes	No
St. Elizabeth Community Hospital	Red Bluff, CA						X				
St. Francis Med Ctr	Lynwood, CA					X					
St. John's Pleasant Valley Hospital	Camarillo, CA		X								
St. John's Regional Med Ctr	Oxnard, CA								X	No	
St. Joseph Hospital	Eureka, CA		X								
St. Joseph Hospital	Orange, CA							X			
St. Joseph's Med Ctr of Stockton	Stockton, CA								x	No	
St. Jude Hospital, Inc. St. Jude Med Ctr	Fullerton, CA								X	Yes	Dr. discretion
St. Mary Med Ctr	Apple Valley, CA								X	No	
St. Mary Med Ctr	Long Beach, CA								X	Yes	Yes
St. Mary's Med Ctr	San Francisco, CA								X	No	
St. Rose Hospital	Hayward, CA								X	No	
St. Vincent Med Ctr	Los Angeles, CA								X	No	

*SA=Sexual assault

Appendix 2:
Hospital Level Mystery Client Survey Results (continued)

Hospital	City, State	Provides EC, by circumstance								Provides referral	Referral led to EC
		On request	Dr. discretion	SA*	SA, exam preg. test req.	SA, doesn't know if exam/ preg. test req.	SA, police report	Doesn't know/unclear	No		
Benedictine Hospital	Kingston, NY							X		No	
Bon Secours Community Hospital	Port Jervis, NY				X						
Cabrini Med Ctr	New York, NY								X	No	
Good Samaritan Hospital	Suffern, NY		X								
Good Samaritan Hospital Med Ctr	Wes Islip, NY		X								
Kenmore Mercy Hospital	Kenmore, NY				X						
Mary Immaculate Hospital	Jamaica, NY				X						
Mercy Hospital of Buffalo	Buffalo, NY		X								
Mercy Medical Center	Rockville Centre, NY	X									
Mount St. Mary's Hospital of Niagara Falls	Lewiston, NY								X	Yes	Yes
Our Lady of Lourdes Memorial Hospita	Binghamton, NY						X				
Our Lady of Mercy Med Ctr	Bronx, NY					X					
Saint Vincent's Hospital	Manhattan New York, NY			X							
Saint Vincent's Midtown Hospital	New York, NY			X							
Seton Health System, Inc., St. Mary's Division	Troy, NY			X							
Sisters of Charity Hospital of Buffalo, NY	Buffalo, NY				X						
St. Anthony Community Hospital	Warwick, NY			X							

*SA=Sexual assault

Appendix 2:
Hospital Level Mystery Client Survey Results (continued)

Hospital	City, State	Provides EC, by circumstance								Provides referral	Referral led to EC
		On request	Dr. discretion	SA*	SA, exam preg. test req.	SA, doesn't know if exam/ preg. test req.	SA, police report	Doesn't know/unclear	No		
St. Catherine of Siena Med Ctr	Smithtown, NY								X	No	
St. Charles Hospital & Rehab Ctr	Port Jefferson, NY								X	Yes	Yes
St. Clare's Hospital	Schenectady, NY								X	No	
St. Elizabeth Med Ctr	Utica, NY							X			
St. Francis Hospital	Poughkeepsie, NY	X									
St. Francis Hospital - The Heart Ctr	Roslyn, NY		X								
St. James Mercy Hospital	Hornell, NY		X								
St. John's Queens Hospital	Elmhurst, NY								X	No	
St. Joseph Hospital	Cheektowaga, NY				X						
St. Joseph's Hospital	Elmira, NY				X						
St. Joseph's Hospital Health Ctr	Syracuse, NY								X	Yes	Yes
St. Joseph's Med Ctr	Yonkers, NY		X								
St. Mary's Hospital at Amsterdam	Amsterdam, NY				X						
St. Mary's Hospital of Brooklyn	Brooklyn, NY				X						
St. Peter's Hospital	Albany, NY						X				
St. Vincent Catholic Med Ctrs, Staten Island Serv Div	Staten Island, NY			X							
Bon Secours St. Francis Hospital	Charleston, SC		X								
Providence Hospital	Columbia, SC				X						
St. Francis Hospital	Greenville, SC								X	Yes	No
St. Francis Women's & Family Hospital	Greenville, SC								X	Yes	No
Deer Park Health Ctr & Hospital	Deer Park, WA								X	No	

