Medication to Prevent Pregnancy After Rape

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Medication to Prevent Pregnancy After Rape

Rev. Donald McCarthy, Ph.D.

The author himself points out that the use of DES after rape is a "difficult and complex moral issue." There are certain very restricted questions within the context on which the magisterium has not provided specific guidance, and this article is an investigative effort to explore these areas within the teaching of the Church, to suggest a line of approach which may need further investigation and assessment before it can be followed in practice.

This is being published because Linacre Quarterly, as a professional journal, presents new and theoretically solid ideas for further investigation to a professionally honest, intelligent and investigative readership.

A professor of moral theology at Mount St. Mary Seminary, Norwood, Ohio, Father McCarthy teaches medical ethics. He has done work for the Catholic Hospital Association and is theologian-member of the medical-morals committee of the Archdiocese of Cincinnati.

In the abortion controversy, one of the most serious challenges to the pro-life position is based on the grave injustice forced upon women made pregnant by the violent act of rape. Yet, according to the traditional teaching of the Catholic Church, even that grave injustice does not excuse the deliberate destruction of a new living human being. Recently renewed emphasis on the possible pre-hominized condition of that new human life until implantation or some point thereafter, combined with an increasing acceptance of a principle of proportionality in conflict situations has led some Catholic moral theologians to consider the permissibility of abortion after rape.

This author sees grave danger of compromising the value of nascent human life in approving any directly abortifacient action to relieve the woman who has been raped of the responsibility for the new human being she has conceived. Any actions which directly attack a newly conceived human life, even if some doubt exists about the presence of a spiritual soul, are excluded by the recent Vatican statement on abortion which said, "Respect for human life is called for from the time that the process of generation begins." Should the use of DES (diethylstilbestrol), often administered in large dosages after rape to prevent pregnancy, be included in this prohibition? Since DES is well known to prevent nidation of any newly conceived embryo, traditional Catholic moralists refer to it as an abortifacient medication and consider it morally objectionable.

The prohibition of DES after rape can present difficulties to Catholic hospitals. The Law Reports newsletter of the Catholic Hospital Association published in its December, 1976, issue an item entitled, "Failure to Administer Abortifacient Leads to Malpractice Charge." The situation was described as follows:

A Catholic hospital, an emergency room physician and a staff nurse have been charged with malpractice for failing to administer the drug diethylstilbestrol to a rape victim brought to the hospital by police officers.

The victim alleges in her complaint that the administration of such a drug is within the definition of "customary and adequate treatment" for rape victims and that the failure of the hospital or its personnel to provide any anti-pregnancy treatment amounted to negligence. Subsequently the plaintiff sustained an ectopic pregnancy and severe permanent injuries therefrom. She is asking for $600,000 in compensatory damages and an additional $100,000 in punitive damages.

Subsequently this suit was dismissed by the Circuit Court because the plaintiff was unable to show any duty on the part of the hospital to provide the services sought.

Since DES admittedly can have an abortifacient effect by preventing implantation, the policy of Catholic hospitals and physicians who refrain from using it after rape surely can be explained as a thoroughly and totally life-respecting policy.

