test is negative and her progesterone level is greater than or equal to 6 ng/mL. In this situation, the timing of the sexual assault could not have coincided with the presence of an ovum. Hence, *it is morally permissible to administer* an emergency contraceptive for the victim's psychological benefit.

- Finally, the woman is determined to be in the *late post-ovulatory phase* if the LH urine test is negative, her progesterone level is less than 6 ng/mL, and she anticipates menstruation in less than seven days. Here, too, *it is morally permissible to administer* a contraceptive medication.

Concerns with the Ovulation Approach

The merit of the ovulation approach is that it seeks to prevent conception resulting from a sexual assault while at the same time seeking to prevent the destruction of human life if conception has already occurred. Despite the considerable merit of this approach, we find several aspects of the approach to be of concern and, when taken as a whole, these concerns suggest to us that the pregnancy approach might be morally and practically preferable.

The first concern is that the ovulation

COMMENT

A physician's point of view

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It never occurred to me that offering emergency contraception to rape victims could be controversial. It wasn't until I was called a few years ago by a researcher doing a survey that I learned that this is an issue. I thought that emergency contraception was the standard of care, like offering thrombolytic therapy to a patient having a myocardial infarction. Therefore, I welcomed the opportunity to comment on the article by Drs. Hamel and Panicola. I am grateful that this subject is being discussed in a reputable forum.

I have been an emergency medicine physician for 20 years. Day in and day out I see the horrors inflicted on my patients by my fellow human beings. Rape is one of the worst of these horrors. Despite seeing large numbers of victims, I have never gotten "used to" these patients. I can dissociate myself from a patient with a gunshot wound. When I step into the vortex of a trauma resuscitation, there is amazingly little interpersonal exchange between the patient and myself before he is whisked away to the operating room or the morgue. But with a rape victim, there is nowhere to hide. I have to take a history that is painful to listen to. I have to perform a physical exam that, besides being painful, is humiliating (taking swabs of the throat, vagina, and anus; collecting fingernail scrapings; plucking hair samples, etc.). After this, I have a frightening conversation about the risks of HIV transmission and sexually transmitted diseases. I discuss the patient's personal sexual history and the terrifying possibility of becoming pregnant as a result of this violent act. After all this, I test for an existing pregnancy. If this test is negative, I offer the patient pregnancy prophylaxis and treatment to prevent a sexually transmitted disease. I arrange for counseling and discharge the patient.

If I had to use the Peoria Protocol, it would be impossible for me to offer prophylaxis at the time of this visit. In most hospitals, there is no such thing as receiving "stat" progesterone level information. This is a complicated assay that is usually sent out to a reference lab and has a turnaround time of several days. This puts the patient well past the effective therapeutic window for prophylaxis. Even if I could get the result back in a day, the patient would need immediate gynecological follow-up. Try arranging that at 3 am on a Saturday morning.

The LH urine test is even more problematic. It is not accurate in patients taking corticosteroids, such as those with asthma. It is not accurate in patients taking certain antibiotics. It is not accurate if the patient's urine is dilute (a common effect of alcohol, which is often involved in rape). It is not accurate in perimenopausal women or in those with polycystic ovary syndrome. Do I deny this large group of women the option of prophylaxis because I cannot trust the results of the LH test?

The Peoria Protocol is neither a practical option nor a medically or scientifically valid approach. Requiring its use would effectively eliminate my ability to treat my rape patients at an acceptable standard of medical care. Maybe my thinking is simplistic, but to me, this is a no-brainer. We clinicians need to do the right thing, and that is to follow the Centers for Disease Control and Prevention and the American College of Obstetrics and Gynecology guidelines for the treatment of women who have been raped. Failing to do so will leave us vulnerable to sensationalistic attacks that will in turn give rise to legislation with far-reaching mandates that most of us would abhor.