*SA=Sexual assault

Appendix 2:
Hospital Level Mystery Client Survey Results (continued)

Hospital	City, State	Provides EC, by circumstance								Provides referral	Referral led to EC
		On request	Dr. discretion	SA*	SA, exam preg. test req.	SA, doesn't know if exam/ preg. test req.	SA, police report	Doesn't know/unclear	No		
Holy Family Hospital	Spokane, WA				X						
Lourdes Med Ctr	Pasco, WA				X						
Mount Carmel Hospital	Colville, WA								X	Yes	No
Providence Centralia Hospital	Centralia, WA			X							
Providence Everett Med Ctr, Colby	Everett, WA								X	Yes	Yes
Providence Everett Med Ctr, Pacific	Everett, WA				X						
Providence St. Peter Hospital	Olympia, WA				X						
Sacred Heart Med Ctr	Spokane, WA							X		Yes	Yes
St. Clare Hospital	Lakewood, WA								X	No	
St. Francis Hospital	Federal Way, WA		X								
St. John Med Ctr	Longview, WA				X						
St. Joseph Hospital	Bellingham, WA			X							
St. Joseph Med Ctr	Tacoma, WA				X						
St. Joseph's Hospital	Chewelah, WA								X	Yes	No
St. Mary Med Ctr	Walla Walla, WA					X					

*SA=Sexual assault

Appendix 3:
Hospital-level Policy Survey Results

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
Citrus Valley Med Ctr-Queen of the Valley	West Covina, CA	No Response	No Response	No Response	No Response	SA, exam/preg. test required
Dominican Hospital	Santa Cruz, CA	No response	No response	No response	No response	SA
Little Company of Mary Hospital	Torrance, CA	No	N/A	N/A	N/A	No
Little Company of Mary-San Pedro Hospital	San Pedro, CA	Yes	Yes	Always	Always	No
Marian Med Ctr	Santa Maria, CA	Yes	Yes	Always	Always	Yes
Mercy General Hospital	Sacramento, CA	No Response	No Response	No Response	No Response	No
Mercy Hospital	Bakersfield, CA	No	N/A	N/A	N/A	Doesn't know/ Unclear
Mercy Hospital of Folsom	Folsom, CA	No	N/A	N/A	N/A	Dr. discretion
Mercy Med Ctr	Redding, CA	No Response	No Response	No Response	No Response	SA
Mercy Med Ctr Merced	Merced, CA	Yes	Yes	Always	Always	SA, doesn't know if exam/ preg. test required
Mercy Med Ctr Mount Shasta	Mount Shasta, CA	No Response	No Response	No Response	No Response	SA, police report
Mercy San Juan Med Ctr	Carmichael, CA	No Response	No Response	No Response	No Response	Dr. discretion
Mercy Southwest Hospital	Bakersfield, CA	No	N/A	N/A	N/A	No
Mission Hospital Regional Med Ctr	Mission Viejo, CA	No	N/A	N/A	N/A	Yes
O'Connor Hospital	San Jose, CA	No	N/A	N/A	N/A	Yes

*Sexual Assault Patients

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
Petaluma Valley Hospital	Petaluma, CA	Yes	Yes	If patient not referred off site	Don't know	Dr. discretion
Providence Holy Cross Med Ctr	Mission Hills, CA	No Response	No Response	No Response	No Response	No
Providence Saint Joseph Med Ctr	Burbank, CA	No	N/A	N/A	N/A	No
Queen of the Valley Hospital	Napa, CA	No Response	No Response	No Response	No Response	Yes
Redwood Memorial Hospital	Fortuna, CA	No	N/A	N/A	N/A	No
Saint Agnes Med Ctr	Fresno, CA	Yes	Yes	Always	If not pregnant†	SA, exam/preg. test required
Saint John's Health Ctr	Santa Monica, CA	No	N/A	N/A	N/A	Yes
Saint Louise Regional Hospital	Gilroy, CA	No	N/A	N/A	N/A	No
Santa Rosa Memorial Hospital	Santa Rosa, CA	No Response	No Response	No Response	No Response	SA
Scripps Mercy Hospital	San Diego, CA	No Response	No Response	No Response	No Response	No
Seton Med Ctr	Daly City, CA	No	N/A	N/A	N/A	Doesn't know/ Unclear
Seton Med Ctr Coastside	Moss Beach, CA	No	N/A	N/A	N/A	No
St. Bernardine Med Ctr	San Bernardino, CA	No	N/A	N/A	N/A	No
St. Elizabeth Community Hospital	Red Bluff, CA	Yes	Yes	Always	Always	SA, police report
St. Francis Med Ctr	Lynwood, CA	No Response	No Response	No Response	No Response	SA, doesn't know if exam/preg. test required

