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Winter is over and the blooms of Spring are with us - so here we are with the first issue in 2001 of Health Care Ethics USA. Over recent months there have been several important developments at the Center for Health Care Ethics that I would like to mention.

First, due to University reengineering two of our staff left the Center, Donna Troy and Charlotte Ruzicka. So, on behalf of everyone at the Center and the readers of this journal, I convey sincere gratitude to Donna and Charlotte for so many years of loyal and abundant service and I send every good wish for future success and happiness.

Second, the PhD program in health care ethics has been receiving strong applications from potential students to study at the Center, so we are anticipating a very strong group of new students for next Fall. Our PhD program has an interdisciplinary 48 hour curriculum including 12 courses and the doctoral dissertation, taking between 3-4 years to complete. The program is very competitive and currently we are able to offer full-time funding for all our students in course work. The program began in 1996, so last May our first students graduated (Dan O'Brien at Ascension Health and Mike Panicola at SSM Healthcare - both based in St. Louis). This year another two students will graduate, Sr. Louise Lears, SC, and Craig Paterson who now holds a tenure-track faculty position at Providence College in Rhode Island. We send our sincere congratulations to both of these students, wishing them every success for their future careers.

Third, our Center recently established another partnership to support one of the graduate students in our program. This graduate assistantship is being sponsored by the Sisters of Charity of Leavenworth Health System. This sort of partnership not only provides financial support for our students but also provides them with superb experience to integrate their academic scholarship with practical experience in health care. So we are thrilled at this exciting opportunity and we look forward to working together.

Fourth, we are currently in the process of a national search for a post-doctoral fellow to join us next year. The fellow will be a member of our faculty who will contribute to teaching, research, and service in the Center. We have created this fellowship primarily to replace one of our faculty (Jim DuBois) who has been awarded an early research leave. Hearty congratulations to Jim on being awarded such a competitive award long before he is due the usual sabbatical leave after 7 years of service at the university! We look forward to welcoming the post-doctoral fellow as a new member of faculty and we wish Jim well during his research leave.

Fifth, the Center has been extraordinarily busy this semester working on recent developments in human genomics and stem cell research. Our 16th Annual Edward J. Drummond, SJ lecture on March 30th addressed this topic with a lecture by myself on "The Ethics of Stem Cell Research" - predictably, there was a large turnout and very dynamic discussion! The Center plans to commit significant resources to continue our research in this area in service to our graduate students and our partners in Catholic health care.

Finally, the time of our annual Institutes is here again. In early May the Center will host two continuing education Institutes that are designed primarily for members of ethics committees in Catholic health care. Each Institute lasts for three days: the first Institute (May 7-9, 2001) considers the foundations for ethics in Catholic health care; and the second Institute (May 10-12, 2001) examines organizational ethics in Catholic health care. We have planned the two Institutes to run back-to-back to enable registrants to attend both if they desire. There is a great roster of ethicists to lead the sessions,
including the Center's personnel, ethicists from Catholic health systems and from the Catholic Health Association. The first Institute on Ethics Foundations for Catholic health care includes sessions on the recent revision of the *Ethical and Religious Directives*, sponsorship and mission, ethical principles, integrity and decision making, professional relationships, social justice, e-technology issues, and the work of ethics committees and consultations. The second Institute on Organizational Ethics in Catholic health includes sessions on stewardship, professional leadership, developing organizational ethics committees, the health care work environment and human resources, care for the poor, managed care, unions, and applying the controversial *principle of material cooperation* to partnerships in Catholic health care. You will find an advert with the relevant contact and registration information in this e-journal.

As usual, this issue of *Health Care Ethics USA* has three essays addressing ethics foundations, organizational ethics, and medical ethics. The first essay (by myself) deals with foundational ethical concerns about emerging research based on the recent mapping of the human genome - while we can anticipate many new genetic therapies we also need to be apprehensive about potential abuses, such as via genetic discrimination in health insurance and patient safety in research protocols. The second essay, on a topic in organizational ethics, is by Ann Suziedelis at our Center. Ann discusses the importance of understanding and applying the theology of work in Catholic health care - she explains that the ethical principles of solidarity and subsidiarity need to be held in dynamic tension to maintain a balanced approach to many aspects of the work environment in health care today. The third essay, on a topic in medical ethics, is by Michael Panicola from SSM Healthcare System in St. Louis. Mike discusses treating victims of sexual assault within Catholic facilities - he compares and contrasts views in the Catholic tradition (including the *Ethical and Religious Directives*) in order to offer practical guidelines for practitioners in Catholic health care. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future essays.

