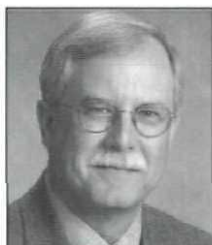


EMERGENCY CONTRACEPTION AND SEXUAL ASSAULT

Assessing the Moral Approaches in Catholic Teaching

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Sexual assault is an egregiously violent act that inflicts unspeakable trauma upon the person assaulted. This trauma is exacerbated for women, particularly those of reproductive age, who may become pregnant as a result of the assault. In the face of such violence and because of their fundamental commitments, Catholic health care providers should offer compassionate and understanding care focused on the person's physiological, psychosocial, and spiritual well-being; collect forensic evidence for police support and possible identification of the assailant; and, when the person is a woman, provide every moral means of preventing conception from this unjust attack for which she is in no way responsible. Although it is never permissible for Catholic health care providers to terminate an established pregnancy or administer medications that "have as their purpose or direct effect the removal, destruction, or interference with the implantation of the fertilized ovum," Catholic teaching allows for the administration of emergency contraception* within certain moral limits. Measures taken to prevent conception in such cases fall outside the general prohibition against contraception because the assailant's act is a violation of justice, and any semen within the woman's body is considered a continuation of the unjust aggression against

which she may licitly defend herself.¹ Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* supports this position and provides further guidance on the matter:

A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization.²

Though the directive specifies when and for what purposes emergency contraceptive medications can be administered, it does not spell out precisely what constitutes "appropriate testing" and "evidence that conception has occurred." Consequently, some variability exists among Catholic health care providers (as well as ethicists and theologians) as to how these phrases are interpreted.³ Two general approaches to treating women who have been sexually assaulted have thus emerged in Catholic health care. The first might be referred to as the "ovulation approach" and the second as the "pregnancy approach."

The ovulation approach seems to be gaining ascendancy within some Catholic circles, where it is sometimes heralded as the only morally acceptable approach for Catholic health care providers, short of directly transferring the woman to another facility or doing nothing at all. Evidence of this can be found in the positions taken by some bishops and theologians in support of the ovulation approach as well as in the increasing number of Catholic hospitals espousing some version of the approach. This article calls into question the belief that the ovulation approach is

*For purposes of this article, "emergency contraception" refers to the Yuzpe regimen containing ethinyl estradiol plus a progestin and progestin-only regimen containing levonorgestrel. Some authors include mifepristone, which is a progesterone antagonist and known abortifacient, in their definitions of "emergency contraception." All data presented on emergency contraception refer to the former regimens and not mifepristone, which is actually unavailable at this time to women in the United States for emergency contraception.

the preferable or only permissible moral approach to preventing conception in women who have been sexually assaulted. It argues instead that the pregnancy approach is morally justified and shows how this approach is in keeping with the Catholic moral tradition as well as reflective of the scientific literature and what is considered by most clinicians to be good medical practice.

This article is divided into three sections. The first describes the general tenets of the ovulation approach and illustrates how it is applied in what has become known as "the Peoria Protocol." The second identifies concerns with the ovulation approach. The third provides the moral grounding or justification for the pregnancy approach. We limit our examination to the ovulation and pregnancy approaches, recognizing the existence of another school of thought, which claims that emergency contraception can never be administered to women who have been sexually assaulted, regardless of where they are in their menstrual cycle, for fear of harming a conceptus. Because that third approach does not fall within the reasoning and spirit of Catholic teaching and Directive 36, we do not address it in this article.

