Kevin T. McMahon, "Why Fear Ovulation Testing?"
Ethics & Medics, vol. 28, no. 6 (June 2003)

WHY FEAR OVULATION TESTING?

Questions about the testing required in Catholic hospitals before providing emergency contraception (EC) to sexual assault victims have grown in significance. Legislative efforts requiring hospitals to treat rape victims and provide EC (e.g. H.R. 4113 and H.R. 3887), and a push toward greater availability of EC to prevent pregnancies in other situations, indicate the urgency of the testing issue.[1] Such efforts highlight the broader implications of accepting testing protocols which discount probable abortifacient effects of EC—effects making the potential number of lost lives significantly higher than in cases of rape alone.

Directive 36 requires appropriate testing prior to EC, but apart from referring to the guidelines of the Pennsylvania Catholic Conference, which require ovulation testing, the directive does not specify what testing is required. Dr. Hamel's reminder that neither "the ovulation [n]or the pregnancy approach reflects a CHA position" is significant, given the authority some hospital administrators attribute to the CHA. Although I did not claim so in my article, I appreciate his concern that readers of the CHA materials may reasonably conclude that the CHA prefers the pregnancy approach. Given his disclaimer, I hope readers of *Health Progress* will not misconstrue Hamel's own leaning toward the pregnancy approach as the CHA's position, despite his being its senior director for ethics.[2]

Directive 36 permits medications that prevent ovulation, sperm capacitation, or fertilization, but not those whose purpose or *direct effect* is the removal, destruction, or *interference with the implantation of a fertilized ovum*. Our concern is the latter.

Possible Abortifacient Effects of EC

If the effects of high dose oral contraceptives in the ECs under discussion—Ovral and Preven (combinations of estradiol and progestin, the combined oral contraceptives or COC), and Plan-B (a progestin-only pill or POP)—could be proved solely to inhibit ovulation, sperm capacitation, or prevent fertilization, there would be no debate. However, the scientific literature, including Hamel's sources, notes that ECs also cause endometrial changes, acknowledging that these changes *may* prevent implantation, but finding no *conclusive* evidence that they do.[3] However, conclusive evidence of implantation prevention requires proof that fertilized ova had failed to implant precisely because of the changes. This determination is impossible without endangering human life, and even then, tests could not prove conclusively that such abortions were due *only* to endometrial changes. (See Larimore and Stanford, 127.)

Since conclusive evidence is impossible, scientific studies can present only the probable effect that endometrial changes have on implantation. Thus, Hamel quotes Glasier's conclusion: "No scientific evidence supports an abortifacient effect." Note, however, Glasier's view that "the prevention of pregnancy before implantation is contraception and not abortion" (Glasier, 1063). Hamel quotes a study noting decreased effectiveness of ECs (COC and POP) over successive twenty-four hour intervals (Rivera, 1266). He takes this as evidence that ECs have no significant postfertilization effects. However, a very recent study of POP found this decrease in effectiveness to be insignificant.[4] Also, in previous paragraphs of Hamel's citation, Rivera summarizes studies in which endometrial effects of ECs (COC) range from "not sufficient to prevent implantation" to ensuring that "implantation would be unlikely." A more recent study concludes:

> The evidence to date supports the contention that use of EC does not always inhibit ovulation even if used in the preovulatory phase, and that it may unfavorably alter the endometrial lining regardless of when in the cycle it is used, with the effect persisting for days. The reduced rates of observable pregnancy compared with the expected rates in women who use hormonal EC in the preovulatory, ovulatory, or postovulatory phase are consistent with a post-fertilization effect, which may occur when hormonal EC is used in any of these menstrual phases. (See Kahlenborn et al.)

A number of studies report the effects of EC on tubal transport and the consequent danger of ectopic pregnancy. Glasier notes: "Early trials of high-dose estrogen given after intercourse to women at risk for conception were associated with an increased incidence of ectopic pregnancy, but it is likely that, as with the intrauterine contraceptive device, this method is better at preventing intrauterine pregnancies than tubal pregnancies." (See Glasier, 1059.) This concern has prompted governmental warnings in the United Kingdom and New Zealand.[5]

Certainly, the interpretation of these data is subject to the interpreter's own biases, and honest evaulation must consider the strength of arguments. Still, facts are facts, and the fact is that the literature supports the conclusions of the two sources cited in my previous article. There is, indeed, *real* risk of EC causing abortions. The *reality* of that risk is relevant in using EC. Numerical estimates of pregnancies resulting from rape range from 1 to 4.7 percent. Whatever the actual number, it is certain that one hundred percent of the time when pregnancy results, *the woman has ovulated*.