Professor Gerard Magill, PhD
Executive Director & Department Chair
Center for Health Care Ethics
Ethical Perspectives On Mapping The Human Genome

The official publication of the map of the human genome has taken our breath away. In mid-February two separate groups published remarkably similar analyses of the human genome. Dr. Francis Collins, the scientific leader of the Human Genome Sequencing Consortium that is funded substantially by the National Institutes of Health and the Wellcome Trust of London, published his team's results in the journal Nature. Dr. Craig Venter, the scientific leader and CEO of the private corporation Celera Genomics, published his team's results in the journal Science. These competing groups, one public and the other private, jointly announced their analysis of the human genome, just a few months after rolling-out an earlier draft in summer 2000. Although they adopted different approaches, their results are remarkably similar.

The entire genome is contained in the nucleus of every bodily cell. Organized in the form of a spiraling double helix, deoxyribonucleic acid (DNA) resembles a twisting rope ladder. The rungs or steps are composed of a series of 4 bases, A, T, C, and G (Adenine, Cytosine, Guanine, Thymine) that pair up in a regular manner (A & T; G & C). The long thread of DNA with corresponding base pairs folds around proteins in a set of tightly packed coils. The human genome is a single molecule, distributed over our 23 chromosomes. That is, over the length of human chromosomes there are approximately 3 billion base pairs (rungs) of chemical letters. The amazing accomplishment of the recent mapping of the human genome is to have deciphered and arranged in the correct sequence these 3 billion chemical letters of DNA across our 23 chromosomes. This assembly and analysis of the human genome - so tiny in size yet almost limitless in its potential for health - constitutes an astonishing breakthrough in science and technology that certainly equals the marvel of harnessing atomic energy or landing on the moon.

Principles

There are some ethical principles and perspectives that can help us navigate an ethical path across the genetic landscape that opens before us with the new map of the human genome. We can rightly anticipate many drug discoveries to cure, prevent, or alleviate devastating conditions. We must also pause with appropriate apprehension about the possible dangers and difficulties we may encounter. So, on the one hand, we can celebrate the accomplishments of the human endeavor in science; on the other hand, prudence encourages us to be cautious in the face of outstanding breakthroughs whose full implications for the human species cannot be properly anticipated just now. In the subsequent sections each of these considerations will be discussed.

Discussion

Anticipation of New Therapies
It is almost impossible to grasp the significance of this virtual blueprint of the human condition that we can now see, read, study, and apply. Some have referred to this map as the so-called "book of life" (a sort of "language" used by God to created life), or the "holy grail" of molecular medicine, that will enable us to develop treatments for a vast array of diseases at their genetic roots. Hopefully, help will be on the way for so many in the United States afflicted with gene related dysfunction, such as cardiovascular disease (50 million), diabetes (15 million), cancer (8 million), or Alzheimer's disease (8 million) - not to mention so many other costly ailments, such as psychiatric disorders, multiple sclerosis, and obesity. There is little doubt that we will have effective genetic therapies within a few years. So, it is no wonder that society applauds this remarkable accomplishment. Hopes are high and anticipation abounds!

Naturally, modesty must also prevail at such an exciting moment. After all, it is somewhat humbling to be informed that the human species possesses only 30,000 or so genes (not the 100,000 that many projected), just 11,000 more than the laboratory roundworm (19,000 genes sequenced in 1998), or just over twice as large as the fruit-fly genome (13,600 genes decoded in March 2000)! But the real cause
for modesty lies in the complexity of the task ahead as we use the map of the human genome to develop reliable therapies for so many diseases and disabilities. Of course, it is very likely that our proteins (probably over 300,000 of them) produced by our genes will provide the crucial clue for many medical breakthroughs. Hence, proteomics has become just as important a buzz-word as genomics in this fast developing arena of molecular medicine. From this perspective, the map of the human genome provides basic clues about proteins that constitute our biological building blocks as chemical messengers and mechanisms underlying diseased as well as healthy bodies. Simply, by exploring the connections between our genes and our proteins we are more likely to develop new drug therapies.

