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The USCCB and Rape Protocols

Peter J. Cataldo

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by

Peter J. Cataldo, Ph.D.

The author is Director of Research, National Catholic Bioethics Center, Boston, MA. *The following is reprinted from* Ethics & Medics, *Volume 29, No. 4, April, 2004.*

After a review of the moral and scientific literature, and a consultation with physicians, theologians, and ethicists on the question of "emergency contraception" in rape protocols, the United States Conference of Catholic Bishops' Committee on Doctrine recently concluded in part that rape treatment protocols that only provide pregnancy testing prior to administering postcoital anovulatory drugs do not violate Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services*.[1] The central reason for this conclusion is that it is uncertain whether these drugs in addition to suppressing ovulation might prevent pregnancy by a prefertilization, contraceptive effect, or by a post-fertilization, abortifacient effect.[2] I submit that the committee's reason and conclusion rest on two erroneous assumptions. The first is that the purpose for testing the woman's ovulation phase is to ascertain the possibility of conception.[3] The second assumption, related to the first and critical to the argument for pregnancy-only testing, is that the prevention of fertilization includes destruction of a bound oocyte and spermatozoon at any point prior to formation of the zygote (prefertilization, contraceptive effect).[4] These assumptions are problematic and require examination in order to assess whether ovulation phase testing is morally obligated according to Directive 36. The pertinent portion of Directive 36 for the issue of testing as it relates to the use of hormonal anovulatory drugs is the following:

> 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.

Pregnancy-Only Testing

Some advocates of pregnancy-only testing appear to misconstrue the focus of the preventative measures mentioned in Directive 36 to be on conception (formation of a zygote), both in terms of the purpose of ovulation phase testing and the meaning of preventing fertilization. Two inferences may be drawn if conception is the single standard by which preventative measures are to be understood: a) ovulation phase testing is interpreted as an ineffective attempt to determine possible conception, because conception cannot be determined from that test; and b) actions that intervene up to the point of conception are morally permissible. Knowing whether an oocyte could be present at the time of administering the medications has no moral relevance because, according to the pregnancy-only testing view, there is no demonstrable evidence that they cause an abortifacient effect; and, more importantly, these medications could possibly act to prevent fertilization by "disrupting the fertilization process."[5] However, the purpose of ovulation phase testing is not to determine a possible conception but to determine whether the drug is more likely to suppress ovulation and thereby prevent an oocyte from being available for fusion with a spermatozoon. In this way knowledge about the suppression of ovulation is also directly related to any attempt to prevent fertilization after ovulation.

Preventing Fertilization

Fertilization is inclusive of the many integral biological steps that occur from the binding of an oocyte and a spermatozoon up to and including the formation of a zygote.[6] Recent Catholic teaching recognizes this scientific fact.[7] The fact that fertilization might not be complete until the formation of a zygote should not be relevant to what Directive 36 counts as the prevention of fertilization. This completion point is not what Directive 36 states may be prevented by medications in cases of rape. The directive states that "she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization." It does not state medications are permitted that prevent the "completion of fertilization after the process has begun." To prevent fertilization is to prevent the process from ever beginning, whether that process is defined as inclusive of, and completed by, the formation of the zygote or not.[8] Thus, medications that act on an oocyte and a spermatozoon bound or fused together up to the moment of syngamy (fusion of the two pronuclei), would not count as preventing fertilization but as interfereing with it and should not be allowed according to Directive 36.

Self-Defense and Ovulation Phase Testing

The intent of the statement in Directive 36 regarding preventative medications is to allow only those medications that will prevent male and female gametes from initially interacting as a matter of self-defense. This includes 1) preventing the release of an oocyte, 2) preventing the ability of spermatozoa from reaching an oocyte, and 3) preventing the binding of an oocyte with a spermatozoon through either 1) or 2). These are all truly self-defensive measures because they are aimed at thwarting the action of the attacker's sperm as a lingering effect of the attack, not at destroying an entity (the bound oocyte and spermatozoon) which exists independently and is neither a cell of the attacker nor of the woman. By taking these measures, the woman is defending her fertility, her oocyte, from being joined with the attacker's germ cell. Consistent with self-defense, ovulation phase testing helps to ensure actions that will suppress ovulation to prevent the interaction of gametes, not to intervene after the fertilization process has begun but has not yet resulted in a zygote. Directive 36 was in part designed to allow morally certain self-defensive measures against the unjust meeting of gametes, not to accommodate every request for postcoital hormonal drugs short of RU-486, as tragic as the circumstances may be.[9]

