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

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

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

***COMMENT***

## An issue of moral certitude

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

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

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