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17. For a systematic history of the work of these moralists and a tentative synthesis of the principle of proportionality see Richard A. McCormick, S.J., The Ambiguity in Moral Choice (Milwaukee, Wis.: Marquette University Department of Theology, 1973 Pere Marquette Lecture), 112 pp.

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 not 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 falls at two levels: 1) the history of abortion repeats the sad story that any infamy starts with the first excep-
tion (i.e., the gas chambers in Germany); 2) it neglects the thundery fact that mothers throughout history have indeed died seeking justice for their children — and will again. It is neither human nor motherly for a woman to destroy her own flesh and blood because of an injustice done to her. Parents — mothers and fathers — must be the first and major protection to their children.

Father McCarthy’s quiet insistence on respect for life is most welcome in this day when so many people are involved in an intellectual fervor to rationalize an “up-to-date” position for the Church in favor of “some abortions.”

Before entering into a discussion of Father McCarthy’s major points, it would perhaps be worthwhile to review some basic definitions.

Contraception is defined as a method or process by which the union of sperm and egg is prevented artificially or chemically. Anti-conception refers to a method or a process, the end result of which is to render the user incapable of becoming pregnant after its use-effectiveness has left the body. Technically this is distinct from sterilization, in which the reproductive organs or their functions are destroyed. While law and others have successfully indicted the contraceptive pill in a small percentage of women as being anti-conceptive. Conception, as traditionally referred to, is the process of fertilization when, from a genetic point of view, the half number of species chromosomes are joined each from the egg and sperm to fulfill the total number of species chromosomes in an entirely new individual.

Interception is not contraception — the sperm does not fertilize the egg. For their own purposes, the Interceptors define pregnancy as a two stage process: a) fertilization; b) implantation which many adamantly and erroneously call “conception.” They therefore maintain with incredible logic (?) that interception is not contraceptive because it allows union of sperm and egg. It is, in their opinion, not an abortive agent because it destroys the fertilized egg before it can implant in the wall of the womb (in their terminology, before conception). Not to muddy the waters but to demonstrate the “tricks with words” that are employed in this field, it is perhaps worth noting that outside the United States abortion is not uncommonly referred to as contraception by means of abortion.

Interception, of course, represents yet another devious way of confusing the unwary physician and incidentally embarrassing the Roman Church. Interception means that the fertilized ovum dies as it is about to implant itself into the wall of the mother. It is of interest that a fertilized ovum at this stage is referred to as the “Morula” which means “mulberry.” Those who feel they can do an abortion before implantation — interception, that is — belong to what is called “the mulberry group.”

In Father McCarthy’s thesis, he proposes two questions largely concerned with the timing of ovulation at the occasion of rape and whether or not diethylstilbestrol can be used. In the first question he discusses three possible outcomes: a) If the rape victim has ovulated within 12 to 24 hours, she could conceive and DES would thus prevent implantation. Father McCarthy correctly interprets this to be an abortifacient action and therefore, not permissible.

Comment: There is, of course, the difficulty in the practical order in determining if ovulation occurred 12 to 24 hours before.

b) If the rape victim were nearing the point of ovulation at the time of rape, according to Father McCarthy’s thesis, it seems reasonably clear that the use of DES would prevent ovulation as soon as it took effect, perhaps even within thirty minutes. He is raising the question of DES as a contraceptive which is actually the key to his paper. He also mentions that the use of DES as a contraceptive under these conditions is defended by the argument for the use of contraceptives by religious sisters threatened with rape in the Congo.

Comment: To not a few obstetricians, the use of, to take one example, the Pill by nuns in the Congo, if indeed it was permitted, was based upon incomplete or poor medical advice and the mounting complications of the Pill, some of them obvious from the time of its first use, would seem to be not an acceptable practice for the nuns under these conditions from a purely medical point of view.

c) If the rape victim had ovulated more than 12 to 24 hours before the rape, DES could not prevent nidation, since the ovum could no longer have been fertilized and thus it would be medically unnecessary.

Comment: Again, in the practical order we mention the difficulties in determining in the random average patient, that ovulation had taken place 12 to 24 hours before the act of rape. Father McCarthy’s second question raises the major key to his paper — the use of DES with contraceptive intent, but uncertain outcome.

Perhaps the most definite statement upon which this key idea is based is found in the paper’s eighth paragraph: “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 doses of DES administered before ovulation prevent pregnancy by preventing ovulation rather than implantation. An example, however, of research on ovulation-prevention by DES is the work of J. M. Morris in 1966.”