THE OVULATION APPROACH

The ovulation approach tests for a pre-existing pregnancy (i.e., a pregnancy that existed before the sexual assault) and assesses whether the woman is at or near the time of ovulation in order to determine the possibility of conception resulting from the sexual assault. Typically, this is done by inquiring about the woman's menstrual history and/or administering one or more tests to screen for ovulation. The underlying rationale is that a pregnancy test will not be positive from a recent sexual assault and, as such, ovulation is the only clinical indicator capable of providing evidence that the conditions are such that conception could occur. Under this approach, emergency contraceptive medications are offered to the woman if her pregnancy test is negative *and* personal and/or empirical data indicate she is not at or near the time of ovulation. This approach seeks a high degree of certainty that the medications will prevent conception only by inhibiting ovulation. If the woman is about to ovulate or has ovulated recently, contraceptive medications *are not* offered because it is presumed they may (or can only) have an abortifacient effect.* In

other words, if the woman is at a point in her cycle where the medications "would not be effective in preventing ovulation," then they would not be administered because "given the slight chance that conception could have occurred, a possibly abortifacient result might follow."⁴

One popular version of the ovulation approach is known as the Peoria Protocol, which was first developed in 1995 at Saint Francis Medical Center in Peoria, IL. Like other versions of this approach, the Peoria Protocol rests on the premise that the occurrence of ovulation suggests conception *may* have taken place, and that this possibility is sufficient to cause caregivers to refrain from offering emergency contraception, which may (or can only) have an abortifacient effect if administered after ovulation. Where the Peoria Protocol goes further than other versions of the ovulation approach is in the assessment of ovulation. In addition to testing for a pre-existing pregnancy unrelated to the recent assault and asking the woman about her menstrual history to ascertain where she is in her cycle, the Peoria Protocol also requires caregivers to conduct (1) a urine dip-stick test to determine luteinizing hormone (LH) surge, which is believed to be a reliable guide to the prediction of ovulation; and (2) a blood test to determine the woman's progesterone level, which is another indicator of ovulation and helps to categorize the timing of the woman's ovulatory cycle. Depending on the results of these tests, the Peoria Protocol directs different courses of action⁵:

- If the woman who has been sexually assaulted is determined to be in the *pre-ovulatory phase* of her cycle, emergency contraception *may be administered* if her menstrual history and findings of a physical exam are consistent with the pre-ovulatory phase, the LH urine test is negative, and the woman's progesterone level is less than 1.5 ng/mL. In this situation, the first dose of the emergency contraceptive should be given immediately and the second dose 12 hours later. If the first dose is not administered immediately, the risk that the medication could have an abortifacient effect increases.

- On the other hand, the woman is determined to be in her *midcycle LH surge phase* or her *early post-ovulatory phase* if her LH urine test is positive or her LH urine test is negative *but* her progesterone level is greater than or equal to 1.5 ng/mL or less than or equal to 5.9 ng/mL *and* her menstrual history is consistent with midcycle and early post-ovulatory phases (menstruation is expected in more than seven days). In these situations, emergency contraception *should not be given*.

- The woman is determined to be *past the early post-ovulatory phase* of her cycle if the LH urine

*We use the phrase "may (or can only)" because some proponents of the ovulation approach believe that emergency contraception *may* have an abortifacient effect, whereas others believe that when administered after ovulation, these medications *can only* have an abortifacient effect.

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 turn-around 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.

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.

emergency department within at least 24 hours of ovulating. In such a scenario, the medications would act by way of preventing fertilization from ultimately occurring—which is permissible according to the directive—not by destroying a conceptus because fertilization could not possibly have been completed, if indeed it had actually begun. Proponents of the ovulation approach, however, do not concur because they assume that contraceptive medications may (or can only) have an abortifacient effect if given immediately before or after ovulation has occurred. We will address this assumption below.

The second concern is that the ovulation approach gives too much weight to ovulation in setting the moral limits of treatment. Ovulation does not provide evidence that conception *has occurred* but only that it *may occur*. Yet even this may be overstating the matter. A well-known study on the relationship between the timing of intercourse and ovulation that involved 221 healthy women trying to conceive demonstrated that “[e]ven with daily intercourse, most ovulatory menstrual cycles (an estimated 63 percent in our study) may be incapable of producing a conception.”⁶ Coupled with the fact that the rape-related pregnancy rate is approximately less than 1 percent to 5 percent,⁷ the results of this study indicate it is highly improbable that emergency contraception would contribute to the demise of a conceptus, even if the woman had ovulated recently and the medications had an abortifacient effect. This consideration is not meant in any way to diminish the seriousness of the loss of even one conceptus, should that occur. It is simply meant to underscore the improbability of that occurring. Furthermore, it must be considered in conjunction with the next concern.