On the other hand, there is an often overlooked but very definite possibility that if a rape victim receives sufficiently large doses of DES after rape and before ovulation, the medication will prevent pregnancy by preventing ovulation (a contraceptive effect) rather than by preventing nidation (an abortifacient effect). Much medical literature about the use of DES and other hormones simply stresses the effectiveness in preventing pregnancy without discussing the fact that large dosages of DES administered before ovulation prevent pregnancy by preventing ovulation rather than implantation. An example, however, of the research on ovulation-prevention by DES is the work of J. M. Morris in 1966. He assembled a small group of volunteers who kept basal temperature records, specifically attempted to conceive, and took DES in dosages of 50 mgms. a day for five days immediately following coitus. Basal temperature charts showed suppression of the ovulatory rise even in several cases where there had already been an elevation prior to coitus and the administration of the drug. In these instances the depression of the temperature rise occurred within 24 to 48 hours of the ingestion of the drug. The effectiveness of large dosages of hormones in preventing ovulation cannot be overlooked in analyzing the use of DES after rape, but unfortunately in most cases a physician will not know precisely the actual time of ovulation of the rape victim and hence will not know for certain if DES will act as a contraceptive or an abortifacient or neither.
If a physician has reasonable certainty that ovulation has not yet occurred when he or she prescribes DES, could this medication justifiably be used on the basis of preventing ovulation rather than nidation? Or if, as is more likely, the physician is unable to determine the time of ovulation and cannot know for sure which effect will take (contraceptive, abortifacient, or neither) could the classical principle of legitimating performing an action with double effect (good and bad) justify prescribing DES? This article will explore these two questions in the hope of fostering a consensus among physicians and ethicists. First we will examine carefully the three possible outcomes of using DES depending on the time in a woman's reproductive cycle in which it is actually administered. Then a longer discussion will present the moral implications of administering this medication for contraceptive purposes with a possible abortifacient outcome if the time of ovulation cannot be known for certain.

1) Three Possible Outcomes

In terms of the actual effect of DES three possible situations arise:

A) If the rape victim has ovulated within 12 hours previous to the act of rape (some authors would stretch this to 24 hours), she may conceive when sperm approach the ovum. If a longer time has elapsed since ovulation, fertilization is no longer medically possible. Studies have indicated that sperm may enter the Fallopian tube to reach the ovum within 5 to 30 minutes after intercourse. If fertilization should occur before DES is administered then the medication would in all probability act in an abortifacient manner by preventing nidation. As mentioned above, Catholic moral teaching has traditionally forbidden direct abortion. Since in the situation considered here the primary effect of DES seems to be the prevention of nidation, this use of DES seems to belong morally to the category of an abortifacient activity. Hence Catholic moral teaching offers no justification for using DES when this outcome is known to follow and is intended.

B) If the rape victim is nearing the point of ovulation in her menstrual cycle at the time of the act of rape she may subsequently conceive if she ovulates during the period of viability of the sperm which were violently and unjustly ejaculated within her body. A reasonable estimate would place this as normally a three (or at maximum four) day period of potential conception. It is known that the emotional trauma of an experience of rape may itself prevent ovulation in some instances. But if the victim were going to ovulate, it seems reasonably clear that the use of DES would prevent ovulation as soon as it took effect, perhaps even within 30 minutes.

Using DES in this way for its temporary sterilizing effect may seem opposed to the literal teaching of Humanae Vitae. However, in the case of potential rape, responsible Roman moral theologians have argued for the permissibility of contraceptive medication, using the example of religious sisters threatened with rape in the Congo. Humanae Vitae argues most directly against corrupting the marital embrace of husband and wife by eliminating the procreative meaning while seeking to express the unitive. Since the act of rape has no unitive meaning but violently misuses the life power, the act of temporary sterilization can be described in this case as an attempt to protect the victim against the full impact of that misuse.

The physical interference with fertility through DES may be seen as a reluctant use of "violence" to counter the violence of the rape aggressor. A woman does surely have the right to protect her reproductive power from the intrusion of the aggressor's sperm just as she would have the right, it would seem, to protect herself with a diaphragm. Therefore it does not seem that magisterial teaching of the Church would definitively forbid use of DES if this outcome were known to take place and so intended.

C) If the rape victim already ovulated more than 12 (or at most 24) hours before the act of rape the medication cannot prevent nidation since the ovum could no longer have been fertilized. Nor does the medication have a contraceptive effect since ovulation has already passed in that cycle. Therefore use of DES in this situation would be medically useless but not necessarily morally objectionable.

If the rape victim uses the medication more than about three or four days before ovulation, while it may well have a sterilizing effect for the remainder of that cycle, this really has no bearing on the effects of the act of rape itself since conception could not have occurred anyway because the sperm would no longer be able to fertilize the ovum.

