Treatment For Rape Victims
In Catholic Health Facilities

Part One: Prescriptions to Prevent Fertilization

This is the first of three articles that will deal with the topic of licit medical treatments in Catholic health facilities for a victim of rape. It will deal especially with the moral considerations of rape treatments which allegedly attack the sperm. Part Two will deal briefly with the issue of legal liability and moral reasons prohibiting the use of methods that prevent implantation. Part Three is concerned with methods that delay ovulation and with future possibilities.

Basic Needs of Victims and The Mandate to Respond

Understanding, concern, and respect are the most basic needs innocent rape victims have. These are apparently often denied in a society that still may view victims with suspicion, as somehow guilty, or as having "asked for it."

From their very core purpose for existing — the carrying out of the healing ministry of Jesus — Catholic hospitals have the resources to supply the compassion, concern, and understanding particularly needed by the victims of this heinous crime. Sensitization programs have been developed for policemen to assist them in the better understanding of rape victims. Such programs may be especially helpful also for male members of emergency room staff.

The rape victim has other serious spiritual, psychological, and legal needs that cannot properly be dealt with in these brief articles. Administrators and hospital personnel, especially the staff of emergency facilities need, however, to be aware of these needs and of ways to help the victim meet them. The hospital chaplain's office, for example, will want to develop special approaches, as well as to intermesh procedures with the emergency room (ER) in order to meet spiritual needs more effectively. In the case of other needs, especially legal and psychological ones, the networking of hospitals with other caring programs such as rape crisis centers may be the best approach. Still, certain non-medical responsibilities cannot be avoided by hospital administrators. For example, rape is a serious crime and the proper forms need to be ready for reporting it to the appropriate authorities if the rape survivor so chooses.

Catholic hospitals may have tended to avoid treating rape victims in the past due to the confusion regarding approaches taken to prevent any possible pregnancy. There is valid concern that certain methods are abortifacient and should not be used by a Catholic facility. Could legal liability result if it did not? Apparently not — due to the conscience clauses in the law, but this fact has not been widely recognized. According to reports, there is very little danger of rape-induced pregnancy in the first place, for reasons to be examined more in depth in the final article of this series. The point here is simply that Catholic hospitals need not avoid treating rape victims because of such legal concerns. They can and should provide suitable treatment for rape victims and need to develop a comprehensive policy for this purpose.

The spermicide methods to be described in this first article do not seem to offer much hope for preventing pregnancy. Nonetheless, we start this series reviewing these methods in light of recent medical-moral thinking. They have been used for a long time and many people are under the impression that they all are morally licit and medically effective. More to the point, the scientific and moral considerations in their use lay the...
groundwork for distinguishing treatments that may be anovulant (and therefore moral) from those which are abortifacient (and therefore immoral) as well as for understanding the special questions involved when both effects are possible.

Moral Considerations in Prescribing Prophylaxis

Preventing pregnancy is a vague reference frequently applied to both contraceptives and abortifacients. Since Catholic teaching views human life as if existing with basic human rights from the time that fertilization is complete and onwards, this distinction is very important. For the treatment of rape victims, Catholic medical morality allows the prescribing of medication and other treatments to prevent fertilization as long as these do not prevent nidation (implantation in the uterine wall). While such treatments of rape victims physically prevent conception, they do not have a morally contraceptive purpose. With increasing clarity, the Church has focused on the contraceptive intention as being the heart of what we mean morally by contraception. In moral terms contraception is understood to be an attempt at interfering with the natural consequences of a true conjugal act. To be a true conjugal act, it must be freely and deliberately entered into by both spouses. In fact, the conviction is spreading that a conjugal act not freely performed by both deliberately entered into by both spouses. In fact, the conviction is spreading that a conjugal act not freely performed by both parties cannot be the conjugal act at all, but morally may be rape.

A number of authors draw this conclusion from Church doctrine as found in Paul VI's Humanae Vitae. [See Bayer, Rape Within Marriage: A Moral Analysis Delayed (Lanham, MD: University Press, 1985), especially pages 96-102 and 121-122.]