The third concern is that the ovulation approach leans too heavily on the presumption that emergency contraception acts in some instances (or only) as an abortifacient once ovulation has occurred by inhibiting implantation or interrupting an early pregnancy after implantation. Although it is *possible* that emergency contraceptive medications may cause histologic changes in the endometrium that inhibit the implantation of a conceptus or have a post-implantation effect, conclusive evidence supporting this position has not surfaced.⁸ Even studies hypothesizing that emergency contraception acts as an abortifacient have difficulty finding definitive evidence to substantiate this hypothesis and thus ultimately proffer tentative conclusions about post-fertilization effects.⁹ Of interest is a recent review article by Anna Glasier in which she reports that “the group with the greatest expertise and track record in research on the

endometrium was unable to demonstrate *any* effect which might be associated with the inhibition of implantation.”¹⁰ The fact is, the scientific literature suggests that emergency contraceptive medications act primarily by inhibiting ovulation or disrupting fertilization and have only relatively minor and secondary, if any, post-fertilization effects. Rivera and colleagues¹¹ describe this well:

[E]ven though the precise mechanism of action of modern contraceptives is not yet fully known, scientific evidence suggests the main mechanism of action for each method. Inhibition of ovulation and effects on the cervical mucus are the primary mechanisms of the contraceptive action of hormonal methods. . . . All these methods, directly or indirectly, have effects on the endometrium that might prevent implantation of a fertilized ovum. However, so far, no scientific evidence has been published supporting this possibility. No scientific evidence supports an abortifacient effect.

That emergency contraception prevents conception and is most likely not abortifacient is also supported by recent studies showing that the medications are “most effective when administered within 24 hours of unprotected sex” and decrease in effectiveness substantially and progressively when “administered in the 24-48 hour and 48-72 hour intervals.”¹² As Croxatto et al point out, “this fact alone does not allow for discriminating between possible modes of action, [however] it does lend support to a *significant* role of pre-fertilization mechanisms in their contraceptive effectiveness.”¹³ If emergency contraceptive medications truly had post-fertilization effects, then “the same level of effectiveness ‘should continue beyond 24 hours, possibly even until implantation is established.’”¹⁴ The fact that emergency contraception is most efficacious early on before fertilization could possibly be completed, if indeed it had actually started, suggests that the medications act primarily by suppressing ovulation or disrupting fertilization and have only relatively minor and secondary, if any, post-fertilization effects.

The fourth concern is that the ovulation approach, especially more rigorous versions such as the Peoria Protocol, seems to seek a degree of certainty more akin to absolute rather than to moral (no reasonable fear of error). It does so by insisting that emergency contraceptive medications cannot be administered if the woman is about to ovulate or has ovulated recently because conception is then a possibility and the medications would not be capable of inhibiting ovulation but instead might harm or destroy a concep-

tus. However, the risk that a conceptus will be destroyed seems to be extremely small, if it exists at all, given the facts that most ovulatory menstrual cycles do not result in conception, that the rape-related pregnancy rate is extremely small, and that emergency contraception most likely acts by preventing conception, not inhibiting implantation. Even this small or nonexistent risk, however, seems to be too great for proponents of the ovulation approach. We shall return to the matter of moral certainty and risk later.

The final concern is that proponents of the ovulation approach do not accurately characterize the moral object when contraceptive medications are administered either immediately before or after ovulation has occurred. They view the moral object in such circumstances as the destruction of a conceptus (in other words, the act is viewed morally as an abortion) because they presume that emergency contraceptive medications may (or can only) have an abortifacient effect if administered at these times. However, as previously noted, the evidence does not seem to support this assumption.