In both these cases just described, the use of DES does not prevent either conception or implantation from the act of rape. The rape victim would not knowingly use the medication in these circumstances, though, since she would realize it to be unnecessary. However, DES will most frequently be used in these very circumstances if DES is administered after rape although the time of ovulation cannot be known for certain.

2) Use of DES with Contraceptive Intent but Uncertain Outcome

If a physician is able to ascertain that ovulation probably occurred within the 12 to 24 hours previous to the act of rape, the use of DES would be known to be abortifacient as mentioned above in outcome A, and would be contrary to the pro-life position of Catholic moral teaching. Undoubtedly some physicians currently follow a policy of routinely prescribing DES after rape if there is any possibility of pregnancy without concern as to whether the outcome is contraceptive or abortifacient or neither. Many of these physicians are persons who have no strong objection to the abortifacient outcome or else they...
consider it justified by the cruel circumstances of rape.

Pro-life physicians, on the other hand, are understandably reluctant to prescribe DES with even a possible abortifacient outcome. The concern to avoid such an outcome may overshadow the possibility described in outcome B that DES may function in a contraceptive rather than abortifacient manner. Yet conscientious physicians must not overlook the right of the woman who has been raped to self-defense against rape by contraception when possible. If the physician were sure that DES acted exclusively in an abortifacient manner in preventing pregnancy there would be no grounds for the pro-life physician to consider administering DES. If the pro-life physician knew of a hormone medication which were only contraceptive and never abortifacient he or she would solve the difficulty by using this medication. However, use of other hormones than DES which can prevent ovulation seems to risk the same abortifacient effect of DES once fertilization has occurred because of their effect on the endometrium.

Undoubtedly there are cases of rape where no pregnancy will occur, as in cases of women who are postmenopausal, or sterilized, or already using contraceptive pills or the IUD, or even women who are sure that ovulation had already safely passed before their trauma occurred. Furthermore, there may well be women who would refuse DES because of its possible abortifacient effect. But most rape victims are terrified at the prospect of pregnancy and will plead with their physicians to use whatever medication will prevent pregnancy. How far should the pro-life physician go in responding to the right of his or her patient for a contraceptive protection against pregnancy when the medication may actually cause the loss of a newly conceived human being?

If the physician makes an effort to determine the time of ovulation and still has no reasonable certainty that DES will function as an abortifacient, may he or she justify using DES according to the classical principle of Catholic moral theology, the principle of double effect? This would mean intending only the good effect of preventing ovulation and tolerating the possible abortifacient outcome if it should occur instead. Obviously the more heroic path would be to forego such a risk, but would adhering to traditional Catholic morality require such heroism from the rape victim? Must the pro-life physician implicitly insist on such heroism by refusing to prescribe DES even though he or she is not reasonably certain it will function as an abortifacient?

Before discussing the principle of double effect and its possible application to some rape situations, an attempt will be made to estimate the frequency in which DES would produce an abortifacient or contraceptive effect or neither when administered to women who have been raped. There is no reason to suspect that rape occurs more frequently at some points in a woman's menstrual cycle than in others.

Thus it is known that very few pregnancies come from rape. Since a woman can only conceive during the 12 to 24 hours of ovum life during a menstrual cycle which averages 28 days in length one might estimate possible pregnancy as one occurrence in 35-40 instances of rape. However, the rapist may be sterile or the act may not be performed completely or the simple proximity of sperm and ovum may just not bring about fertilization. Thus a most conservative estimate would suggest one pregnancy in 50 situations of rape where a woman is known to be fertile. This would be a statistical maximum; because fertilization does not automatically follow the proximity of sperm and ovum, especially for older couples, the real risk of pregnancy may be one in 100-500 situations.