This is, I think, a critical paragraph for the following reasons. Dr. John McLean Morris, professor of gynecology at the Yale Medical School, is perhaps the recognized authority on the use of DES in
preventing pregnancy. Certainly he is among the leading authorities. Secondly, it is regrettable that the paper referred to was published in 1966, as we'll point out below.

Thirdly, one of the reasons why there is so little comment in the literature about the effectiveness of DES as an ovulation preventer, is that it has been shown simply not to work that way, especially within the time limits set by Father McCarthy.

In the American Journal of Obstetrics and Gynecology, Vol. 115:101-106, Jan. 1, 1973, Doctor Morris and his associate, Doctor van Wagenen state: "It has been shown that high doses of estrogen given in the early post-ovulative period will prevent implantation in women. Estrogens do not interfere with fertilization and in the primate will not interrupt an established implantation. Under such circumstances, they are properly neither contraceptive nor abortifacient. (Emphasis added.) The term interceptives has been suggested for agents that interfere with implantation."

And again: "It must be emphasized that the interpreptive effect of estrogens is post-ovulatory rather than post-coital."

"...A basal temperature chart may be of value (in evaluating the victim of rape) especially if exposure is early in the cycle. If the patient is in the follicular phase, treatment is sometimes postponed until the basal temperature reaches 98 degrees F."

Again in the paper by Doctor Morris, in the American Journal of Obstetrics and Gynecology, Vol. 117:167-176, Sept. 15, 1973: "Although estrogens were shown to have an anti-fertility effect in the rat as early as 1926, the first potential application to man was the observation of Sturgis and Albright in 1940 that various estrogens given early (emphasis W.A.L.) in the menstrual cycle could inhibit ovulation in women. More recently, it has been observed that estrogens administered to women in very much higher doses after ovulation will prevent implantation. The term interception has been suggested for the process of preventing implantation after fertilization has occurred."

And again: "While both estrogens and progestogens will prevent ovulation, pre-coital progesterone appears to interfere with mechanisms prior to fertilization and post-coital estrogen appears to disrupt those after fertilization." (Emphasis added.)

"...On the other hand, estrogens (and norethindrone) proved active intercepters if given in sufficiently high doses both before and after fertilization. In the case of estrogens, this is very probably because of residual hormone levels persisting into the post-coital period."

Dr. Morris points out that estrogen has no observed effect on the fertilized ova as seen 48 hours after estrogen. "Of more significance is the fact that estrogens reduce the endometrial carbonic anhydrase levels which rise in response to progesterone in pregnancy. In the absence of endometrial carbonic anhydrase and without blood supply, the developing ovum cannot dispose of carbon dioxide and maintain pH."

Again Doctor Morris, in a report on post-coital contraception and interception prepared for "Reproductive Biology and Contraceptive Development, A Review of Research and Support," Roy O. Greep, Ph.D., Project Director, reviews the entire history of DES as interceptive, contraceptive, morning-after pill, whatever terminology one might select.

He lists some 25 "effective interceptive agents." He points out that "In addition to requirements of effectiveness, interception involves the serious danger that at marginal doses or with incorrect timing, a compound may prove teratogenic. This has not been observed with post-coital estrogens but teratogenesis has been noted with a variety of other interceptive agents."

Again, "The reason for the dosage and timing should be explained. There was no question from laboratory evidence that estrogen was an effective interceptive agent if given during the immediate post-ovulatory period. If x is the effective daily dose of an estrogen in the rabbit, the estrogen could be given as a single large dose (5x), but proved more effective if it were divided into three small doses (3x) during the pre-implantation period. The dose of estrogen necessary to interrupt early established implantation was found to be approximately 30x. The effectiveness, if any, of large doses of an estrogen in the pre-ovulatory period appears to be merely a reflection of sufficient estrogen levels persisting into the post-ovulatory period that implantation was prevented." (Emphasis W.A.L.)

"In terms of clinical effectiveness, estrogen must be considered a post-ovulatory rather than a post-coital anti-fertility agent." (Emphasis added.)