Apprehension of New Difficulties
We must temper this legitimate anticipation with a healthy dose of apprehension. Midst the euphoria of such "eureka" moments we also need to recognize potential problems and difficulties. If we are not cautious, our genome map is capable of leading some astray on the ethical landscape of genetic manipulation. Of course, no one wants to yell "fire" in the movie theatre without cause. But already we have encountered sufficient predicaments in genetic science to warrant hesitancy as we begin to explore this exciting landscape of the human genome. Sometimes old maps in antiquarian bookshops indicate areas of unexplored territories by writing "there be dragons" - as we begin to explore our new map of the human genome, prudence cautions us to be wary of miniscule monsters that could assault and possibly cause devastating harm to the human condition!

So why should we have apprehension regarding what seems to be such good news about using molecular medicine for the treatment of disease at its genetic roots? Well, caution makes most sense when we can identify particular events that genuinely illustrate serious underlying ethical concerns. Here are a few such situations.

First, we will have to monitor privacy, consent, confidentiality, and discrimination issues in the new genetic landscape of medicine. Naturally, there will be many new tests and screening opportunities to diagnose molecular predispositions and risks for gene related diseases. That scenario can be good news insofar as it will encourage a helpful shift to preventative care. But it may also be bad news if we invade privacy, compromise consent or confidentiality, or foster discrimination (even unwittingly). For example, some employers or insurers may be inclined to obtain genetic information to decline cover or claims. Just recently, on February 9, the Equal Employment Opportunity Commission (EEOC) filed a lawsuit in U.S. District Court for the Northern District of Iowa in Sioux City. The lawsuit claimed a company violated its employees' privacy rights by requiring genetic tests. The company had a nationwide policy requiring some employees who filed claims of a specific work-related injury to provide blood samples for genetic tests. Interestingly, within a matter of days after the lawsuit was filed the company discontinued its policy requiring genetic tests! Congress has yet to pass regulation in this controversial arena - but it urgently needs to pass a federal bill outlawing genetic discrimination.

Second, we need to ensure that our scientists, hospitals, and genomics corporations do not place any patient in jeopardy in the race to file patents and develop highly profitable new genetic therapies. There are strict protocol requirements for medical research that must be followed to ensure the safety of human research subjects. Sadly, the avoidable death of the first reported gene therapy patient, Jesse Gelsinger, in Fall 1999 illustrates the need for such caution. The teenager died with severe immune reaction to an experimental genetic therapy virus for an inherited liver disease. Subsequently, the family filed a lawsuit, alleging fraudulence and negligence in recruiting their son as a patient, and eventually settled out of court.

Third, we need to be aware that genetic intervention may hold terrible surprises for the human species, especially from the perspective of safety. In January an Australian research team reported that an apparently harmless animal experiment had disastrous consequences. The team inserted into the mouse pox virus (a cousin of the human smallpox virus) a mouse gene to trigger the mouse immune system as a means of controlling fertility - but the virus crippled the immune system and killed the mice population. This unforeseen but disastrous result simply illustrates the difficulty of navigating our genetic terrain. That difficulty will not be removed even with a reliable map of the human genome.