Judgments of Conscience

Directive 36 permits medications that prevent ovulation, sperm capacitation, or fertilization, but not those whose purpose or *direct effect* is the removal, destruction, or *interference with the implantation of a fertilized ovum*. Therefore, determining the possible effect of EC on each particular rape victim is essential for moral certitude about the act that the victim assents to and that the medical personnel perform. This knowledge comes only through considering the full range of EC's possible effects in light of all the reality-making factors of the

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ETHICS & MEDICS

VOLUME 28, NUMBER 6
JUNE 2003

situation. ECs cannot inhibit ovulation if ovulation has already occurred. Nor, after intercourse, can they prevent the capacitation of *all* the sperm in the woman's reproductive tract. If she has conceived, the only effects of ECs are the postfertilization effects already examined.

To omit ovulation testing is to accept the full range of the EC's effects, including possible abortion. With ovulation testing, both victim and medical personnel can have moral certitude that the direct effect of their action is contraceptive. That is why "appropriate testing" must include ovulation testing. It is both reliable and feasible, and it makes no sense not to use it. Hamel says that "a positive test for ovulation would mean denying emergency contraceptive medications (and the consequences of that) to the woman who has been sexually assaulted." Since in this situation it is improbable that EC prevents fertilization, Hamel must accept its other effects. After conception, these would be abortifacient. Any doubt about the abortifacient effects of EC must be resolved in favor of avoiding serious evil. As Grisez notes: "A person who purposely does what *might* destroy ... a particular human good [life] is willing actually to do so."[6]

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Notes

[1]See for example, National Family Planning & Reproductive Health Association, "Emergency Contraception is Just That, Contraception!" listing medical organizations supporting national EC availability without a prescription. [http://www.nfprha.org/pac/factsheets/ecps.asp] (April 21, 2003). The report states that "emergency contraception reduces the need for abortion. The medical community defines pregnancy as beginning with the successful implantation of a fertilized egg. Emergency contraception works to prevent pregnancy *before* implantation" and refers to the American College of Obstetricians and Gyne-cologists. See also Anna Glasier, "Drug Therapy: Emergency Postcoital Contraception," *New England Journal of Medicine* 337.15 (October 9, 1997): 1058–1064.

[2]R.P. Hamel and M.R. Panicola, "Emergency Contraception and Sexual Assault," *Health Progress* 83.5 (September–October 2002): 17, 18.

[3]H.B. Croxatto et al., "Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: A Review of the Literature," *Contraception* 63.3 (March 2001): 111–121; C. Kahlenborn et al., "Postfertilization Effect of Hormonal Emergency Contraception," *Annals of Pharmacotherapy* 36.3 (March 2002): 465–470; W.L. Larimore et al., "The Abortifacient Effect of the Birth Control Pill and the Principle of Double Effect," *Ethics and Medicine* 16.1 (Spring 2000): 23–30; W.L. Larimore and J.B. Stanford, "Post-fertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent," *Archives of Family Medicine* 9.2 (February 2000): 126–133; B.W.J. Mol et al., "Contraception and the Risk of Ectopic Pregnancy: A Meta-Analysis," *Contraception* 52.6 (December 1995): 337–341; R. Rivera et al., "The Mechanism of Action of Hormonal Contraceptives and Intrauterine Contraceptive Devices," *American Journal of Obstetrics and Gynecology* 181.5 (November 1999): 1263–1269; J. Trussell et al., "Updated Estimates of the Effectiveness of the Yuzpe Regimen of Emergency Contraception," *Contraception* 59.3 (March 1999): 147–151.

[4]Helena von Hertzen et al., "Low Dose Mifepristone and Two Regimens of Levonorgestrel for Emergency Contraception: A WHO Multicentre Randomised Trial," *Lancet* 360.9348 (December 7, 2002): 1803–1810.

[5]L. Donaldson, chief medical officer, Department of Health, United Kingdom, "Levonelle/Levonelle-2 emergency contraception: new advice," *CMO's Update* 35 (January 2003). M. Harrison-Woolrych, "Progestogen-Only Emergency Contraception and Ectopic Pregnancy," Information for Health Professionals, *Prescriber Update* 23.3 (October 2002): 40–41.

[6]G. Grisez, *Christian Moral Principles*, vol. 1, *The Way of the Lord Jesus* (Chicago: Franciscan Herald Press, 1983), 290.

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