*Sexual Assault Patients
†Specific criteria under which hospitals "sometimes" offer EC or a prescription for EC

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
St. John's Pleasant Valley Hospital	Camarillo, CA	No	N/A	N/A	N/A	Dr. discretion
St. John's Regional Med Ctr	Oxnard, CA	No	N/A	N/A	N/A	No
St. Joseph Hospital	Eureka, CA	No Response	No Response	No Response	No Response	Dr. discretion
St. Joseph Hospital	Orange, CA	No	N/A	N/A	N/A	Doesn't know/ Unclear
St. Joseph's Med Ctr of Stockton	Stockton, CA	No	N/A	N/A	N/A	No
St. Jude Hospital, Inc. St. Jude Med Ctr	Fullerton, CA	No Response	No Response	No Response	No Response	No
St. Mary Med Ctr	Apple Valley, CA	No Response	No Response	No Response	No Response	No
St. Mary Med Ctr	Long Beach, CA	No	N/A	N/A	N/A	No
St. Mary's Med Ctr	San Francisco, CA	Yes	Don't know	Always	Don't know	No
St. Rose Hospital	Hayward, CA	No	N/A	N/A	N/A	No
St. Vincent Med Ctr	Los Angeles, CA	No Response	No Response	No Response	No Response	No
Benedictine Hospital	Kingston, NY	Yes	Yes	Always	Always	Doesn't know/ Unclear
Bon Secours Community Hospital	Port Jervis, NY	Yes	Yes	Always	Always	SA, exam/preg. test required
Cabrini Med Ctr	New York, NY	No Response	No Response	No Response	No Response	No
Good Samaritan Hospital	Suffern, NY	Yes	Yes	Always	Always	Dr. discretion
Good Samaritan Hospital Med Ctr West	Islip, NY	No Response	No Response	No Response	No Response	Dr. discretion
Kenmore Mercy Hospital	Kenmore, NY	Yes	Yes	Always	Always	SA, exam/preg. test required

*Sexual Assault Patients

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
Mary Immaculate Hospital	Jamaica, NY	Yes	Yes	Always	Always	SA, exam/preg. test required
Mercy Hospital of Buffalo	Buffalo, NY	No Response	No Response	No Response	No Response	Dr. discretion
Mercy Med Ctr	Rockville Centre, NY	Yes	No	If patient brings it up	If not pregnant†	Yes
Mount St. Mary's Hospital of Niagara Falls	Lewiston, NY	Yes	Yes	Always	Always	No
Our Lady of Lourdes Memorial Hospital	Binghamton, NY	Yes	Yes	Always	Always	SA, police report
Our Lady of Mercy Med Ctr	Bronx, NY	No Response	No Response	No Response	No Response	SA, doesn't know if exam/preg. test required
Saint Vincent Catholic Med Ctrs, Staten Island Serv. Div.	Staten Island, NY	Yes	Yes	Always	Always	SA
Saint Vincent's Hospital Manhattan	New York, NY	No Response	No Response	No Response	No Response	SA
Saint Vincent's Midtown Hospital	New York, NY	Yes	Yes	Always	Always	SA
Seton Health System, Inc., St. Mary's Division	Troy, NY	Yes	Yes	Always	Always	SA
Sisters of Charity Hospital of Buffalo, NY	Buffalo, NY	Yes	Yes	Always	If not pregnant†	SA, exam/preg. test required
St. Anthony Community Hospital	Warwick, NY	No Response	No Response	No Response	No Response	SA

*Sexual Assault Patients
†Specific criteria under which hospitals "sometimes" offer EC or a prescription for EC