Doctor Morris' studies seem to indicate that estrogens don't interfere with fertilization (paper, January, 1973, see above). Secondly, in terms of clinical effectiveness, estrogen must be considered a post-ovulatory rather than a post-coital anti-fertility agent. He refers in the September, 1973, paper to the work of Sturgis and Albright that various estrogens could inhibit ovulation when given early in the menstrual cycle. He seems to insist that pre-coital progesterone could interfere with mechanisms prior to fertilization, but post-coital estrogens appear to disrupt those after fertilization.

There seems to be no question in Doctor Morris' mind that there really isn't any purpose in giving estrogens pre-ovulatory, that they are not contraceptive, but are post-ovulatory interceptors or, as we would refer to them, abortifacients.

In summary, Doctor Morris' work seems to indicate that progestogens and progesterone given before ovulation can prevent ovulation sometimes but should ovulation and pregnancy occur, there is a dis-
tinct danger of teratogenesis particularly since the degenerating fertilized ova can be recovered and the finding of fetal malformation after progesterone at the time of coitus in the rabbit suggests that progesterone prior to ovulation could conceivably have a deleterious effect on the fetus.

He also feels that, in his experience, estrogen under such circumstances has not produced teratogenesis but in view of the DES-vaginal adenosis-vaginal carcinoma story, he personally recommends that in any case in which DES fails to prevent a pregnancy in the rape victim that she be required to give prior permission for an elective abortion lest an abnormal baby be born!


"The treatment appears effective when given within 72 hours following exposure but fails to interfere with gestation once implantation has taken place. The post-coital use of high doses depresses the secretion of progesterone. The mechanism is not thought to be luteolysis but interference with tubal transport. For the time being this treatment is associated with a variety of unpleasant side effects, cannot be repeated often, and must be absolutely regarded as an emergency measure rather than an established routine method."

This statement, coming as it does from an area where the enthusiasm for pregnancy as a disease, has shown little concern for the safety of measures employed and further, from a scientific fountainhead where "absolute" in any variety of the term is apt to be looked upon with disdain, is indeed a potent statement.

It talks about: one, so-called post-coital contraceptive effect; two, DES as an effective treatment but fails to mention prevention of ovulation as a mechanism. Rather, it selects interference with tubal transport. Three, if anything, it seems to assume that fertilization must have taken place.

Comment: I appreciate the tone and the approach of Father McCarthy in his paper and recognize an honest attempt to be helpful in a difficult situation. From a medical point of view, I cannot see how DES can be used legitimately or safely for the reasons given above. Interception by any other name is abortion.

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Some Reflections on Telling the Truth

Seymour Siegel

Rabbi Siegel, currently a senior research fellow at Georgetown University's Kennedy Institute for Bioethics, is a professor of theology and ethics at The Jewish Theological Seminary of New York. This paper was stimulated by Prof. David Daube's article, "Medical and Genetic Ethics," Oxford Centre for Postgraduate Hebrew Studies, 1976.

Rabbi Siegel is a member of Linacre's editorial advisory board.

"Everything can be imitated except the Truth"...Rabbi Menachem Mendel of Kotzk.

In ancient times, seals were placed on documents indicating that they were authentic. The seal would bear some form of identification so that it would be known whose signature was on the document. "The seal of the Holy One, Blessed be He, is truth (emet)," says an old rabbinic saying. Wherever there is truth, there is also God's presence. When the truth is cherished, God Himself is being acknowledged.1

The moral teachers of all times and all cultures have abhorred lying and falsehood as a betrayal of our human estate.

The ability to lie is an oblique compliment to the human species. Only men have the ability to lie. It is the specific form of evil introduced by humans into the harmonies of nature. Only man can lie, for only men know the truth. Without knowing the truth, how can one lie? "In the lie, the spirit practises treason against itself."2

Yet it is generally accepted that truth is not an absolute good. It is rare to find a moral teacher (Immanuel Kant seems to be one exception) who would instruct a prisoner to tell the truth when being interrogated by his captors.

The question which we wish to address is whether the physician has the duty to tell his patient the truth, and nothing but the truth. This is an ancient question and much has been written about it.3 Judaism, an old and venerable tradition, has said some very interesting things about this issue.

The Midrash, a collection of rabbinic sayings which comment on various verses in the Bible, says the following:

Rabbi Simon said: "When the Holy One, Blessed be He, came to create the first man, the angels formed themselves into various groups. Some said, 'Let him be created' and others said, 'Let him not be created.' Truth said, 'Let him not be created, for he will do justice.' Peace said, 'Let him not be created, for he will..."