

The ‘Morning-After Pill’, Rape Victims and ¹ *Ethical and Religious Directives for Catholic Health Care Services*

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In 2001 the U.S. Conference of Catholic Bishops issued their revised “Ethical and Religious Directives for Catholic Health Care Services”. Directive 36 states:

*“A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum”.*¹

The Directive does not specify what constitutes “appropriate testing” or

¹ The statement follows the Directives of 1994 and the statement by the Pennsylvania Catholic Conference “Guidelines for Catholic Hospitals Treating Victims of Sexual Assault” (April 1, 1993), *Origins* 22: 81D (May 6, 1993). The Pennsylvania statement (which refers to ovulation testing (see below)) is cited in a footnote to Directive 36 as an example of a policy that tries to respect ethical concerns about early human life. In the UK and Ireland statements were made by the Joint Committee on Bioethical Issues of Bishops’ Conferences of Scotland, Ireland, England and Wales: “‘Use of the ‘Morning-After Pill’ in Cases of Rape”, *Origins* (Jan. 31, 1986), 15: 633, 635-638 (March 13, 1986); Joint Committee on Bioethical Issues of the Bishops’ Conference of Great Britain and Ireland, “A Reply: Use of the ‘Morning-After Pill’ in Cases of Rape” (1986), *Origins* 16: 237-238 (Sept. 11, 1986). This Joint Committee is in the process of investigating further evidence on these issues.

“evidence that conception has occurred”. Consequently, Directive 36 has been subject to different interpretations.

One school holds that giving women a pregnancy test followed by a “morning-after pill” if the test is negative is morally permissible and in line with Directive 36. As pregnancy testing, at present, can only reveal a pregnancy prior to any recent rape, and not whether a recent rape has itself resulted in pregnancy, this school holds, for reasons laid out below, that the only relevant factor to consider before giving a morning-after pill is whether the woman patient has a prior-to-rape pregnancy which would be endangered by the administration of a pill.

Opposed to this school is the ovulation-testing school, which insists that, as well as a pregnancy test, a simple urine dipstick test together with any personal data on the woman’s ovarian cycle stage² should be obtained

² A simple urine dipstick test can be done for the LH (luteinizing hormone) surge that triggers ovulation. This test if it gives a negative result does not necessarily tell you whether the woman is before the cycle’s LH surge (where drugs can be given to prevent ovulation) or just after (in which case sperm and ovum may have already have joined and the drug is likely to work as an abortifacient). A progesterone blood test is then recommended as a follow-up, in order to answer the question of whether conception has taken place. Results from this test, however, can be difficult to interpret.

in order to assess whether a) “emergency contraception” can be appropriately used to prevent ovulation or sperm capacitation, and b) whether such “emergency contraception” will be at all necessary in a given case. This approach aims to avoid giving unnecessary and potentially dangerous drugs to women, and further aims to take seriously the possibility that drugs administered at mid-cycle or early post-ovulatory phases could endanger the life of a newly conceived child.

Pregnancy-only testing

The influential journal of the Catholic Health Association, *Health Progress*, published in 2002 an article defending the “pregnancy-only-testing” strategy.³

The following claims were made:

- a) the risk of pregnancy resulting from rape is very small.
- b) the “scientific literature” indicates that emergency contraceptive medications most likely act by preventing ovulation or fertilization and do not have post-fertilization effects sufficient to prevent the embryo from implanting in the womb.
- c) the probable direct effect of administering the medications is prevention of conception occurring from an act of unjust sexual aggression rather than causing the death of a conceptus.
- d) any conceptus that is present and fails to implant will have been destroyed as an unintended and even unforeseen effect given the “lack of evidence supporting abortifacient effects of the medications”.

Some have also recommended an ovarian scan as a way of determining the stage of the woman’s cycle.

³ Ronald P. Hamel, Ph.D., and Michael R. Panicola, Ph.D., “Emergency Contraception and Sexual Assault”, *Health Progress* (September-October 2002).

The piece further criticises adherents of the “ovulation-testing” school.

Following this article, and consultation with experts from both sides of the debate, a letter was privately circulated by the Chairman (since retired from that position) of the Bishops’ Committee on Doctrine, Bishop Donald W. Trautman, which said that, based on “the present state of scientific and medical research”, the Committee had concluded that testing only for a pregnancy unrelated to the sexual assault is not inconsistent with Directive 36.⁴ However, in spite of this interim conclusion being made public, through a letter not intended for publication, the Committee has made no public statement concerning it, and will continue to study the issue and hold further consultations with experts in the field. In the meantime, individual bishops in the U.S. remain free to interpret Directive 36 as they see fit.

The leaked letter has led to a situation that is troubling, not least because the *Health Progress* article defending pregnancy-only testing is deeply flawed. Furthermore, groups antipathetic to the Church’s general stance on life issues have seized on the guidance given in the letter in their efforts to promote distribution of “emergency contraception” in all hospitals.⁵

Flaws in the Hamel and Panicola article

- a) Very little has been firmly established as to how frequent conceptions are in the case of rape.

⁴ Place, Michael, “A Venue for Theological/Ethical Issues”, *Health Progress* (July-August 2003).

⁵ See for example http://www.mergerwatch.org/edfund_docs/ec_toolkit_docs/strategy-4_change.pdf

Given this, it is disingenuous to make bold empirical statements in this area. Moreover, our concerns should not be about general probabilities, but more focused on the likelihood of conception in a particular case, taking into account facts about the individual rape victim.