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
St. Catherine of Siena Med Ctr	Smithtown, NY	No Response	No Response	No Response	No Response	No
St. Charles Hospital & Rehab Ctr	Port Jefferson, NY	Yes	Don't know	Always	Always	No
St. Clare's Hospital	Schenectady, NY	No Response	No Response	No Response	No Response	No, regardless of circumstance
St. Elizabeth Med Ctr	Utica, NY	Yes	Don't know	According to SA policy	Don't know	Doesn't know/ Unclear
St. Francis Hospital	Poughkeepsie, NY	Yes	Yes	Always	Always	Yes
St. Francis Hospital - The Heart Ctr	Roslyn, NY	No Response	No Response	No Response	No Response	Dr discretion
St. James Mercy Hospital	Hornell, NY	Yes	No	Dr. discretion	Don't know	Dr. discretion
St. John's Queens Hospital	Elmhurst, NY	No Response	No Response	No Response	No Response	No
St. Joseph Hospital	Cheektowaga, NY	No Response	No Response	No Response	No Response	SA, exam/preg. test required
St. Joseph's Hospital	Elmira, NY	Yes	Yes	Always	If not pregnant†	SA, exam/preg. test required
St. Joseph's Hospital Health Ctr	Syracuse, NY	Yes	Yes	Always	Always	No
St. Joseph's Med Ctr	Yonkers, NY	No Response	No Response	No Response	No Response	Dr .discretion
St. Mary's Hospital at Amsterdam	Amsterdam, NY	Yes	Yes	Always	If not pregnant†	SA, exam/preg. test required
St. Mary's Hospital of Brooklyn	Brooklyn, NY	No Response	No Response	No Response	No Response	SA, exam/preg. test required
St. Peter's Hospital	Albany, NY	No Response	No Response	No Response	No Response	SA, police report

*Sexual Assault Patients
†Specific criteria under which hospitals "sometimes" offer EC or a prescription for EC

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
Bon Secours St. Francis Hospital	Charleston, SC	No	N/A	N/A	N/A	Dr. discretion
Providence Hospital	Columbia, SC	No Response	No Response	No Response	No Response	SA
St. Francis Hospital	Greenville, SC	No	N/A	N/A	N/A	No
St. Francis Women's & Family Hospital	Greenville, SC	No Response	No Response	No Response	No Response	No
Deer Park Health Ctr & Hospital	Deer Park, WA	No	N/A	N/A	N/A	No
Holy Family Hospital	Spokane, WA	No Response	No Response	No Response	No Response	SA, exam/preg. test required
Lourdes Med Ctr	Pasco, WA	No Response	No Response	No Response	No Response	SA, exam/preg. test required
Mount Carmel Hospital	Colville, WA	Yes	Yes	Don't know	Always	No
Providence Centralia Hospital	Centralia, WA	Yes	Yes	Always	Always	SA
Providence Everett Med Ctr, Colby	Everett, WA	Yes	Yes	Always	Always	No
Providence Everett Med Ctr, Pacific	Everett, WA	Yes	Yes	Always	Always	SA, exam/preg. test required
Providence St. Peter Hospital	Olympia, WA	Yes	Don't know	Always	Always	SA, exam/preg. test required
Sacred Heart Med Ctr	Spokane, WA	Yes	Yes	Always	Always	Doesn't know/ Unclear
St. Clare Hospital	Lakewood, WA	Yes	Yes	Always	Always	No
St. Francis Hospital	Federal Way, WA	Yes	Don't know	Don't know	Always	Dr. discretion
St. John Med Ctr	Longview, WA	Yes	No	Always	Don't know	SA, exam/preg. test required

*Sexual Assault Patients

Appendix 3:
Hospital-level Policy Survey Results (continued)

Hospital	City, State	Treats SAPs*	Written EC protocol	EC counseling offered	EC pills/Rx offered	Provides EC (mystery client response)
St. Joseph Hospital	Bellingham, WA	No Response	No Response	No Response	No Response	SA
St. Joseph Med Ctr	Tacoma, WA	Yes	Don't know	Dr. discretion	Dr. discretion	SA, exam/preg. test required
St. Joseph's Hospital	Chewelah, WA	No	N/A	N/A	N/A	No
St. Mary Med Ctr	Walla Walla, WA	No Response	No Response	No Response	No Response	SA

*Sexual Assault Patients

Appendix 4:
Rape Crisis Advocates Survey

Introduction

In this portion of the study, we sought to gain the perspective of rape crisis advocates about Catholic hospitals' management of sexual assault patients with regard to EC in the past 12 months.[17]

Methodology

We attempted to identify a rape crisis advocate for each of the 37 hospitals that reported treating sexual assault patients using various methods, namely browsing the Virginians Aligned Against Sexual Assault 2004 Directory, "Sexual Assault Crisis Centers and Coalitions in the United States,"[18] searching the internet for contact information and/or telephoning the corresponding hospital to request the name of a rape crisis advocate with whom they coordinate. We also obtained contact information for rape crisis advocates from those that did not qualify for study inclusion.