THE PREGNANCY APPROACH AND ITS MORAL JUSTIFICATION

Given these concerns with the ovulation approach, we believe that it is not the preferable or only permissible moral approach to treating women who have been sexually assaulted. Rather, we find the pregnancy approach to be both morally permissible as well as morally preferable. As the name suggests, the pregnancy approach tests only for a pre-existing pregnancy. The underlying rationale is that no tests presently available or personal information supplied by the woman can provide evidence of conception from a recent sexual assault, and this being the case, the most that can be done is to rule out a prior pregnancy unrelated to the recent assault. Under this approach, emergency contraceptive medications are offered to the woman if her pregnancy test is negative.

We believe the pregnancy approach is morally justified for several reasons when taken together as a whole. First, prior pregnancy is always ruled out, and once this occurs, nothing is done that would directly harm a developing embryo or terminate a pre-existing pregnancy. This is assuming, of course, that emergency contraception actually has a teratogenic or abortifacient effect on a developing embryo or fetus, neither of which has ever been proven convincingly.

Second, once a prior pregnancy is ruled out, moral certainty exists sufficient to justify administering emergency contraceptive medications to the woman upon her request, even if she has ovulated recently. This moral certainty is rooted in a

constellation of factors that coalesce to support this action. First, the risk of pregnancy resulting from a sexual assault is very small (less than 1 percent to 5 percent). Second, the scientific literature indicates that emergency contraceptive medications most likely act by preventing ovulation or fertilization and do not have post-fertilization effects sufficient to prevent implantation. Third, given these two considerations, the probable direct effect (or moral object) of administering the medications is prevention of a conception from an act of unjust sexual aggression rather than bringing about the demise of a conceptus.* Fourth, the intention in administering emergency contraception is to prevent conception and not to inhibit implantation. If a conceptus is present, but fails to be implanted and ultimately is destroyed, this would be an unintended and even an unforeseen effect, given the extremely low likelihood of conception occurring as a result of the sexual assault and the lack of evidence supporting abortifacient effects of the medications. Finally, a proportionate reason exists for administering emergency contraceptive medications, namely, the prevention of pregnancy resulting from the sexual assault and its subsequent impact on the overall well-being of the woman.

Some might argue that the tradition requires taking the safer, even tutioristic, course in situations of doubt when a value of great importance (e.g., innocent human life) is at stake. In such situations, not even a slight risk can be taken that might lead to undermining the value. One of the examples frequently offered to make the point is the hunter in the woods. A hunter is in the forest and notices movement behind a bush. However, the hunter is unsure whether what is behind the bush is a deer or a human being, possibly another hunter. In the face of this doubt, may the hunter shoot? The tradition answers in the negative. The

*It may seem as though we are invoking the principle of double effect here. However, we are not convinced that the principle applies in its classic form because the action of administering emergency contraception to women who have been sexually assaulted does not really have a "double" effect—one good and intended (prevention of conception) and the other bad and foreseen but unintended (inhibition of implantation). First, no evidence to date definitively supports the claim that emergency contraceptive medications in fact produce the unwanted effect, so it is not certain that a bad effect actually results from the action. Second, even if the administration of the medications results in a bad effect, this obviously cannot occur at the same time as the good effect. Either the medications will work as a contraceptive *or* as an abortifacient but not as both. For a further discussion of the appropriateness of the principle of double effect to this situation, see Cataldo and Moraczewski, p. 11/14.

hunter must first resolve the doubt and, if this is not possible, refrain from shooting.

Like Cataldo and Moraczewski,¹⁴ we do not believe that the example is applicable in the case of sexual assault. In this classic example, the doubt is about the nature of what is behind the bush (a deer or a human). There is definitely something behind the bush; the hunter is simply not sure what it is. In the case of sexual assault, however, the doubt is about whether there is anything (i.e., a conceptus) there at all. And the probability is that there is not. Furthermore (and here we go beyond Cataldo and Moraczewski), in the example, the hunter's intention is presumably to kill what is behind the bush and the assumption is that the shot will be lethal. Neither of these conditions applies to administering emergency contraception in cases of sexual assault. As we have already noted, the intention is certainly not to destroy a conceptus, and it is unlikely that contraceptive medications have an abortifacient effect.