Notice that the above calculation was derived from the situation of rape when a woman is actually fertile, i.e., an ovum is already prepared for fertilization. There will be additional risk of pregnancy if the time of sperm life effectiveness after the act of rape overlaps with the subsequent preparation of an ovum. (See Figure 1.) In other words, if the woman ovulates during the 3-4 days subsequent to the act of rape while the unwanted sperm may still fertilize her ovum, she may still become pregnant. This additional time period of 3-4 days might suggest 3-4 more possible pregnancies per 28 day average female cycle. However, the factors mentioned above (sterile rapist, incomplete act, non-fertilization despite proximity of sperm and ovum) must again be taken into account. Thus a conservative estimate might suggest an additional risk of 3-4 pregnancies in 50 situations of rape where a woman is known to be fertile. This again may more likely be a real risk of 3-4 pregnancies in 100-500 situations of rape.

FIGURE 1
Pregnancy After Rape

GENERAL FACTORS PREVENTING PREGNANCY:
- Rapist sterile, act incomplete.
- Victim sterile, or already using contraceptive or IUD.
- Despite physical proximity of sperm and ovum, conception often does not occur, especially in older women.
- Trauma of rape may spontaneously stiffle ovulation.

TIME FACTORS IN FERTILITY:

<table>
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<tr>
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<th>Maximum sperm life: 3–4 days</th>
<th>Maximum ovum life: 12–24 hrs.</th>
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<td>Day 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28</td>
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Effective sperm life averages 3–4 days, effective ovum life averages 12–24 hours; conception cannot occur unless the days of effective sperm life overlap the time of effective ovum life.

August, 1977
In summary, an educated guess has been made about potential pregnancies among women who are known to be fertile and are rape victims. Using only the most conservative estimates it would seem that there is at most the risk of 1 pregnancy in 50 situations of rape because the woman is actually fertile at the time of rape, and another possible risk of 3-4 pregnancies because the woman may ovulate subsequent to the act of rape but during the effective sperm life from the act of rape. Thus pregnancy could not possibly occur in more than 4-5 out of 50 situations of rape (more likely 4-5 out of 100-500 situations of rape).

Various Outcomes

Looking now at the administration of DES to rape victims, the various outcomes should be calculated. First of all, the DES will prevent implantation and hence function as an abortifacient in the maximum of one situation in 50 where the woman was already fertile when raped. Secondly, it may function in the same way if the woman conceives by ovulating during the interval from the act of rape until DES is administered and takes effect to prevent ovulation. Allowing both for delays of 6 to 12 hours in receiving the medication and for taking effect to prevent ovulation, it would seem that the abortifacient effect would not occur for more than a statistical maximum of one situation in the 3-4 situations of possible pregnancy from ovulation occurring after the act of rape. On the other hand, the use of DES would successfully prevent ovulation and function in a contraceptive manner in 2-3 situations out of 50 occasions of rape. (See Figure 2.) If conscientious physicians refrain from using DES when they suspect ovulation is about to occur or has just occurred they will diminish further the risks of these abortifacient or contraceptive outcomes. Note that use of DES, even though no effort is made to avoid the most fertile time of the cycle, would still not produce either a contraceptive or abortifacient effect in at least 45 situations out of 50, or at least 90% of the time.

All of the above statistical estimates are based on the most tentative kind of estimation and produced merely for purposes of illustration. Three significant facts can be cited which clearly affect these tentative statistics. First, if physicians establish a personal policy of not using DES when they estimate that ovulation may have just occurred or be just about to occur, they reduce the risk of either the abortifacient or the contraceptive outcomes but some risk of these outcomes remains and there is still little hope of being certain which of these two may occur. Secondly, if physicians use DES even when ovulation may have just occurred or be just about to occur, the risk of either the abortifacient or contraceptive outcomes is much higher, but probably there is still only about a 50-50 chance that the outcome will be abortifacient rather than contraceptive if it is one of these two, since the ovulation cannot be pinpointed exactly. Thirdly, the above estimates have presumed that DES would be administered within the first 6-12 hours after rape; if the delay is longer the possibility of the abortifacient outcome increases accordingly since a greater exposure time for fertilization has occurred before the medication could begin its contraceptive effect.