We conducted the research for this portion of the project in July and August 2005. A trained female interviewer attempted to contact the identified rape crisis advocates and followed a written script to explain the purpose and nature of the study, and invited the respondent to participate. The interviewer made at least three attempts to contact each rape crisis advocate.

At the beginning of each interview, we asked respondents to report on the number of adult female sexual assault patients their organization served and who were treated at the hospital of interest. Therefore, the hospital is the unit of analysis.

Results

Thirteen respondents agreed to participate in the survey and reported on 15 separate hospitals. Eight of the hospitals are located in New York, five in California and two in Washington. Among the 13 respondents who participated in the survey, 10 (77%) were rape crisis advocates, two (15%) were sexual assault nurse examiners who provided services to the hospital, and one (8%) was employed by a hospital-operated rape crisis center.[19] For the purposes of this study, all respondents are referred to as rape crisis advocates.

Among the 15 hospitals of interest for this study component:

- Nine (60%) had a written protocol for providing EC to sexual assault patients
- Five (33%) did not participate in the policy study component
- One (7%) did not know if their hospital has a written EC protocol.

Overall, respondents were satisfied with the treatment that sexual assault patients received at the hospitals of interest. They reported that all but one of the hospitals provided all sexual assault patients with information about EC (Table 1).

Among the fourteen hospitals in which all sexual assault patients received information about EC, nine (69%) also provided every patient with EC or a prescription. Respondents noted that all of the sexual assault patients who did not receive information/EC at the five other hospitals were not eligible for EC—that is, they were either menopausal, did not experience penetrative

intercourse, were using birth control, were pregnant before the assault or the timeframe for administration had already passed. Only one (20%) of these hospitals did not provide written or verbal notification to sexual assault patients about the reason(s) they were not being offered EC or a prescription.

Table 1:
Number and Percent of Hospitals Providing Sexual Assault Patients with Information and EC

Proportion of patients provided with…	
Information about EC	**Number (%) of Hospitals**
100%	14 (93%)
67%	1 (7%)
EC or a prescription	**Number (%) of Hospitals***
100%	9 (69%)
<100%	4 (31%)

*Respondents did not know how many sexual assault patients were given EC at two hospitals.

Eleven of the hospitals (92%) provided sexual assault patients with EC on-site and one hospital (7%) gave these patients a prescription that could be filled at the in-house pharmacy (Table 2).

Table 2:
Number and Percent of Hospitals, by how EC was Provided

	Total
EC on site	11 (92%)
A prescription for EC	1 (8%)

*Three hospitals are missing for this variable because the respondents did not know how many sexual assault patients were given EC.

When respondents were asked if they would like to share additional information regarding sexual assault patients' experiences at the hospitals of interest, their perceptions were generally positive as demonstrated by the following comments:

"They [the hospital staff] are pretty good about giving EC, especially since the legislation passed. Before the law, they used to refer patients to another hospital for EC. Now they give it on site." (New York)

"The hospital has been incredibly supportive and generous. They provide Plan B free of charge to sexual assault victims." (California)

"We've been pleased. The hospital has seen it [EC] as a medical need, not a moral issue." (New York)

Two comments illustrate respondents' sense that the hospitals are taking steps to address sexual assault patients' needs:

"There are problems with the ER, but they are working to improve the situation." (New York)

"The hospital has made sure that the two pharmacists who oppose EC on moral grounds do not work the same shift so that there is always someone available to dispense EC." (New York)

One advocate made the following comment about administering a pregnancy test prior to dispensing EC:

"Everyone gets a pregnancy test first—not just at Catholic hospitals. All SART hospitals in the area do this." (Washington)

Overall, respondents rated the quality of care that sexual assault patients receive at the 15 hospitals as an 8.1, with "1" being the "poorest quality of care" and "10" being the "best quality of care." As shown in Table 3, the ratings ranged from 6 to 10.

