

U.S. Catholic Hospitals and the Treatment of Rape

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Most hospitals in the United States prescribe what is euphemistically called ‘emergency contraception’ to rape victims who are diagnosed as not being pregnant. There are two kinds of emergency contraceptives, one that contains both estrogen and progestogen (Preven) and the other that contains progestogen only, (Levonorgestrel) – LNG. There is evidence that both types of pill, also called the ‘morning-after pill’ (MAP) can act as a contraceptive or alternatively, can cause an abortion by preventing the implantation of an embryo in the endothelial lining of the uterine cavity.

The Colorado Emergency Contraception Bill

Governor Bill Ritter’s Bill (January, 2007) concerning the availability of emergency contraception to a survivor of sexual assault requires hospitals to adopt protocols to inform such a survivor of the availability of emergency contraception. The Bill does not require hospitals to provide emergency contraception to a pregnant woman, nor does it require a health care professional to provide either information about emergency contraception or the emergency contraceptive itself, if the professional objects on religious or moral grounds.

Three questions need to be asked. Will Catholic hospitals, if they provide information on emergency contraception, include the scientifically proven embryological fact that these contraceptives may also act as abortifacients, and will they impart Catholic teaching in regard to emergency contraception? Secondly, If a Catholic institution delegates the duty of providing such information to a person who had no moral or religious objection to emergency contraception, will that person commit to teaching the fact that emergency ‘contraceptives’ can possibly act as abortifacients, and will that delegate commit to communicate Catholic teaching? Even if the answer to both of these questions is ‘yes’, could not such activity still be morally wrong?

The Colorado Bill does not appear to require Catholic hospitals to educate rape victims on the procedures used to determine ovulation, or to determine if the victim is pregnant, though some hospitals may choose to do so.

The Biological/Theological Debate

Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services* states that a female who has been raped may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization, "... If after appropriate testing, there is no evidence that conception has occurred." "Appropriate testing" is of two kinds. One is known as the "pregnancy approach." The patient is tested for a pre-existing pregnancy unrelated to the assault, using a human chorionic gonadotropin (HCG) test. The problem is that this test becomes positive *only* at implantation of the embryo in the endometrium of the uterus. This test may fail to demonstrate a pregnancy that had occurred within eight to ten days before the rape. A pregnancy that occurred before the rape, could, therefore, be missed.

The second kind of "appropriate" testing is known as the "ovulation approach." This tests for pre-existing pregnancy and in addition, also tries to ascertain whether the woman is at the point in her cycle where conception might have occurred, that is, near the time of ovulation. The MAP is offered if the HCG test is negative and personal and empirical data indicate the woman is not at, or near, the time of ovulation. If she is near that time, the MAP is not offered.

The Peoria Protocol goes further in assessing ovulation. It requires care givers to conduct (1) a urine dip-stick test to determine the presence of a luteinizing hormone (LH) surge, a guide to ovulation, and (2) a blood test to determine the woman's progesterone level, another indicator of ovulation. Different courses of action are determined by the results of these tests. A serious problem with this approach is that the LH assay may fail to indicate the presence of a pregnancy and plasma levels of progesterone may fail to distinguish whether a woman is in the phase *before* or *after* ovulation.¹ The fact that there is no elevation of the progesterone level does not necessarily mean that ovulation has *not* taken place. It takes a few hours before that increase shows up in the blood.

The most commonly used emergency contraceptive is levonorgestrel, a progestogen. The Catholic Health Association of the United States, (CHA), proponents of the above pregnancy approach to testing rape victims, and many others as well, tell us that levonorgestrel, rarely if ever, prevents implantation of the embryo, that is, causes an abortion, and that there is no scientific evidence to show that it can.² This statement is still a matter of serious debate. The World Health Organization has reported that the morning after pill (MAP), for example, Preven, which is a combination of oestrogen and progestogen, can act as a contraceptive by inhibiting ovulation, or it may cause an abortion by preventing implantation. Some studies indicate that the emergency contraceptive that acts as a progestogen only, levonorgestrel, (LNG) acts *primarily* as an abortifacient.³

Although there is *no direct experimental* evidence that links oral contraceptives with embryo loss, oral contraceptives *are* known to thin the endometrium, and to alter its biochemical and protein composition. An endometrium of average thickness of 5 –13 mm. is needed to maintain a pregnancy. The average endometrial thickness in women taking oral contraceptives is 1.1.mm.⁴

In another study LNG taken before the LH surge altered the luteal phase secretory pattern of glycodelin in serum and the endometrium.⁵ Furthermore, treatment with emergency contraceptive pills containing only LNG during the peri-ovulatory phase may fail to inhibit ovulation but, nevertheless, reduce the length of the luteal phase and the total luteal phase LH concentrations. This observation suggests a post-fertilization effect.⁶ Levonorgestrel, whose action is more abortifacient, is the more commonly used pill today because it is more effective and causes less nausea and vomiting.