The above three facts suggest the possibility that a pro-life physician may be attracted to a middle course between routine use of DES for all fertile women who have been raped and complete avoidance of DES. In the middle course the physician would have two possible rules

FIGURE 2

A) ESTIMATED RISKS OF PREGNANCY BY RAPE

PREGNANCY FROM FERTILITY AT ACTUAL TIME OF RAPE:
Average 12-24 hour effective ovum life during an average 28-day cycle, but adjustments will diminish risk (sterile rapist, incomplete act, etc.).
STATISTICAL MAXIMUM: 1 pregnancy in 50 situations (2% risk).
REALISTIC ESTIMATE: 1 pregnancy in 100-500 situations (1% to .2% risk).
RANGE OF RISK: from 2% risk to .2% risk.

PREGNANCY FROM OVULATION AFTER ACT OF RAPE:
Average 3-4 days effective sperm life during an average 28-day cycle, but adjustments will diminish risk (sterile rapist, incomplete act, etc.).
STATISTICAL MAXIMUM: 3-4 pregnancies in 50 situations (maximum 8% risk).
REALISTIC ESTIMATE: 3-4 pregnancies in 100-500 situations (4% to .6% risk).
RANGE OF RISK: from 8% risk to .6% risk.

B) ESTIMATED FREQUENCY OF ABORTIFACIENT OR CONTRACEPTIVE EFFECTS

ABORTIFACIENT:
2% to .2% from women fertile at time of rape, plus
2% to .2% of women who ovulate shortly after rape (presuming DES used 6-12 hours after rape).
TOTAL: 4% to .4% risk of abortifacient effect.

CONTRACEPTIVE:
Remainder of women who ovulate later after act of rape (presuming DES administered 6-12 hours after rape) will experience contraceptive effect, therefore:
TOTAL: 6% to .4% risk of contraceptive effect.
of thumb: 1) avoid DES when the rape has occurred near the estimated time of ovulation, while still considering its use with contraceptive intent at other times of the cycle where it would more likely affect only ovulation and less likely function as an abortifacient; 2) avoid using DES when more than 18-24 hours have elapsed since the time of rape to avoid the higher proportionate possibility of the abortifacient outcome.

Could a truly pro-life physician consider using DES at all since there would almost always be some possibility of the abortifacient outcome, even though the risk would be perhaps less than 1%? Mention has already been made above of the possibly pre-hominized condition of the new human life in the initial stages after fertilization until implantation or even some later point. This author doubts that such a position is supported by "compelling" arguments as Fr. Bernard Haring recently suggested. Still this possibility adds an additional range of uncertainty about the truly abortifacient role of DES. In the classical example of indirect abortion a cancerous uterus is removed to save the life of a mother with 100% risk to the life of a fetus. Is any analogy to be made in the case of using a medication for a contraceptive intent which is made legitimate by the circumstance of rape, when the risk of an abortifacient outcome could hardly exceed 2 situations in 50 or 4% and might well be one-tenth of that (.4%) or even less? The analogy limps badly in one point of comparison, i.e., the DES does not save the life of the mother, although it saves her considerable trauma and unjustly inflicted hardship.

The justification of the indirect abortion by removal of the cancerous uterus rests on the classical principle of the twofold effect as traditionally applied by Catholic moral theologians. Could this principle be applied to justifying the use of DES after rape? For purposes of discussion some assumptions will be made based on the preceding discussion: a) that the DES will never be used when the abortifacient outcome is reasonably certain to occur; b) that whenever DES is used there is at least a reasonable possibility that the contraceptive effect can occur (our estimates suggest that this will be at least as probable as the abortifacient effect in most cases, if either of the two will occur); c) that the contraceptive effect can be legitimately intended in cases of rape as a form of self-defense; and d) that no other medication is available which would produce uniquely the contraceptive effect without risking the abortifacient effect.