Fourth, we also need to ask whether science seeks to play God in its control of the human genome by enabling couples to have so-called "designer babies" - not just to avoid disease related genes (such as those associated with sickle cell disease or Tay-Sachs disease), but also to select preferred traits such as skin color, complexion, and intelligence. Already, we have encountered the first known case of
a genetically screened baby born to save the life of a 6 year old sibling, Molly Nash from Colorado. Molly was born with Fanconi anemia, a rare genetic disorder that prevents bone marrow being made by the body, a condition that can kill by the age of 7 years. A blood transplant from a matching sibling offers 85 percent rate of success for this disease. So, the parents opted for a process of genetic screening and assisted reproduction from the Reproductive Genetics Institute in Chicago. Adam Nash was born on August 29, 2000 having been genetically screened and selected via in-vitro fertilization (IVF) technology from 15 embryos (at eight-cell stage when one cell typically is removed for genetic testing prior to implantation in the mother’s womb). Not surprisingly, the ethical problem with this undertaking was the creation and destruction of the other embryos via IVF technology. The embryo was selected via pre-implantation genetic diagnosis (PGD) using two tests, one to detect Fanconi anemia and the other to ensure genetic compatibility with Molly. This clinical intervention was the first recorded combination of genetic and stem cell therapies. After Adam was born, his sister received transfusion of stem cells from his umbilical cord and placenta - and so far the transplant is working well for Molly.

Conclusion

Of course, there will be many other crucial issues that may cause us pause as we explore the human genome. Perhaps the most obvious question about future genetic intervention pertains to manipulated traits inherited by our progeny. How will science assess the relative risks of germ-line genetic manipulation that will alter the progeny of the patient and subsequent offspring? In sum, we might ponder this point: if evolution has enabled the human species to flourish in its biological diversity over a period of 500 million years, it should be with great modesty that we celebrate our astounding accomplishments in mapping the human genome and with even greater fear and trepidation that we use this map to manipulate our genetic make-up. After all, we may encounter unfriendly dragons!


Professor Gerard Magill, PhD,
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Center for Health Care Ethics

Suggested Readings


Questions for Discussion

1. What advantages and problems do we anticipate emerging from breakthroughs that will result from mapping the human genome?

2. What policy measures should we pursue to establish appropriate ethical safeguards for the human species in light of new genetic therapies that may be developed?
The Theology of Work and The Principles of Solidarity and Subsidiarity

It has been said that the Catholic notion of work lies between the extremes of Godless labor on the one hand, and endless charity on the other. This is a challenging statement to reflect upon while pondering the plight of St. Benedict's Hospital, a small facility faced with budget constraints that require rather draconian staff reductions. The lab, for example, is confronted with the loss of twenty percent of its personnel. Human Resources has been deciding which employees to let go, and how to redesign the work schedule. Lab technicians, catching wind of the impending changes, have their own ideas about how to handle the matter. Hackles begin to rise.

Such interaction with others is an unavoidable part of human life, for like the smallest in a set of Russian dolls, each of us is part of a number of larger and larger communities. We exist not only as individuals, but also in constant relationship with others; as members of a family, students in a school, citizens of a nation, and so on. Catholic Social Teaching (CST) draws on two thousand years of Tradition to provide us with guiding principles for living well with others in all our human endeavors. And just as our relationships are inter-connected, so too are these principles. This essay, however, focuses on two principles of CST that are crucial to the workplace - solidarity and subsidiarity. Specifically, on what part they play in maximizing Catholic health care's efforts to realize the common good while recognizing the human dignity of each worker. We'll return to St. Benedict's in the discussion below, to see how subsidiarity and solidarity, properly understood in the context of a Catholic workplace, can help the hospital deal with its lab situation.

Principles

Solidarity

As Christians, we are called to build God's Kingdom on earth, which by definition entails promoting the common good of society. It cannot be stated too emphatically that it is this end - the common good - toward which all the principles of CST are at all times directed. It is solidarity that guides us by reminding us that we are, indeed, our sisters' and brothers' keepers, and that as members of one human family this applies to all persons, regardless of race, gender, nationality, faith, or social class. To be in solidarity with others means to have a strong and abiding determination to commit ourselves to the common good of all. Perfecting the sum total of all conditions of living - economic, political, and cultural - makes it possible for women and men to achieve the fullness of humanity in interdependence with one another.