While a rape-conceived human is innocent of the evil involved in the rape act and possesses all the rights and dignity of any other human from the moment of conception, the invading sperm from a rapist represent the continuation of an unjust act and may be stopped at any point up to fusion of the sperm's pronucleus from a rapist represent the continuation of an unjust act and may be stopped at any point up to fusion of the sperm's pronucleus from a rapist represent the continuation of an unjust act and may be stopped at any point up to fusion of the sperm's pronucleus from a rapist represent the continuation of an unjust act and may be stopped at any point up to fusion of the sperm's pronucleus from a rapist represent the continuation of an unjust act and may be stopped at any point up to fusion of the sperm's pronucleus. Unlike sperm from the conjugal act, the rapist's sperm is unjustly deposited in the woman's vagina, and the victim has the right to treat the sperm accordingly (see, T.J. O'Donnell, S.J., Medicine and Christian Morality, Society of St. Paul, 1976, p. 266). This right and duty to defend against such unjust actions begins before the rape act. For example, Catholic moralists have taught that a woman in real, un­avoidable danger of rape may insert a diaphragm or, if no other method is available, take an anovulant drug. Following rape a woman could legitimately on her own or through the assistance of medical personnel, including the staff of a Catholic hospital emergency facility, do whatever is possible to delay ovulation or incapacitate the sperm for fertilizing (see, B. Ashley, O.P., and K. O'Rourke, O.P., Health Care Ethics, CHA, 1982, p. 292).

Methods That Attack the Rapist's Sperm

In light of earlier medical understanding of the moral principles described above, curettage and vaginal/intrauterine spermicidal douches were at one time viewed as medically and morally acceptable treatments for rape victims to prevent fertilization. Medically these techniques are no longer considered to be dependable antifertility methods.

Spermicidal douches are useless because we know that at least some sperm may remain within five minutes of coitus. Thus a vaginal spermicidal douche after rape would be expected to destroy sperm remaining in the victim's vagina, but those already arrived in the fallopian tubes would be unaffected. Evidence is not clear that among these trailblazers one will be the "winner," but many reproductive experts do feel that fertilization within fifteen minutes of coitus is a real possibility if an ovum is available.

Following intravaginal ejaculation, chemicals within the ejaculate allow active spermatozoa to pass from the 'semenal pool' deposited in the vagina to the 'mucus carpet' of the cervix. This chemical action (buffer) is believed to last for about a half hour. Then the vagina again becomes too acid for the sperm to survive so that further transfer from the seminal pool to the cervix is unlikely. Thus, a vaginal douche as an antiseptic may have good reason be used for preventing veneral disease. It should be understood, however, that unless the douche can be administered immediately after the sperm's entry into the vagina, it is unlikely that it will contribute to preventing conception. Due to the rapid entry of sperm into the fallopian tubes, even within this thirty-minute period the douche cannot be depended upon to prevent fertilization.

How long sperm remain viable (i.e., capable of fertilizing an ovum) after entering the cervix is another important but controversial point. Under late-cycle circumstances sperm form a reservoir in the clefts and crypts of the endocervix from which cohorts of sperm make periodic ascents to higher parts of the genital tract. While the sperm remaining in the vagina are quickly destroyed by the acid condition that returns to this area soon after ejaculation, those that make it early into the cervix can maintain their motility for 48-72 hours and perhaps under rare, optimal conditions, for as long as 5-7 days after exposure. These greater longevities (over 72 hours) have been reported in the literature by only a few researchers. Still, even the remote possibility of viable sperm in the endocervix makes the use of a spermicide in these areas realistic during the time of this potential sperm life. Unfortunately, there is apparently a slight possibility of spermicidal fluids passing through the fallopian tubes, out into the peritoneal cavity to cause complications. This possibility may make intrasaline douches dangerous. Moral considerations need to include the fact that if an embryo had been implanted before the rape it would likely be aborted. Also, if fertilization had taken place before the douche, implantation would most likely be prevented by the effects on the endometrium.

Principle of Double Effect?