One final point should be made here. The Catholic tradition does not insist on the "safest" course even when *actual* human life is at stake, let alone when the presence of human life is seriously doubtful, as in the case of sexual assault. For example, the tradition permits the administration of opioid analgesics for patients in severe pain even though the possibility exists this action might hasten or even cause the patient's death. The tradition also justifies bombing military targets even when the possibility exists or it is likely that civilians will be killed in the attacks. From these examples, it is clear that the tradition is willing to allow certain actions that may result indirectly in the loss of human life for a proportionate reason. It would seem to follow that the tradition would also be willing to permit the administration of emergency contraceptive medications, which have not been proven to be destructive, when the fact of conception is so seriously in doubt. Although the destruction of a conceptus cannot be absolutely ruled out,

COMMENT

An issue of moral certitude

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As the authors point out, Directive 36 is ambiguous. As we interpret it in the context of the tradition, this directive requires that one only have *moral certitude* that the act of giving emergency contraception (in the care of rape victims) would not have an abortifacient effect. Moral certitude of this nature could be established in two ways. One way is to have more reason to believe that anovulatory medications do not have effects that would destroy or interfere with the implantation of a fertilized ovum than to believe that they do. In the absence of such certitude, a second way is to have more reason to believe that a fertilized ovum is not already present as a result of the sexual assault than to believe that one is present. The latter, however, is only necessary if one does not already have moral certitude concerning the former. In light of the inconclusive medical data regarding the first issue,* we suggest that neither the "pregnancy approach" nor the most restrictive "ovulation approach" is the only acceptable option. Although we agree that both approaches can be consistent with the tradition, we also believe that neither approach sufficiently acknowledges that the determination of whether and when moral certitude has been obtained

properly belongs to the physician and patient, in accord with the norms of conscience.

In our opinion, therefore, an appropriate protocol would (1) require testing for a pre-existing pregnancy per the medical standard of care; (2) allow for the administration of anovulatory medication, given moral certitude that either the medication does not have abortifacient effects or, lacking that, that a conceptus is not present; (3) identify the limits of moral certitude beginning with the "constellation of factors that coalesce" to support the "pregnancy approach" and terminating with a variety of possible indicators that would preclude the possibility of conception having occurred (medical and menstrual history, LH surge test, progesterone test, etc.); and (4) provide physicians with the necessary information to make a decision—in collaboration with the patient—in good conscience. Such a protocol would be consistent with respect for human life and would appropriately respect the physician-patient relationship, the institutional conscience of Catholic health ministries, the right of the victim to advance her own welfare through informed consent, and the morally sound practice of medicine.

* If the medical data were to reveal more conclusive evidence about the effects of anovulatory medications, then our position would have to be revised accordingly.

it is highly unlikely to occur as best we can determine given the current state of medical knowledge. If it should occur, as we have previously stated, it would be an unintended and even an unforeseen tragic consequence.

For all these reasons taken together, we believe that the pregnancy approach is morally justifiable. We also believe that it is morally preferable for two reasons. First, Directive 36 is contained in the professional-patient relationship section of the ERDs and *not* in the beginning of life section. This suggests that treating a woman who has been sexually assaulted is primarily an issue of caring for a vulnerable patient in the context of the therapeutic relationship, allowing for some degree of discretion on the part of the professional and patient within moral limits. The decision about whether to use emergency contraception is one that is rightly made between the woman and her physician, taking into account medically and morally significant considerations. Some women will choose to accept emergency contraception solely on the basis of the exclusion of a prior pregnancy. Others may prefer a "safer" course. However, routinely subjecting the victim of sexual assault to added testing for ovulation, delays in treatment, and increased anxiety, especially when the most the tests can offer is verification that conception is a remote possibility, seems to add to the woman's trauma and humiliation and to impose an unnecessary burden upon her. Turning away a woman who has been so traumatized and victimized on the basis that she is likely to ovulate soon or has ovulated recently and on the unproven assumption that emergency contraceptive medications are abortifacient only seems to add further to the harm already done her.