Subsidiarity

The second principle, subsidiarity, may be less familiar, but is no less crucial. It advances the common good by addressing the relationship between different levels of authority, requiring that responsibility for action be accorded always to the most appropriate level. In respecting the human dignity of each, it emphasizes that the most appropriate level is actually the lowest appropriate level, and that we should resist the temptation to default to higher authority. In other words, in order to be in true solidarity with one another, higher levels of authority ordinarily should not interfere in the legitimate activities of those at appropriate lower levels. Exceptions are allowable only when intervention by the higher level of authority can, in reality, more effectively achieve the single overarching goal of protecting the common good. For example, subsidiarity argues for the right of workers to form unions if they freely choose to, yet upholds the right and duty of government to intervene (though to the minimal degree necessary) in some strike situations. For the same reason, subsidiarity also allows the state to set minimum wages, restrict the work of children, and regulate working conditions.

Subsidiarity also acknowledges that sometimes the highest level of authority actually is the lowest appropriate level of authority. For example, it is the appropriate task of our federal government alone to build armies, make treaties, and, as we see today, to re-craft the US health care system. At the same time, however, while higher levels of authority are expected to do what lower levels cannot appropriately do for themselves, subsidiarity also holds individuals and smaller communities
responsible for doing what they are able to do; for honoring their rightful obligations to higher authority; and for living their lives with an eye toward the common good.

The principles of CST have focused on different groups at different points in history. Originally formulated to address the rights of individuals and small groups of workers, recent teachings expand the horizon to the international community and global interaction. Still, just as it is hard to imagine the well-being of an extended family if the nuclear families within it are broken by abuse, economic struggle, or illness, so it is that we cannot ignore indignities suffered by individuals or lesser communities if we expect to achieve the common good of all. Instead, we must ask repeatedly how the most vulnerable among us are faring. If common wisdom is correct that an entity is only as strong as its weakest link, then the absolute necessity of practicing subsidiarity, within the framework of striving for solidarity for the sake of the common good, is clear. But what does CST specifically say about work, and how might the principles of subsidiarity and solidarity apply to St. Benedict's current dilemma?

Discussion

In CST, human work is seen as the primary human activity; the key - perhaps the essential key - to the whole social question. For when we work, we not only alter things, nature, and society, but we alter ourselves as well, actually becoming more fully human. Indeed, work is much more than a way to make a living: Work is an expression of our dignity and a form of continuing participation in God's creative activity. So paramount is John Paul II's sense of the dignity of work that he argues that all who are able not only have a right to work, but are, in fact, obligated to do so. This duty derives both from God's command and from a responsibility to oneself and to all humanity. Thus, work enhances all our relationships, first with God, by sharing in his creative powers, and second with all human persons, through the building of community and the common good. Given the importance of work, it is incumbent upon us all to create workplaces where every person can flourish. It is important to be clear that the teachings of the Church regarding the ethic and theology of work are not simply a list of ways that employers must show justice to employees. It is not a one-way street. For a proper work environment cannot exist if any group, whether executives or hourly laborers, deals unjustly with another, impeded by such sins as covetousness or sloth. Employers who manifest a lack of concern for others because of an exaggerated emphasis upon maximizing financial gain, cannot properly support the well-being of their employees. Employees who do only what work they have to do to avoid being fired, or who let costly errors go unreported, fail their employers. When either group behaves in such a manner, they vitiate the possibility of creating the solidarity that is needed to truly work together for the common good.

Thus, employers must provide fair wages, adequate benefits, safe and decent working conditions, and opportunities for advancement, learning, and growth. Employees must seek not only their own best interests, but also what is best for their co-workers and for the mission of the institution that employs them. For those who work in a Catholic health care community to achieve solidarity, actions of employees and employers alike must be consistent not only with civil laws and regulations, but with the principles of CST.

For that reason, while it is outside the purview of St. Benedict's lab employees to determine the appropriateness of cutbacks and layoffs, subsidiarity demands that they be allowed the right to participate in related decisions that will affect them and their work. It also requires that out of respect for their dignity they be allowed to articulate their concerns about the implications of these layoffs in a serious forum, and that their spokespersons be freely-chosen representatives and not merely acquiescent appointees, handpicked by the administration. Their ideas and concerns should be heard with respect, for if the morale in the laboratory is low, and its personnel perceive their ideas and wishes to be disregarded, the common good of the hospital community as a whole cannot be realized.