Presently the only other utilized technique to attack the sperm itself before conception is dilatation and curettage (D and C). This technique involves scraping the endometrium lining. While it
might seem that such a procedure could be an effective means of removing sperm, in actuality the reservoirs of sperm in the endocervix remain after the D and C. All this technique does is prevent an already fertilized ovum from being implanted or destroying an already implanted embryo. Number 24 of the The Ethical and Religious Directives for Catholic Health Facilities reads in part: “It is to be noted that curettage of the endometrium after rape to prevent implantation of a possible embryo is morally equivalent to abortion.” (emphasis added)

From this brief review of techniques attacking the sperm, it is apparent that presently none are really acceptable from a moral or medical perspective. This being so, in the next articles of this series we will turn to methods that prevent implantation (abortifacients) and are, therefore, illicit, or that may prevent ovulation and, therefore, are licit under the conditions cited.

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A Matter Of Life And Death

When is Life-Support the Prolongation of Dying?

In seeking to be compassionate, Alan L. Otten in The Wall Street Journal (June 5, 1983) proposes that committees set rules for deciding how to withdraw life from elderly men and women whose bodies are tragically wrecked beyond repair.” Note well that these persons need not be terminally ill. Earlier in his article, Otten raises the anguished question, “Why do we treat aged and loved animals better [by “putting them to sleep”] than we treat our aged and loved human beings?”

While it is appropriate to kill a terminally sick or incapacitated aged animal, is it morally right to treat sick and aged human beings in the same manner? Is it not rather that we treat suffering human beings with love and respect not by killing them, but by providing what they need to continue living pain free and alert to the extent their actual condition permits?

Discarding the Unusable

If a shirt gets torn beyond repair we destroy it, tear it to rags. If a cup gets cracked or broken, we throw it away. If an automobile is “totaled” it is discarded for junk. When an old building is no longer suitable for habitation it is torn down. The operative principle here is that when an inanimate object is no longer able to perform its function, then it is destroyed or discarded. A similar principle is applicable to animals, pets or otherwise: When an animal is injured or sick beyond recuperation, it is “put out of its misery,” i.e., killed. If an old and sick dog is no longer able to eat, we terminate its life. A horse, at least in the past, with a broken leg was shot. Undoubtedly, most people would probably treat pet animals with more sensitivity than inanimate objects.

But what about humans who are injured or ill beyond recuperation? How do we treat them? Up to the recent times we have treated our sick, dying fellow humans with compassion, trying to heal them, if possible, but at the very least maintaining comfort and care. To do less would be to disrespect them, to affront their human dignity. But is it cruel not to hasten their death in their final illness? Is it disrespectful to their human dignity not to terminate their lives by a deliberate act of commission (or by omitting an act to which we are obligated) when they are experiencing intense pain?

Unlike our disposal of inanimate objects and animals, we do not discard human beings, nor have we, up to the present, considered it right deliberately to terminate their lives. To do so has rightly been considered murder. The expression “mercy killing” still retains the word “killing”. But is it merciful to kill someone who is terminally ill or is in a chronic vegetative state?

Patient and Family

There are at least two or more persons to be considered: 1) the patient who may be in great pain or is in a irreversible coma, and 2) the family (and others) who have the care of the patient and upon whom the continued care of the patient may be placing a heavy burden. Both groups need to be considered in making a moral evaluation.

Recent studies have shown that pain can be controlled adequately. (See, McGivney and Crooks, J. Am. Med. Assoc. March 2, 1984, pp. 1182-88.) Experts in the field point out, however, that in many cases an insufficient amount of analgesics is used. A number of drugs are available for the relief of pain, but surprisingly these are frequently underutilized. (See, Argell, New Eng. J. Med., Jan. 14, 1982, pp. 98-99.) If the patient fails to respond to the anti-pain medication there are other procedures available such as surgery or chemical ablation of critical pain pathways. In addition, the environment of the patient has an important influence as to how the patient experiences painful stimuli. The hospice philosophy has proven effective in the pain management of terminal cancer patients. Once it is recognized that death is the inevitable consequence of the patient’s condition, this philosophy is directed toward maintaining the patient pain free but alert, and at home if possible. In addition, a friendly, cheerful atmosphere where patients can receive visitors freely contributes greatly to the patients comfort and care. Most persons are rightfully “scared to death” by the thought of spending days, weeks, months or even years in constant severe pain. Once it is realized that pain can be adequately controlled, that spectre is laid to rest and the demand for the active termination of life becomes less urgent.

Concern for the family is also important. The emotional and financial stresses resulting from a prolonged terminal illness of