Ron Hamel, "Rape and Emergency Contraception," Ethics & Medics, vol. 28, no. 6 (June 2003).

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# RAPE AND EMERGENCY CONTRACEPTION

In the September 2002 issue of *Ethics & Medics* (27.9), Rev. Kevin T. McMahon commented on an advisory sent to members of the Catholic Health Association (CHA) regarding the use of emergency contraception in Catholic hospitals for victims of sexual assault ("Directive 36 and 'Contraceptives'"). One of the last sections of the advisory (n. 7) explains two approaches to the application of a portion of number 36 of the *Ethical and Religious Directives for Catholic Health Care Services*: "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."

## Two Approaches to Testing

The advisory notes that there are two approaches to understanding "appropriate testing" amongst health care providers. One tests for ovulation (the "ovulation" approach) to determine whether the woman is at that point in her cycle when conception might occur. If she is, then she might have conceived as a result of the rape and, some believe, the medications could have an abortifacient effect. In such a situation, the medications are not administered. The other approach (the "pregnancy approach") tests only for a pre-existing pregnancy unrelated to the sexual assault in order to avoid any deleterious effect on an embryo. If the woman is not pregnant, then the medication is administered. The brief explanation of the two approaches ends by noting that many orthodox moral theologians believe that the "pregnancy" approach is consistent with Catholic moral teaching and with Directive number 36.

Fr. McMahon takes issue with this observation. He argues that "the ovulation approach meets the appropriate testing standard of Directive 36 while the pregnancy approach alone does not" (p. 2). He offers two reasons for his position. One is the presumed abortifacient effect of emergency contraceptive medications. The other is the ease of administering at least some tests to determine whether ovulation has occurred.

Several observations must be made with regard to Fr. McMahon's critique of the CHA advisory, lest what is said there be misconstrued. First, the advisory was a *description* of the two approaches and not a moral analysis or defense of either or both. It did not offer all the moral justifications for either position. Hence, Fr. McMahon rejects the moral justifiability of the pregnancy approach on the basis of only a limited explanation of why some moral theologians believe it to be morally acceptable. *Further, it should not be construed that either the ovulation or the pregnancy approach reflects a CHA position.*

## Is There an Abortifacient Effect?

Second, as regards Fr. McMahon's rejection of the pregnancy approach, his argument appears to hinge primarily on the belief that the medications employed "have an abortifacient effect" (p. 1). In support of this belief, Fr. McMahon quotes from the *Physicians Desk Reference* and from Dr. Eugene Diamond's *A Catholic Guide to Medical Ethics* regarding the effects of Ovral (one of the medications used for emergency contraception). He concludes from these sources that "it [the medication] would lead to the death of the conceptus in either of two ways. It would prevent the movement of the conceptus down the tube in proper phase for implantation; or it would alter the lining of the uterus making implantation impossible" (p. 2).

The description found in the CHA advisory is consistent with primary scientific sources which clearly indicate that the matter is not as definitive as the two secondary sources that Fr. McMahon cites seem to suggest. Rather, recent scientific literature about the two FDA approved medications for emergency contraception (Preven and Plan-B) raise doubts about the abortifacient effect of these medications. What they say instead is that while the medications do cause histologic changes in the endometrium, there is no conclusive scientific evidence that these changes are sufficient to inhibit the implantation of a conceptus or have a postimplantation effect.[1] Further they suggest that emergency contraceptive medications act primarily by inhibiting ovulation or disrupting fertiliza-

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tion and have only secondary post-fertilization effects. One author, for example, puts it this way:

> [E]ven though the precise mechanism of action of modern contraceptives is not yet fully known, scientific evidence suggests the main mechanism of action for each method. Inhibition of ovulation and effects on the cervical mucus are the primary mechanisms of the contraceptive action of hormonal methods.... All these methods, directly or indirectly, have effects on the endometrium that might prevent implantation of a fertilized ovum. However, so far, no scientific evidence has been published supporting this possibility. No scientific evidence supports an abortifacient effect.[2]