Second, implementing versions of the ovulation approach that require screening for ovulation (such as the Peoria Protocol) places an added burden on some Catholic hospitals and an excessive burden on others. This approach requires having ovulation screening kits on hand, health professionals available who are trained in administering the test, laboratory technicians on call at all times to interpret the tests, or easy access to an external lab. The consequences of adhering to this type of protocol could lead Catholic hospitals to forgo providing care to women who have been sexually assaulted because of the expense and/or the practical difficulty or impossibility of fulfilling the requirements of the protocol.

The pregnancy approach is responsive to the needs of the woman who has suffered untold trauma from being sexually assaulted and is consistent with the Catholic moral tradition generally and Catholic teaching on this matter particularly. Among other reasons, the improbability that the

woman has conceived as a result of the assault and the unlikely abortifacient effects of emergency contraception provide moral certainty sufficient to justify the administration of the medications, even if the woman is about to ovulate or has ovulated recently. In these tragic situations, Catholic health care providers have a unique opportunity to reveal God's healing presence by responding with compassion and sensitivity to the vulnerable woman in need of care. We believe the best way to do this is by using the pregnancy approach, which allows Catholic health care providers to stay true to fundamental values while at the same time showing profound concern for the woman. □

NOTES

1. For a discussion of the theological justification of preventing conception in cases of sexual assault, see Edwin F. Healy, *Medical Ethics*, Loyola University Press, Chicago, 1956, pp. 275-78.
2. United States Conference of Catholic Bishops, *The Ethical and Religious Directives for Catholic Health Care Services*, 4th ed., USCCB, Washington, DC, 2001, p. 21.
3. See, for instance, Steven S. Smugar, Bernadette J. Spina, and Jon F. Merz, "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *American Journal of Public Health*, vol. 90, September 2000, pp. 1372-76.
4. Joseph J. Piccione, "Rape and the Peoria Protocol," *Ethics and Medics*, vol. 22, September 1997, p. 2.
5. St. Francis Medical Center, *Interim Protocol, Sexual Assault: Contraceptive Treatment Component*, Peoria, IL, October, 1995.
6. Allen J. Wilcox, Clarice R. Weinberg, and Donna D. Baird, "Timing of Sexual Intercourse in Relation to Ovulation—Effects on the Probability of Conception, Survival of the Pregnancy, and the Sex of the Baby," *New England Journal of Medicine*, vol. 333, no. 7, December 1995, p. 1520.
7. Melissa M. Holmes, Heidi S. Resnick, Dean G. Kilpatrick, and Connie L. Best, "Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women," *American Journal of Obstetrics and Gynecology*, vol. 175, August 1996, p. 320. Interestingly, proponents of the ovulation approach contend that the rape-related pregnancy rate may be lower than studies suggest because the studies tend to rely on data from the general population rather than on data generated from women who have been sexually assaulted. Were the latter group of women studied, the thinking is the rape-related pregnancy rate would be lower because sexual offenders experience a high degree of sexual dysfunction and many women who are assaulted are not at risk of pregnancy because they are taking contraceptive medications, have been sterilized, or are not of reproductive age. For further discussion on this point, see Eugene F. Diamond, "Ovral in Rape Protocols," *Ethics & Medics*, vol. 21, October 1996, p. 2; and Julie A. Mickelson, "Pregnancy Prevention After Sexual Assault," in *Catholic Health Care Ethics: A Manual for Ethics Committees*, Peter J. Cataldo and Albert S. Moraczewski, editors, National Catholic Bioethics Center, Boston, 2001, p. 11/10.

