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A Critique of the Pregnancy Method In the Aftercare of Rape Victims

by

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The proposal by Hamel and Panicola[1] that emergency contraception be given to all rape victims in the emergency room who are not pregnant is called by them: "The Pregnancy Approach." The scientific rationale for the justification of this approach is seriously open to question.[2]

They state, for example, "Emergency Contraception may still act as a contraceptive even if administered after the LH surge.[2] It does this by interrupting the fertilization process."[3] Since the process of conception has not completed in the first 24 hours, they infer that emergency contraception can be given to any woman who is seen in the first 24 hours after assault. This would comprise the majority of cases of reported rape. Is there a plausible justification for declaring this 24-hour free-fire zone?

There is no evidence in the medical literature to suggest that emergency contraception "disrupts the fertilization process." Emergency contraception has no confirmed effect on the zygote or the process of conception during the first 24 hours. If there were such an effect, that is, if the hormones in the "morning after" pill were to be toxic to the zygote or its progressive development, such an effect would not be a contraceptive effect but rather an abortifacient effect. Once fertilization has taken place, even though it is followed by subsequent cell divisions or with the subsequent stages of the morula, blastula, or the implantation of the blastocyst, all interferences are, strictly speaking, not contraceptive but abortifacient. As stated by Dr. Ward Kischer[3] past chairman of Human Embryology at the University of Arizona College of Medicine, "From the moment the sperm makes contact with the oocyte all subsequent development to the birth of the newborn is a fait accompli."

The "evidence" cited by the authors for the claim that emergency contraception does not interfere with implantation of the blastocyst consist not in data but a statement by Glasier[5] that "The group with the greatest experience was unable to demonstrate it." No matter how Glasier appeals to her own special expertise and that of her friends, there is formidable evidence for effects on the endometrium. Glasier's objectivity is further called into question by her bias in favor of the discredited claim that pregnancy begins at implantation. All embryology books[5] state that life begins with union of the sperm and ovum, contrary to the American College of Ob-Gyn and Planned Parenthoods' propaganda in denial of abortifacient contraception by defining pregnancy as beginning with implantation. The term "contraceptive" describes an action preventing the union of sperm and ovum. All subsequent actions are abortifacient.

The authors, in their bibliography refer to the work of Larimore and Stanford.[7] This is a 35-year review of the literature in which the post-fertilization effects of oral contraceptives are supported by no less than 77 references from the peer reviewed medical literature. This body of evidence is difficult to dismiss, as the authors do, as "advocate science" or the product of scientists who fail to qualify as "experts."

Another non sequitur in the argumentation is the claim that emergency contraception acts "within the first 24 hours." This is based on a claim that it is most effective when given during the first 24 hours after assault. The fact that emergency contraception is most effective in the first 24 hours is not proof that its actions are limited to the first 24 hours. The effect of the estrogen and progesterone in oral contraceptives is primarily to inhibit the release of FSH and LH from the pituitary. The authors cite the work of Rivera[8] to support the fact that emergency contraception works best when given within the first 24 hours. However, Rivera also states in the same paper that "at least seven days of uninterrupted use of oral contraceptives is necessary to suppress follicular development" The manufacturers of Ovral caution that its contraceptive effect is not reliable until after a week's use of oral contraceptives.[9] The authors quote Croxatto[10] in support of the fact that emergency contraception works best when given in the first 24 hours. Croxatto further states, however, that this "does not allow for discriminating between possible modes of action." Another plausible explanation for the evidence that emergency contraception works better when administered during the first 24 hours could be related to its effects on the endometrium being started sooner. Since the migration of the blastocyst to the endometrium takes about seven days, it would arrive after a longer period of exposure of the endometrium to anti-implantation effects of emergency contraception including the suppression of integrins (adhesive chemicals necessary for testing of the

blastocyst).[11] If emergency contraception were given later, after 72 hours, for example, the period of exposure to these same anti-implantation effects would be shortened.