The doubt about the abortifacient effect of these emergency contraceptive medications is further reinforced by recent studies that show that the medications are "most effective when administered within 24 hours of unprotected sex" and decrease in effectiveness substantially and progressively when "administered in the 24–48 hour and 48–72 hour intervals."[3] As Croxatto and associates point out, "this fact alone does not allow for discriminating between possible modes of action, [however] it does lend support to a *significant* role of pre-fertilization mechanisms in their contraceptive effectiveness."[4] What is more, if emergency contraceptive medications truly had post-fertilization effects, then "the same level of effectiveness should continue beyond 24 hours, possibly even until implantation is established."[5] Hence, there seems to be some doubt, if not considerable doubt, about the abortificient effects of these medications. This doubt is critical to the belief by many that the pregnancy approach is morally permissible. The matter of the abortifacient effect of emergency contraceptive medications is more complex than Fr. McMahon's claims suggest.

## Testing for Ovulation

Third, Fr. McMahon discusses the matter of testing for ovulation and comments, in opposition to the pregnancy approach, that "at least some of these tests could be used in every Catholic hospital that treats victims of sexual assault" (p. 2) even if not all hospitals can perform the blood test to determine hormonal levels indicating whether or not ovulation has occurred. The issue here is not only the *feasibility* of administering certain tests. Testing for ovulation only makes sense if there is a high risk that conception might result from the sexual assault (and, in fact, there is an extremely small risk) and if the medications that would be administered would be abortifacient (and there is considerable doubt about this). Furthermore, a positive test for ovulation would mean denying emergency contraceptive medications (and the consequences of that) to the woman who has been sexually assaulted. This would occur even though in that particular instance there most likely is not a conceptus present and it is doubtful whether the medications have an abortifacient effect. In addition, ease of applicability of these tests is not a sufficient consideration. One must also be concerned about *reliability* of the tests and their *applicability* to the general population of women who have been sexually assaulted. There are questions about both reliability and applicability of the tests that Fr. McMahon mentions.

Finally, Fr. McMahon suggests that in Directive 36's wording: "If, after appropriate testing, there is no evidence that conception has occurred already," the words "appropriate testing" include tests for ovulation. This could be. However, at best, the statement is ambiguous. There is no appropriate testing that would provide evidence that conception has occurred already (except a test for a pregnancy not associated with the rape). Testing for ovulation surely does not provide this evidence. It only indicates whether the woman is at that point in her cycle when conception *could* occur. In short, the matter of testing is more scientifically complex than Fr. McMahon's discussion would suggest.

The administration of emergency contraceptive medications in Catholic hospitals to women who have been sexually assaulted is a highly complex issue—medically and morally. Addressing it adequately and in a manner that takes into account the care of the victim as well as our commitment to life requires a careful engagement of the most up-to-date and reliable scientific literature as well as careful moral analysis. Only in this way will we do justice to a search for truth in this matter, wherever that search may lead.

Ron Hamel, Ph.D.
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## Notes

[1]Anna Glasier, M.D., "Drug Therapy: Emergency Postcoital Contraception," *New England Journal of Medicine* 337.15 (October 9, 1997): 1058–1064, at 1060. See also Horacio B. Croxatto et al., "Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: A Review of the Literature," *Contraception* 63.3 (2001): 111–121, at 117; and Melissa Sanders Wanner and Rachel L. Couchenour, "Hormonal Emergency Contraception," *Pharmacotherapy* 22.1 (2002): 43–53, at 44.

[2]Roberto Rivera, M.D., Irene Yacobson, M.D., and David Grimes, M.D., "The Mechanism of Action of Hormonal Contraceptives and Intrauterine Contraceptive Devices," *American Journal of Obstetrics and Gynecology* 181.5 (November 1999): 1263–1269, at 1267. See also Peter J. Cataldo and Albert S. Moraczewski, O.P., who note that "the chance of an abortifacient effect in a sexual assault survivor should be 1.2% or less (even less under the restrictions of the St. Francis Medical Center Protocol)." "A Moral Analysis of Pregnancy Prevention after Sexual Assault," in *Catholic Health Care Ethics: A Manual for Ethics Committees* (Boston: The National Catholic Bioethics Center, 2001), at 11/14, note 8.

[3]Rivera, Yacobson, and Grimes, "The Mechanism of Action," 1266.

[4]Croxatto et al., "Mechanism of Action of Hormonal Preparations," 117, emphasis added.

[5]Rivera, Yacobson, and Grimes, "The Mechanism of Action," 1266.