Moral Certitude

Given that the self-defensive actions of using medications are aimed at, and are morally justified on the basis of, preventing the gametes from meeting, Directive 36 presumes that this result is known with a moral certitude when the drugs are used. Moral certitude is the absence of prudent fear of erring in a practical judgment that includes indecisive reasons contrary to the judgment. This is not absolute, one hundred percent certitude, as may be possible in the natural or empirical sciences, and is not required in matters of human action. However, to argue that this general standard is alone sufficient for assessing the issue of postcoital hormonal rape treatment, and that this standard is essentially different than some of the casuist systems for determining moral certitude, is question-begging.[10] The general principle regarding certitude appropriate to the subject matter is the conceptual justification for the use of moral certitude. The casuist systems were applications of this general principle (albeit flawed in some cases), and as such there is no essential difference between the two.

The Catholic moral tradition on moral certitude also required the safer course of action in cases involving matters of great value such as putting innocent human life at significant risk. It should be clear that this requirement does not presume knowledge of actual human life at risk, but

knowledge either of evidence pointing to a possible human being (e.g., the hunter aiming at an object behind a bush) or of something that could harm a human being actually known to exist (e.g., a person about to drink a suspicious beverage).[1] However, the safer-course requirement is not applicable in the use of anovulatory hormonal agents because there is no conclusive evidence pointing to the existence of a possible human individual who might be harmed at the time that the drugs are given. This fact does not help the pregnancy-only-testing position because, irrespective of the lack of evidence for a human individual, destroying the bound spermatozoon and oocyte prior to syngamy cannot count as prevention of fertilization in the 20-30 percent of cases in which suppression of ovulation might fail, and about which the actual mechanism of action is uncertain.

To conclude that administering only a pregnancy test does not violate Directive 36 is to conclude that ovulation-phase testing is not obligated by the directive. However, this second conclusion rests on the erroneous assumption that preventing fertilization includes something other than preventing the gametes from ever interacting as a matter of self-defense. Based upon the foregoing argument, the conclusion of the Committee on Doctrine should be reconsidered, and, it seems, a clarification of the text of Directive 36 by the bishops would be warranted as well.

References

1. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, D.C.: United States Conference of Catholic Bishops, 2001).

2. Prefertilization effect here means the destruction of a bound oocyte and spermatozoon prior to the formation of the zygote. Abortifacient effect means the prevention of the implantation of an embryo.

3. See Ronald P. Hamel and Michael R. Panicola, "Emergency Contraception and Sexual Assault," *Health Progress* 83.5 (September-October 2002); Ron Hamel, "Rape and Emergency Contraception," *Ethics and Medics* 28.6 (June 2003).

4. See Ron Hamel and Michael R. Panicola, "Low Risks and Moral Certitude," *Ethics & Medics* 28.12 (December 2003): 3; see also Hamel and Panicola, "Emergency Contraception." Any evidence of this particular prefertilization effect, described in H.B. Croxatto et al., "Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: A Review of the Literature," *Contraception* 63.3 (March

2001) – a source used by Hamel and Panicola – is very tenuous, if even intended by Croxatto et al.

5. Hamel and Panicola, "Rape and Emergency Contraception," 3.

6. See, for example, Bruce M. Carlson, M.D., Ph.D., *Human Embryology and Developmental Biology* (St. Louis: Mosby, 1994): 27-32.

7. Congregation for the Doctrine of the faith, *Donum Vitae, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (Boston: Pauline Books & Media, 1987), I, n.1, see also idid., II, introduction note* and I, n. 1 note*.

8. See Kevin T. McMahon, "Directive 36 and 'Contraceptives,'" *Ethics & Medics* 27.9 (September 2002): 1.

9. See James J. Mulligan, "Peace of Conscience for Rape Victims" *Ethics & Medics* 28.12 (December 2003).

10. See Hamel and Panicola, "Rape and Emergency Contraception."

11. For a fuller account of moral certitude in the Catholic moral tradition as it applies to rape protocols and the issue of the safer course see Peter Cataldo, "A Moral Analysis of Pregnancy Prevention after Sexual Assault," in *What Is Man, O Lord? The Human Person in a Biotech Age*, Eds. Edward J. Furton and Louise A Mitchell (Boston: The National Catholic Bioethics Center, 2002): 243-259; see also Daniel O'Brien and John Paul Slosar, "Rape Protocols and Moral Certitude," *Ethics and Medics* 28.2 (February 2003).