Further studies suggest that LNG may have an anti-implantation effect. In one study 243 women took LNG on a day in the cycle when ovulation could not be inhibited, one day earlier or one day later than the moment of expected ovulation. LNG effectiveness was 88%: 46% of the women took the pill within 24 hours after intercourse, 36% within 24-48 hours, 19% between 48-72 hours.⁷ Other studies have shown continued effectiveness of LNG even when taken between 72 and 100 hours after intercourse. This makes it highly likely that LNG was taken on days when it was

impossible to block ovulation, given that a woman's fertile days are up to 5 days before ovulation.^{8,9,10}

Stanford and Kahlenborn state that evidence based on alterations in endometrial biochemistry and histology, endometrial thickness, and receptivity from research studying in vitro fertilization and endometrial integrins all support the possibility of peri-implantation or post-implantation effects (abortion). However, few data assisted in quantifying those post-fertilization effects. For the perfect use of the combined oral contraceptive, a post-fertilization mechanism would be likely to have a small, but not negligible role. For progestin only pills (levonorgestrel), post fertilization effects are likely to have an increased role. The medical literature does not support the hypothesis that post-fertilization effects of oral contraceptives do not exist.¹¹

An editorial in the journal *Contraception*¹² states that Croxato et al.^{13, 14,} have argued that most, if not all, of the contraceptive effect of both combined and progestogen only emergency contraceptive pills (MAPs) can be explained by inhibited or dysfunctional ovulation. Based on their studies on humans and animals, some are tempted to conclude that there is no post fertilization effect, no prevention of implantation. It is unlikely, the editorial stated, that this question can ever be unequivocally answered, and we therefore, cannot conclude that MAPs never “prevent pregnancy after fertilization.”¹⁵ Such ‘prevention’ is of course, abortion and not contraception.

A further question presents itself; if there is no sure test to show that ovulation has, or has not, occurred in a victim of rape, and the Director of Communications for the Archdiocese of Denver admits that this could be so, then why use an ovulation test in order to administer the morning after pill?

The favourite CHA approach to ‘appropriate’ testing for rape cases, the so-called pregnancy approach, is morally unacceptable. It may fail to detect a pregnancy that has occurred either before or after the rape. In 1998, a World Health Organization study of 2000 women were given an emergency contraceptive after blood or urine had been taken for a pregnancy test at enrolment. However, pregnancy did not exclude participation in the study. Of the women later found to be pregnant, about 10% (4 out of 42) were discovered to have been pregnant before taking the pill! The Preoria Protocol may give a greater degree of probability that a woman is not pregnant, but it too may fail

to detect a pregnancy that resulted from the rape. As Dr. Robb Barbieri, Chief of Obstetrics and Gynecology at Brigham and Women's Hospital, Boston, has said, "... by measuring hormone levels, doctors can often determine whether a woman has ovulated or whether implantation has occurred, but that it is really impossible to pin-point fertilization, the step in between."¹⁶

Earlier in this paper, the question was asked if it would be morally wrong to administer MAPs to rape victims or to give them information about MAPs. Those who support administering MAPs do so by stating that rape is a violation of justice that allows their administration. Could not a similar argument be made for the use of a condom to prevent the spread of sexually transmitted infection, which might also be called a violation of justice?

Brother Daniel Sulmasy, Director of Ethics for St. Vincent's Hospital in New York, says that the Peoria Protocol "...goes beyond the normal protection given to any unborn child" and that it "lays upon the faithful an almost impossible burden."¹⁷ Msgr. William Smith, St. Joseph's Seminary, Dunwoodie, N.Y., says "Catholic hospitals are not free to prescribe or provide anything with abortifacient properties without contradicting their witness."¹⁸ The Pontifical Academy for Life, in a "Statement on the so-called 'morning after' pill". Vatican City, 31 October, 2000, stated that "the absolute unlawfulness of abortifacient procedures also applies to distributing, prescribing and taking the morning after pill. All who, whether sharing the intention or not, directly cooperate with this procedure are morally responsible for it." Pope John Paul II, speaking to Indonesian bishops on June 7, 1980, said "Contraception is to be judged objectively so illicit that it can never, for any reason, be justified." Whether the MAP causes abortion is at present *dubium facti*. An editorial in the journal *Contraception*, 2006, makes the point that it is unlikely that the question whether the MAP causes an abortion can ever be unequivocally answered.¹⁹ Action in regard to its use therefore requires one to be morally certain that it does not cause an abortion. If that doubt cannot be solved, one is not permitted to administer the MAP.

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