Good and Bad Effects

What are the good and bad effects of using DES after rape? The bad effect is clearly the abortifacient one, the loss of the newly conceived human life, even though this occurs very rarely and need not be the intention of the physician or patient. The good effect is withholding ovulation in the face of a possible conception by rape, thereby permitting a woman to exercise her right of self-defense. This occurs at least as frequently as the bad effect and may well be the explicit intention of both physician and patient. These two effects cannot both occur, but the person using DES cannot separate the two by the nature of the situation and thus they both seem to be encompassed in some way in the placing of the act of using DES. In that sense the attempt to intend only the one and merely permit the possibility of the other cannot be known to be an efficacious intention when the act is placed. In all cases, though, use of the medication fosters another good effect in the psychological order, namely the reassurance of the victim that she will not be forced to assume the unjustly imposed responsibility of motherhood outside the covenant of marital parenthood.

Four conditions must traditionally be satisfied before invoking the classical principle of double effect in its usual application. In the use of DES they would be fulfilled as follows:

1) The action of using this medication is not of itself morally evil. Since in many cases the action has no effect on the reproductive process and in some cases it justifiably withholds ovulation, it would seem that the action cannot be judged evil in itself.

2) The bad effect is not the means of producing the good effect. The good effect of withholding ovulation does not presuppose the bad effect of destroying a new human life. Only in rare cases does the bad effect occur at all and then not as a means to the good effect. (When the bad effect does occur it is a means to the psychological good effect of reassuring the victim but it is not the exclusive means to this secondary good effect and need not be intended for that effect.)

3) The bad effect is sincerely not intended, but merely tolerated. Conscientious persons could certainly intend only the good effect and reluctantly tolerate the bad.

4) There is a proportionate reason for performing the action in spite of the bad consequences. If the successful application of the first three conditions can be granted, difficulty may still arise in applying this condition. Is there a proportionate reason for risking a human life which probably is already hominized and possessed of a spiritual soul?

The reason for risking the loss of life in the abortifacient effect of DES is not the saving of another life as in excising the cancerous uterus. Can human lives be risked for other important goods? One precedent may be the bombing of military targets which risks taking the lives of non-combatants and where sometimes the military target is missed entirely and only non-combatants destroyed. The proportionate reason is the common good and survival of the political state waging the just war and the death of the non-combatants is unintended. Since in the use of DES the abortifacient effect will not occur in 96% or even more of the uses of the medication throughout a
menstrual cycle this risk seems considerably less than that involved in military bombing.

The evaluation of whether or not a physician has a proportionate reason for risking the abortifacient effect of DES obviously needs further discussion. It is my own tentative opinion that proportionate reason may be found at least for the middle course described above where the physician follows definite rules of thumb which indicate in practice his or her practical efforts to avoid the abortifacient outcome. I would suggest basing the sufficiency of proportionate reason on two prime considerations: 1) justice and rights: the unjust act of rape and its unjust consequences together with a woman's right to take reasonable steps in self-defense, and 2) the truly minimal risk of causing the loss of life of a human person with the right to life of human persons.

It should be noted that a significant group of contemporary Catholic moralists favor modifying the literal application of the first three conditions outlined above. Their approach, sometimes called the "principle of proportionality," lays strongest emphasis on the proportionate reason for acting in conflict situations which involve the doing of physical evil. This approach has the advantage of simplifying the ethical analysis of the action of using DES although this author is not convinced that this principle should be used as flexibly as some current authors propose. But the above comments have suggested that the use of DES may even be justifiable in the more classical understanding of the principle of double effect. At least the subject seems to deserve further study by ethicists and physicians. If the tentative evaluation presented here can be accepted, Catholic hospitals need not feel that their pro-life commitment and anti-abortion policy would necessitate a policy also totally excluding the use of DES after rape.