The authors refer repeatedly to an action whereby emergency contraception given after or during ovulation will most likely act by "preventing conception." The only way to prevent conception is to prevent ovulation or to prevent capacitated sperm from reaching the ovum. The logistics of post-abortion therapy dictate that emergency contraceptives are administered long after sperm have traversed the cervical mucus and long after capacitated sperm have reached the oviduct. The effect of oral contraceptives on tubal motility is to interfere with the migration of the zygote to the uterus and is therefore an abortifacient effect.

It is not clear what other effect the authors are referring to when they allege "preventing conception" by emergency contraception and not evident that they have evidence from scientific studies that such action actually occurs. The degree of certitude expressed by the authors is entirely unjustified by the facts. They state, for example, "The scientific evidence suggests that emergency contraception acts primarily by preventing conception even when it fails as an anovulant." The U.S. Food and Drug Administration, however, requires that the package insert of every oral contraceptive sold in the United States include (in the Clinical Pharmacology section of the insert) the statement that oral contraceptives produce "changes in the endometrium which may reduce the likelihood of implantation." The FDA requires the inclusion of the statement that oral contraceptives have multiple actions including suppression of ovulation and anti-implantation effects on the endometrium in order that patients have access to fully informed consent regarding the actions of the pill. To withhold such information from those who might conscientiously decline to use oral contraceptives given the risk of abortifacient side effects would be inconsistent with full disclosure. Despite the evidence to that contrary accepted by the FDA, the authors state that emergency contraception "does not seem to have an abortifacient effect."

It is true that the Yuzpe regime was shown in a series of studies involving over 4,000 patients[12] to be 60-90% effective in preventing pregnancy. Kahlenborn[12] has pointed out that in one series involving 400 patients that 2 out of the 6 pregnancies that occurred were patients whose progesterone concentrations at the time of treatment were less than 1.5 ng/mlL. The fact that pregnancies occurred in those whose progesterone levels pointed toward a preovulatory status suggests that other breakthrough ovulation may have occurred. Which could have resulted in pregnancies that were interrupted by failure of implantation. Although this does not prove an abortifacient effect, it suggests that possibility.

The Peoria protocol is a good faith attempt to isolate those patients with no evidence of an LH surge and progesterone levels widely accepted as consistent with early preovulation. This group of patients constitutes that category in which administration most likely, if not absolutely, works as an anovulant. The difference between restricting the use of emergency contraception to this small, thoroughly-tested population rather than giving them will-nilly and indiscriminately throughout the cycle is not "miniscule" as the authors' suggest. In the ovulation approach, the attempt is made to eliminate the possibility of an abortifacient effect. In the pregnancy approach, the possibility of an abortifacient effect is ignored or denied.

The authors suggest that the possibility of an abortifacient effect is irrelevant because the woman "probably won't get pregnant anyway." The rarity of pregnancy resulting from a single act of forcible rape is a reason not to give the morning after pill, not a persuasive reason to give it to all comers.[13]

There is overwhelming evidence that oral contraceptives can have post fertilization effects.[14] The evidence is indirect based on thinning of the endometrium, depletion of integrins and an increased ectopic pregnancy ratio. Thinning of the endometrium and reduction of available integrins have both been shown to be important in the success or failure of in vitro fertilizations.[15] While there is no *direct* experimental evidence that these effects are crucial in vivo, the prudent course is to institute laboratory surveillance of victims of sexual assault. To the extent currently possible, this will assure that emergency contraception will not be used, when the patient is ovulating or immediately pre-ovulatory. The use of testing for the LH surge and ascertaining progesterone levels is the best science now available to accomplish this purpose.

There is a body of opinion that believes[16] that since even the remote possibility of an abortifacient effect cannot be excluded, emergency contraception should never be given in the post-assault situation. If laboratory tests support but do not absolutely prove the safety of post-assault treatment, it must be withheld. This has been characterized as "a theology of perfection."[17] It is, after all, the traditional procedure used by Catholic hospital emergency rooms for many years. There has not been a successful lawsuit against a Catholic hospital for adhering to the policy of withholding post-rape medications.[18]

Nevertheless, the presumption should be on the side of the possibility of life. The best course is to err on the side of a living entity regardless of whether it manifests its personhood. Strategically, it is best that Catholic hospitals not give even the semblance of moral compromise.

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