In the spirit of subsidiarity, then, there are decisions that can be left to St. Benedict's lab personnel, coordinated by the lab director, rather than being mandated from above. Perhaps there are two technicians planning to start families who would like to share one full-time position, or one with seniority (whose job is secure) who might already be toying with the idea of retiring. Perhaps the techs who remain would prefer to work four ten hour days rather than five eight hour days when rescheduling takes place, or would like to return to permanent shifts rather than maintain the current rotating schedule. Allowing them these choices is an example of how administrators, through subsidiarity, can avoid the extreme of a workplace of "Godless labor," and contribute to the solidarity
of the hospital community. In turn, the principles require that these employees recognize that a health care system cannot provide "endless charity" to them. They in turn have an obligation to respect legitimate leadership in accepting the administration's decision to cut their budget; to make every effort to be cost efficient; to take advantage of genuine opportunities to participate in effecting required changes; and to bring legitimate and constructive concerns to the attention of administrators. It is these kinds of challenges that subsidiarity and solidarity require of all St. Benedict's personnel, employer and employee alike. Indeed, it is these kinds of challenges that the principles demand of all workers.

Conclusion

Given what CST teaches about the importance of work, it follows that one of the most significant communities to which we belong is our workplace. It is therefore incumbent upon us to look to those who work for us, to those who work with us, and to those for whom we work, to see (and perhaps to ask) if we are genuinely nurturing a true dynamic of solidarity and subsidiarity. In this way, each individual, the departments in which we work, the system that employs us, and indeed all of Catholic health care can, in solidarity through subsidiarity, influence progress toward the common good of all.


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Suggested Readings


Questions for Discussion

1. How can the principles of subsidiarity and solidarity be used to minimize employee frustration within Catholic health care?
2. What action could be taken by Catholic health care at the management level to inspire all employees to be active participants in building workplaces based on subsidiarity and solidarity?
3. Can Catholic health care based on these two principles be competitive in the marketplace?
Treating Victims of Sexual Assault Within Catholic Health Care Facilities

The treatment of victims of sexual assault within Catholic health care facilities is a contentious issue. Some argue that health care professionals ought never prescribe antifertility medications (e.g., Ovral) to a woman who may be pregnant from a recent sexual assault because they would function as an abortifacient if she was indeed pregnant. Others argue that health care professionals ought to prescribe antifertility medications to the woman as long as she consents because she should be able to defend herself against a possible pregnancy for which she is not responsible. What is the Catholic approach to this divisive issue?

Principles

The truth of the matter is there is not one Catholic approach to treating victims of sexual assault because the issue has never been settled by the moral magisterium of the Catholic Church. Thus, we must arrive at a well reasoned approach that is consistent with current guidelines in the Catholic moral tradition. In constructing such an approach, we look to the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) for guidance. Directive 36 specifically addresses the issue of treating victims of sexual assault:

> 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. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of the fertilized ovum.1

Based on Directive 36, as long as the woman is not pregnant, antifertility medications may be given to prevent ovulation, sperm capacitation, or fertilization. The problem is that a pregnancy test is unlikely to be positive as the result of a recent sexual assault. Therefore, some Catholics argue that the type of care provided hinges on ovulation. For instance, Fr. Benedict Ashley and Fr. Kevin O'Rourke delineate three treatment scenarios contingent upon ovulation:

> If ovulation has not occurred within a current menstrual cycle, antifertility medications may be administered to prevent ovulation. If it is certain ovulation has occurred within the menstrual cycle, antifertility drugs may not be used because their effect could only be to inhibit the implantation [of a fertilized ovum]. If there is doubt as to whether ovulation has occurred or not within the present menstrual cycle, antifertility drugs may be used with the purpose of preventing ovulation. The doubt in question concerns the fact of ovulation, not the fact of conception.2

In essence, what Ashley and O'Rourke are claiming here is that since we cannot determine with certainty whether a pregnancy has been established in a woman who has been sexually assaulted recently, we should use ovulation as the criterion for decision making. If any doubt exists concerning the issue of pregnancy, we must determine whether the woman has ovulated and should not interfere with antifertility medications if she has in fact ovulated.