However, if it is indeed true that pregnancy following rape is extremely rare, then this could be taken to strengthen the argument against giving "emergency contraception" to rape victims,⁶ on the grounds that giving unnecessary emergency contraception is harmful to the woman, as well as sending out a message to the wider community of disregard for the unborn child.

b) It is not true that no evidence exists for an abortifacient effect of the various forms of emergency contraception. The commonest regime of "pregnancy-only testing" is known as the Yuzpe regime, which makes use of *Schering PC4* "emergency hormonal contraceptive". If this drug acts pre-fertilisation, its effect is contraceptive; if it acts post-fertilisation its action may be abortifacient (by affecting the endometrium, or lining of the womb, and rendering it fatally inhospitable to any newly conceived embryo). Evidence suggests that *Schering PC4*, if taken over 24 hours prior to ovulation, can prevent or significantly delay ovulation but later than this may produce an abortifacient effect.⁷ Other types of "emergency contraception"

⁶ See the study by R.B. Everett and R.F. Jimerson, "The Rape Victim: A Review of 117 Consecutive Cases", *Obstetrics and Gynecology* 50: 88-90 (1977).

⁷ Ling W Y et al, "Mode of action of DL-norgestrel and ethinyloestradiol combination in postcoital contraception", *Fertility and Sterility* 32: 297-302 (1979).

include *Levonorgestrel* (Levonelle 2), which is heavily advertised and used (without prescription) in the U.K. While the mode of action of levonorgestrel is unclear at present, one of the few studies carried out found that its preovulatory administration had no effect on ovulation, but that it did affect the endometrium. In other words, it could be that the effects of this so-called "emergency contraceptive" are purely abortifacient.⁸ The present evidence for an abortifacient effect is significant and therefore morally relevant.

Aside from these considerations, the article, and those who support it, define fertilization as a process *ending* in conception. This is highly questionable, not to say worrying, as it appears arbitrarily to locate the moment of conception at the end of the fertilization process (with the lining-up of chromosomes from the sperm and ovum), when many would consider the individual to be already a day old.⁹

c) Given the above, the probable "direct effect" in the vast majority of cases of administering a "morning-after pill" following rape would be an unnecessary disruption of the woman's endometrium¹⁰, rather than preventing

⁸ See Swahn M L et al., "Effect of post-coital contraceptive methods on the endometrium and the menstrual cycle", *Acta Obstetrica et Gynecologica Scandinavica* 75: 738-744 (1996) and also Eugene F. Diamond, M.D., "The Ovulation or Pregnancy Approach in Cases of Rape?" (and citations therein), *National Catholic Bioethics Quarterly* 3: 689-697 (2003). Tests have suggested that *Mifepristone* (RU486), although not licensed as "emergency contraception", can prevent conception, but also has an abortifacient effect.

⁹ See Tonti-Filippini N., "Further Comments on the Beginning of Life", *Linacre Quarterly* 59: 76-81 (1992) and Diamond *op.cit.*

¹⁰ It is a matter of dispute whether the drug's effects on the endometrium are, in the majority

a conception which would not, in any case, have occurred. However, without knowing the stage of the ovulatory cycle of the rape victim, it is difficult to say what the “direct effect” of the morning-after pill will be.

d) In view of (b), the possible abortifacient effect of the “morning-after pill” cannot be classified blithely as an “unforeseen” effect of its use. While it is true that a woman, in taking a “morning-after pill” following a recent rape, need not *intend* to cause an abortion, in bringing about this immediate side-effect of a fatally inhospitable environment for any newly conceived child she, and those who treat her, are morally obliged to take into account the risk at which they place such a child. For this reason, efforts should be made to reduce this risk as much as possible.¹¹

Ovulation testing

The pregnancy-only testing method therefore results in the administering of what will nearly always be unnecessary and harmful drugs to women who have already gone through a terrible ordeal. It also sends out a message that the possible lives of unborn children are to be accorded no significant weight in calculating how best one should act in tragic circumstances.

In contrast to this, the ovulation-testing method tests for pre-existing pregnancy, and also attempts to ascertain whether the raped woman is at or approaching the time of ovulation

of cases, sufficient for a further abortifacient effect.

¹¹ A further possible abortifacient effect of some drugs is that their use may slow the transport of the embryo down the fallopian tube so that it arrives in the womb too late to find a receptive endometrium. Moreover, slowing down the embryo's journey is a risky procedure, as it increases the likelihood of an ectopic pregnancy.

in order to work out whether any new conception is likely to result from the recent assault.¹² In this method, “emergency contraception”¹³ is offered only if the pregnancy test is negative *and* empirical and personal data indicate that the woman is not at or near the time of ovulation. The simple testing gives medical staff the information to know whether they can safely intervene to prevent the release of a woman's ovum, or prevent the sperm from reaching the egg. In this way, any child conceived is exposed to very little risk indeed and a woman treated can be reassured that she was not pregnant.

It is this empirically and ethically sound approach that truly respects women and children, and it is this approach that I believe is in keeping with the intention of Directive 36.

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¹² Details of a widely adopted protocol on ovulation testing are outlined in St Francis Medical Centre, “Interim Protocol, Sexual Assault: Contraceptive Treatment Component”, Peoria, IL, (October 1995).

¹³ It has been suggested that a single, moderate dose of estrogen may be sufficient to delay ovulation while at the same time being very unlikely to bring about any harm to a pregnancy if ovulation had already occurred, though this requires further investigation. If such were the case, estrogen treatment would be the ethically preferable option. See Tonti-Filippini N. & Walsh M., “Postcoital Intervention”, *National Catholic Bioethics Quarterly* 4: 275-289 (2004).