approach limits Directive 36. Nowhere in the directive does it state that Catholic health care providers must refrain from administering emergency contraception to women who are about to ovulate or who have ovulated recently. In fact, Directive 36 explicitly affirms that medications can be administered to prevent fertilization, which occurs after ovulation. By limiting the administration of emergency contraception to situations in which the woman has not yet ovulated or is past the early post-ovulatory phase of her menstrual cycle, the ovulation approach unnecessarily restricts the moral options available to women who are at or near the time of ovulation and wish to prevent a potential conception.

In actual fact, the window of opportunity to administer emergency contraceptive medications is physically or biologically wider than the ovulation approach seems to acknowledge. Conception does not occur immediately after the ovum is expelled from the ovary; it can only be achieved after fertilization is complete. This is important if one recalls that fertilization is not a moment but rather a process that unfolds over *at least* a 24-hour period, with the possible result being a conceptus. Thus, in truly keeping with Directive 36, emergency contraception could always be administered morally to women who have been sexually assaulted, even if they are near ovulation or have ovulated recently, as long as they come to the

COMMENT

A reasonable, realistic, and ethical protocol

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I find much with which to agree in Hamel and Panicola's thoughtful article. However, I think they have overstated the case against the abortifacient effects of high-dose estrogen-progestin pills. Unfortunately, there is "advocate science" on both sides of this issue, and the sources they cite may well provide an example. I have also grown uncomfortable using the term "contraception" in this context. "Contraception" refers to interference in the natural process of intercourse and conception. Rape, however, is an act of violence, contrary to nature, and it is thus that the church can teach that contraception is morally wrong and yet allow a woman who has been raped to "defend herself against a possible conception."

Nonetheless, I find their moral arguments persuasive. Catholic ethics has always been a "real world" ethics. This tradition has never required that one do everything imaginable to avoid harm to actually existing persons, let alone possibly existing future persons. The automobiles we drive cause far more premature deaths than the use of a "pregnancy approach" to implementing Directive 36. Pollutants cause mutations and chemical abnormalities that can kill human persons from fertilization to adulthood. Even responsible drivers cause accidents. But we still drive. And we know that hundreds of thousands of people will die prematurely because we do.

The church does not claim the authority to analyze scientific data scientifically but provides moral principles to guide the conduct of science and its human applications. The accuracy of the "ovulation method" is a matter of scientific dispute. But more importantly, this testing is not reasonably available in most hospitals, especially in the middle of the night. Most hospitals send these tests to an outside laboratory—hardly a timely response to a rape victim. And it is unreasonable to insist that the expensive staff, training, and apparatus be available for use once or twice per year.

The "pregnancy approach" is by no means perfect either. But it is a reasonable, realistic, and ethical protocol. Pregnancy testing is widely available, rapid, and easily interpretable. Above all, this approach maintains absolutely strict adherence to our deeply held conviction that it is never morally permissible to destroy directly any innocent human life from the moment of conception to natural death.

At present, there is significant legislative pressure in some states to require all hospitals to offer "emergency contraception" to every victim of sexual assault without respect for conscientious objection by the institution. In light of this, it is noteworthy that the New York State Catholic Conference, in consultation with theologians, has negotiated guidelines with the State Department of Health that would allow Catholic health care facilities, working with their local bishops, to implement the "pregnancy protocol" in responding to victims of sexual assault. I do not believe a hospital can reasonably be accused of being unfaithful to the Gospel of Life by using a pregnancy approach to Directive 36.