Discussion

While the Ashley and O'Rourke approach to treating victims of sexual assault is the morally safest, it is not morally required within Catholic health care facilities for three primary reasons. First, ovulation is not the moral criterion upon which the treatment of victims of sexual assault hinges. Rather, as Directive 36 prudently states, the actual moral criterion is pregnancy. Second, the occurrence of ovulation only suggests that pregnancy is a possibility, not a biological or moral certainty. A positive ovulation test does not provide moral clarity to the difficult and delicate situation because the fact of
pregnancy will still be in doubt. Third, even if the woman may have ovulated that does not necessarily mean that a fertilized ovum is present and antifertility medications will interfere with implantation as Ashley and O'Rourke imply. There is still the real possibility that the antifertility medications will merely prevent sperm capacitation or fertilization. What is more, fertilization is a complex process that unfolds over a 24-hour period and results in the formation of a human being with the moral right to respect and protection.

Perhaps the United States bishops recognized these problems with using ovulation to determine the morally appropriate form of care for victims of sexual assault and instead chose to focus on the broader criterion of pregnancy in Directive 36. Without question pregnancy is the more precise moral criterion for decision making, but even so cases may arise that pose personal problems for health care professionals. For instance, a woman in her fertile period who has been assaulted sexually may come into the emergency department more than 24 hours after the assault when she could possibly be pregnant because the fertilization process would have concluded (if it had actually started). If the woman's pregnancy test comes back negative, health care professionals within Catholic facilities could offer the woman the option of determining whether she has ovulated to absolutely rule out the possibility of pregnancy and can perform the ovulation test with her consent (if available). If the test indicates that the woman has in fact ovulated and it is clear that the woman is beyond the 24-hour period since the sexual assault occurred, health care professionals within Catholic facilities can refrain from providing antifertility medications that may interrupt a possible, though not certain, pregnancy. However, health care professionals in Catholic facilities are not morally required to withhold antifertility medications from the woman. As Directive 36 points out, "If, after appropriate testing [for pregnancy], there is no evidence that conception has occurred already," the woman may be treated with antifertility medications. No matter what the ovulation test shows, it still does not provide sufficient evidence of pregnancy to morally prohibit health care professionals from administering antifertility medications for the woman if she so chooses. What is morally required on the part of health care professionals within Catholic facilities is that they do not remove, destroy, or interfere with the implantation of a fertilized ovum. Thus, it seems to follow, that barring a positive pregnancy test, health care professionals within Catholic facilities may provide antifertility medications to the woman upon her consent.

It should not go unsaid that if health care professionals within Catholic facilities choose not to treat a woman who is in the ovulation phase of her menstrual cycle and is beyond the 24-hour period since the sexual assault occurred, it is imperative that they enter into discourse with the woman regarding options available to her at other facilities in the surrounding area. Here the health care professionals would be providing the woman with information about other avenues she could legitimately explore to defend herself against a possible, though not certain, pregnancy.

Conclusion

While health care professionals within Catholic facilities should be mindful of the moral issues involved in treating victims of sexual assault, they should never lose sight of the woman in need when discerning how to proceed morally. Regardless of what the pregnancy test shows or where the woman is in her menstrual cycle, compassionate and understanding care should always be provided to her. This care should be directed toward three goals. First, the primary focus of care should be on the woman's physiological, psychological, and spiritual needs. The woman must be treated with dignity and respect, and provided competent and compassionate holistic care. Second, health care professionals must be very delicate when caring for the woman. Care should be provided in a way that allows for the collection of physical evidence for police support and possible identification of the assailant. Third, if the woman is already pregnant or pregnancy results from the sexual assault, then care should be provided in a way that does not harm or jeopardize the developing embryo.

Suggested Readings


Questions for Discussion

1. What approach to the treatment of victims of sexual assault do you consider most consistent with Catholic moral principles and guidelines, the one based on ovulation or on pregnancy?

2. Should Catholic health care facilities be free to adopt a policy on the treatment of victims of sexual assault that adheres to the ovulation approach? If yes, what do such facilities do when the woman refuses to undergo an ovulation test?

3. What should Catholic health care facilities do to accommodate the personal beliefs of emergency department personnel treating victims of sexual assault?