The occurrence of forcible rape is an event which appropriately calls forth an intense emotional condemnation for the perpetrator and sympathy for the victim. There has been a salutary change in the attitudes of society toward this crime of violence, including well-organized measures to improve the aftercare of the rape victim. Most states require hospitals to establish written protocols for the care of rape victims, particularly in emergency room settings. This has created conflicts for Catholic institutions with regard to the recommendation for the use of so-called “morning-after” pills in rape protocols. The conflict relates to the action of hormones (large doses of estrogen or estrogen-progestogen combinations) given during the post-rape period and the intentionality of the health care provider in dispensing the hormones or referring to agencies which will provide them. The crux of the matter is whether the “morning-after” pill is an abortifacient through its effect in preventing implantation or whether it can be a contraceptive through an effect of preventing ovulation when given early in the cycle.

Moral Principles: Contraception and Abortion

Contraception is immoral because normal, marital sexual relations must “preserve the full sense of mutual self-giving and human procreation” (Gaudium et Spes 51). The wrongfulness of contraception consists in the decision 1) to bring oneself into sexual union with one’s spouse and 2) positively to render procreation impossible (Fam. Cons. 32). A rape victim, by contrast, has not made the free choice of sexual union, and she is, therefore, free to attempt to neutralize the effects of the assault which violated her bodily integrity. In a hospital setting, this might involve attempts to prevent sperm transport or sperm capacitation or to suppress ovulation. These measures are contraceptive, broadly speaking, in that they aim to prevent conception. Still, such measures are not contraceptive in the moral sense because the victim has not freely entered into a sexual union.

A woman’s freedom to defend herself from the effects of rape does not extend to measures which endanger or end the life of the child she may have conceived. In Catholic facilities, directly intended abortifacient measures may not be used even in cases of rape. "Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion which, in its moral context, includes the interval between conception and implantation of the embryo" (ERD 45). Drugs which interfere with the earliest stages of human development after conception are abortifacients, not contraceptives.

There have been attempts to redefine “contraception” to include the prevention of implantation. A corollary semantic manipulation has been to define the stages between fertilization and implantation to be “pre-embryonic.” The American College of Obstetrics and Gynecology has redefined pregnancy as beginning with implantation. This manipulation of language is not related to any new scientific understanding so much as the need to fulfill a political agenda. It is ludicrous to quibble about when life begins when we can make life begin in a petri dish by the process of in vitro fertilization. During the period between fertilization and implantation the embryo independently controls a sequence of events which are crucial to its survival. Abortion is no less immoral and repugnant when it occurs in the earliest stages of intrauterine life.

Functions of Postcoital Agents

The usual measure employed for postcoital contraception is two 100 mcg doses of Ovral (an estrogen-progestogen combination) administered 12 hours apart. As stated at the outset, Catholic institutions cannot adopt such a measure without determining whether Ovral, as administered, functions as a contraceptive or as an abortifacient.

From the data provided by Wyeth-Ayerst Pharmaceuticals, the manufacturer of Ovral, it can be inferred...
that the evidence that Ovral does, in fact, act as an anti-ovulant in the aforementioned dosage schedule is meager and inconclusive. The company does not, in fact, claim such an effect. If Ovral is to be administered for ovulation suppression it must obviously be given to a patient who has not ovulated or who is not in the process of ovulating. Ovral given after ovulation or during ovulation could only act by way of its abortifacient effects such as interfering with the tubal transport of the zygote or interfering with implantation itself.

The chemical ingredients in Ovral do have effects on the cervical mucus to prevent sperm penetration as well as sperm transport and sperm capacitation. However, sperm traverse the cervical mucus at peak phase (time of ovulation) in a period of 90 seconds. Sperm transport from the cervix to the site of fertilization in the oviduct occurs in minutes, possibly 5 minutes after intercourse. Given the logistics of the usual aftercare of rape in a hospital emergency room, it is unlikely that Ovral could be administered in time to prevent capacitated sperm from reaching an ovum, should there be one present in the tube.

Risk of Pregnancy After Rape

Postcoital agents are believed to be effective for avoiding pregnancy in rape victims because of studies done on populations other than rape victims, such as women on college campuses who approach student health centers after an episode of “unprotected intercourse.” These studies compare the number of pregnancies following postcoital hormone administration with the number expected following a single act of random unprotected intercourse in any menstrual cycle. The accuracy of these studies is questionable on methodological grounds. However accurate they may be, one must still question whether the “unprotected intercourse” they study provides a good analogue for forcible rape. Some studies suggest that the risk of pregnancy in cases of rape may be much lower than that in cases of random unprotected intercourse. While not all rapes are reported, there is no reason to think that pregnancy is more common after unreported rape than it is after reported rape.

There is no litigated case in which selective denial of “morning-after” pills has resulted in a greater risk of pregnancy. Pregnancy after a single act of forcible rape is rare under any circumstances. In a prospective study of 4,000 rapes in Minnesota, no pregnancies were reported. In a prospective study of 117 rapes there were no pregnancies among the 100 women who received no post-rape hormones.

Some recent studies have helped to shed light on this lower-than-expected incidence of pregnancy due to rape. Possible explanations include the high rate of sexual dysfunction observed in rapists and the fact that about 70% of rape victims face reduced risk because they are, at the time of the rape, on contraceptives, pregnant, post-menopausal, pre-menarchal, or surgically sterilized.

Emergency Room Protocol

The Rape Protocol of a Catholic hospital would in almost every detail conform to that of a non-Catholic hospital. There would be the same procedures for evidence collection, the prevention of sexually transmitted diseases, the determination of whether the woman was pregnant at the time of rape and the provision of immediate and long-term sympathetic counseling. The only difference would be the elimination of the use of Ovral during the stages of the menstrual cycle of the rape victim when its effect could be abortifacient.

The evaluation of the rape victim to determine what stage of the menstrual cycle she was in at the time of forcible rape can raise significant logistical problems. It has been shown in hormone-assay controlled studies that the woman’s own history of her menstrual cycle is unreliable. Accurate evaluation of whether the woman is pre-ovulatory, ovulating, or post-ovulatory will require objective laboratory evidence such as the omniprex to detect the LH surge, urine pregnanediol, and serum progesterone levels.

Ordinarily, the primary intention with which emergency room physicians prescribe Ovral or similar hormones is to render the endometrium hostile to a possible fertilized ovum. It seems disingenuous to promote Ovral for its reputed contraceptive effects when doctors neither prescribe nor do women take it for such a purpose. It is important that we do not try to justify the use of Ovral through some loophole in which we appear to be trying to find a way to circumvent our own ethical directives. (See Msgr. Steven P. Rohils, “Pregnancy Prevention and Rape: Another View,” Ethics & Medics 18, 5 (May, 1993.)

Conclusion

Further studies are needed to find reliable methods to confirm the ovulatory status of a woman when she presents in a post-rape scenario. The estimated date of ovulation which the woman herself may provide is likely to be inaccurate because most women do not keep careful records of their menstrual periods. Moreover, an estimated date is insufficient because it cannot exclude the possibility that Ovral would actually be abortifacient. The mere intent that Ovral act as an abortifacient does not preclude it from functioning as an abortifacient in a given case. If it is impossible to determine whether a woman has already ovulated and whether Ovral will prevent ovulation, Catholic hospitals should not use it.

Catholic hospitals provide comprehensive care for rape survivors. Rape protocols in Catholic facilities are not incomplete because they refuse to provide abortion services or to refer women to those who do provide them. In the unlikely event that a woman becomes pregnant as a result of rape, protocols must take into account both victims, mother and child, not just one.

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