Table 3:
Number and Percent of Hospitals, by Quality of Care Rating

Rating of quality of care	Number (%) of Hospitals*
10	3 (23%)
9.5	1 (8%)
9	1 (8%)
8	3 (23%)
7	3 (23%)
6	2 (15%)

* Two hospitals are missing for this question because the respondents declined to respond.

None of the rape crisis advocates we interviewed reported problems with EC-related services at the Catholic hospitals in question. Several rape crisis advocates noted that the hospitals had been compliant with their respective state laws, and in some cases had supplied EC free of charge to sexual assault patients. A few respondents in New York noted that the change in EC legislation has had a positive impact on how Catholic hospitals handle provision of information and EC. This perception may be more common in New York because of the recent change in legislation whereas Washington and California have had EC legislation for several years now.

It is important to note that we only asked rape crisis advocates about patients they accompanied to the hospital. Therefore, data regarding the proportion of patients receiving information and EC do not include sexual assault patients who may have been treated at the hospital unaccompanied by a rape crisis advocate. In addition, we only interviewed 13 rape crisis advocates who reported on 15 Catholic hospitals therefore these results are not generalizable to all hospitals in this study.

Endnotes

1 S. Henshaw, “Unintended pregnancy in the United States,” *Family Planning Perspectives*, 1998; 30:24-29, 46.

2 M.M. Holmes, H.S. Resnick, D.G. Kilpatrick et al, “Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women,” *American Journal of Obstetrics and Gynecology*, 1996; 175:320-324.

3 C. Ellertson, M. Evans, S. Ferden et al, “Extending the time limit for starting the Yuzpe regimen of emergency contraception up to 120 hours,” *Obstetrics and Gynecology*, 2003; 101:1168-71.

4 Task Force on Postovulatory Methods of Fertility Regulation, “Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception,” *Lancet*, 1998; 352:428-433.

5 Massachusetts’ law on provision of EC to sexual assault patients and through pharmacist collaborative practice agreements went into effect in December 2005.

6 United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, (Fourth Edition), 2001.

7 M.M. Holmes, H.S. Resnick, D.G. Kilpatrick, et al, “Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women,” *American Journal of Obstetrics and Gynecology*, 1996; 175:320-324.

8 H.B. Croxatto, M.E. Ortiz and A.L. Muller, “Mechanisms of action of emergency contraception,” *Steroids*, 2003; 68:1095-8.

9 American Hospital Association, “2002 Annual Survey of Hospitals,” American Hospital Association and Health Forum. Data supplied to authors.

10 Catholics for a Free Choice, *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms*, A national survey conducted by Ibis Reproductive Health for Catholics for a Free Choice, 2002.

11 T. Harrison, “Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff,” *Annals of Emergency Medicine*, 2005; 46(2):105-110.

12 D. Grimes and E. Raymond, “Emergency contraception,” *Annals of Internal Medicine*, 2002; 137:180-9.

13 L. Bucar and D. Nolan, “Emergency contraception and Catholic hospitals,” *Conscience*, 1999; 20: 20-2.

14 K. O’Rourke, “Applying the Directives: The Ethical and Religious Directives concerning three medical situations require some elucidation,” *Health Progress*, 1998; 79:64-9.

15 B.V. Houmes, M.M. Fagan and N.M. Quintana, “Establishing a Sexual Assault Nurse Examiner (SANE) Program in the Emergency Department” *Journal of Emergency Medicine*, 2003; 25(1):111-21.

16 No Catholic hospitals were operating in New Mexico at the time of data collection.

17 The four Catholic hospitals in South Carolina either did not treat sexual assault patients or did not respond to the hospital policy survey. Therefore, no RCAs were contacted for interview in this state.

18 Published by the Virginians Aligned Against Sexual Assault, Charlottesville, VA.

19 Initially we intended to interview an RCA not employed by a hospital. However, in three cases the identified RCA was unable to provide the relevant information, and therefore referred us to a sexual assault nurse examiner or to the hospital’s internal RCA.

Complying with the Law?
How Catholic hospitals respond to state laws mandating the provision of emergency contraception to sexual assault patients

A study conducted by Ibis Reproductive Health for Catholics for a Free Choice

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