It may be objected that Directive No. 11 of the Ethical and Religious Directives for Catholic Health Facilities states that, "Any deliberate medical procedure, the purpose of which is to deprive a fetus or an embryo of its life, is immoral." The purpose, though, of DES, as described here, can surely be anti-ovulatory rather than abortifacient. At least the abortifacient effect which occurs so rarely can hardly be described as "the" purpose of DES if the contraceptive effect is at least equally likely, as maintained here. As already indicated, physicians can follow two specific rules of thumb to minimize the abortifacient outcome of DES and to demonstrate that the significant purpose is contraceptive instead.

To this author's knowledge the magisterium of the Church has not provided specific guidance in this difficult and complex moral issue. Therefore this article has offered a proposal for resolving practical doubts in this area while remaining faithful to the pro-life commitment of the Church as well as the kind of careful analysis which has characterized the principle of twofold effect.

The author wishes to express his gratitude to Dr. Richard F. Schmidt, M.D., head of the department of obstetrics and gynecology of Good Samaritan Hospital in Cincinnati, Ohio, for willingness to explain and discuss the outcomes of using DES based on his own extensive research and study. Dr. Schmidt cannot be held responsible for the ethical reflections proposed here but he has approved the use made of clinical data about DES and other hormones in this article.

REFERENCES


3. Par. No. 12.


5. Law Reports (St. Louis, Mo.: Catholic Hospital Association), No. 10, Dec., 1975, pp. 4-5.

6. Ibid., p. 4.

7. Law Reports (St. Louis, Mo.: Catholic Hospital Association), No. 15, Aug.-Sept., 1976, p. 8.


11. Encyclical letter of Pope Paul VI, July 29, 1968. The whole context of the encyclical is that of marriage and the evil of rendering conjugal acts infecund. In paragraph 13, the Pope speaks even of a conjugal act imposed on a marriage partner without regard for his or her condition or lawful desires as denying an exigency of right moral order in the relationships between husband and wife, The Pope would surely not consider an act of rape a 'conjugal act.'


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**Comments on**

"Medication to Prevent Pregnancy After Rape"

William A. Lynch, M.D.

An obstetrician-gynecologist in the Boston area, Doctor Lynch is president-elect of the National Federation of Catholic Physicians’ Guilds. He is one of the founders of the Human Life Foundation and chairman of its scientific committee. The recipient of the Linacre award for a study on therapeutic abortion some years back, Doctor Lynch is a representative to the World Health Organization’s task force on natural family planning.

Rape is unquestionably a peculiar and a peculiarly vicious form of injustice. It attacks the very personhood and the very femininity of woman.

Pregnancy from rape is quite rare. The rapist is, not uncommonly, sterile or a chronic masturbator with a low count of juvenile sperm. Moreover, the trauma, emotional and physical, inflicted on the woman, is known to be capable of preventing ovulation if that is close at hand.

Further, it is not at all uncommon for a woman to have intercourse at ovulation time and not get pregnant. Apart from statistical surveys and notwithstanding the ravages of endometriosis and pelvic infection, an appreciable number of the seven million infertile married couples in the United States today will attest to this fact.

At the first international meeting held against abortion in New York city in 1967, it was pointed out that out a single pregnancy due to rape had been uncovered in the district attorney’s office in Buffalo, N. Y. in twelve years. At a TV panel in Philadelphia at the time of the publication of the American Law Institute’s recommendations, it was elicited from the architect of the American Law Institute that a pregnancy from rape had not been uncovered in the Commonwealth of Pennsylvania in thirty years. It is possible, even probable, that some women were raped and became pregnant and failed to take any action. Yet the clinical impression is that a pregnancy from rape is distinctly uncommon.

In Father McCarthy’s paper, he makes note of Dedek’s reporting of theological consideration for abortion after the admitted injustice of rape. Such a consideration fails at two levels: 1) the history of abortion repeats the sad story that any infamy starts with the first excep-

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