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8. Anna Glasier, "Drug Therapy: Emergency Postcoital Contraception," *New England Journal of Medicine*, vol. 337, October 9, 1997, p. 1060. See also Horacio B. Croxatto, Luigi Devoto, Marta Durand, et al, "Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: A Review of the Literature," *Contraception*, vol. 63, 2001, p. 117, and Melissa Sanders Wanner and Rachel L. Couchenour, "Hormonal Emergency Contraception," *Pharmacotherapy*, vol. 22, 2002, p. 44.
9. See, for instance, Walter L. Larimore and Joseph B. Sanford, "Post-Fertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent," *Archives of Family Medicine*, vol. 9, February 2000, pp. 126-133.
10. Anna Glasier, "Emergency Contraception," *British Medical Bulletin*, vol. 56, 2000, pp. 733-734. Emphasis added.
11. See Roberto Rivera, Irene Yacobson, and David Grimes, "The Mechanism of Action of Hormonal Contraceptives and Intrauterine Contraceptive Devices," *American Journal of Obstetrics and Gynecology*, vol. 181, November 1999, p. 1267. See also Peter J. Cataldo and Albert Moraczewski, who note that "the chance of an abortifacient effect in a sexual assault survivor should be 1.2% or less (even less under the restrictions of the St. Francis Medical Center Protocol)," in "A Moral Analysis of Pregnancy Prevention after Sexual Assault," *Catholic Health Care Ethics: A Manual for Ethics Committees*, Peter J. Cataldo and Albert S. Moraczewski, editors, National Catholic Bioethics Center, Boston, 2001, p. 11/14.
12. Rivera, Yacobson, and Grimes, p. 1266.
13. Croxatto, p. 117
14. Cataldo and Moraczewski, p. 11/16.

The authors of this article and the editorial staff of *Health Progress* invite readers to continue this important discussion of emergency contraception in the case of sexual assault. We welcome response to this moral analysis in the form of Letters to the Editor. Send them to hpeditor@chausa.org or:

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THE POWER OF THE SOUL

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ments the formal programs with informal, face-to-face interaction with individual employees and teams. The spiritual leader takes every possible opportunity to retell the stories of these heroes, and through each story shapes and fashions the organization's cultural norms.

A PERSONAL JOURNEY

The formation of a spiritual leader is a continuing, personal journey. It begins with the leader's own spiritual transformation as he or she seeks to understand the values that inform and inspire his or her personal ministry, the call to be a leader in Catholic health care.

My journey began in earnest eight years ago. Having exhausted my tool kit of traditional leadership skills, I began searching for the means to reunite my organization and community around our shared mission and to engage them as collaborators in defining our future. I learned, in the most painful of ways, that I cannot do it alone, and that I cannot make choices as to which of the organization's values or stakeholders will be served while others are left behind. I have come to understand that if my organization is to truly succeed, I must be able to ignite the passion of all those who collaborate with me in that pursuit. My job, then, is to create the connectedness of people to each other and to the meaning of their work, to create the conditions within which the spirit of the organization can flourish. I invite you to join me in that journey as we create the future of Catholic health care. □

NOTES

1. Ian I. Mitroff and Elizabeth A. Denton, *A Spiritual Audit of Corporate America*, Jossey-Bass, San Francisco, 1999.
2. Robert M. Pirsig, *Zen and the Art of Motorcycle Maintenance*, William Morrow, New York City, 1974.

EFFECTIVE ORGANIZATIONS

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how the facility wants to act toward its customers—for example, with dignity, excellence, and justice—employees tend to apply the values to themselves as well. They judge the extent to which *they* are being treated with dignity and justice when they answer survey questions about values. Feeling valued as an employee is our indicator of job satisfaction, and research has shown that feeling valued (and being satisfied with one's job) results in high employee retention and workers stating that they are proud to work for their organization.

VALUES ARE KEY

Again, the data show that all these items—feeling valued, willingness to stay in a job, and organizational values—are linked with one another. The most highly performing organizations reveal a dynamic interplay of all these factors. Employees believe they are valued because they are treated in ways that are congruent with stated organizational core values. They see values in action every day in relationships to customers and to themselves. Thus, they feel more satisfied at work, and ultimately, they judge the organization to be effective.

Values are anything but "fluffy" and soft in organizations. Our research supports the conclusion that values are central to efficient functioning of organizations at all levels. In every instance values are good for business. Consequently, values should be essential to any strategic plan and have a central place in every management meeting and organizational initiative. The vision and mission statement point a hospital in the direction it wants to go; values determine how it will get there. Without the principles inherent in values, the ship is rudderless. With values, employees feel grounded and more eager to commit to a common goal. □