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Via Electronic Submission

Office of Public Health & Science
Department of Health & Human Services
Att'n: Rescission Proposal Comments
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

**Re: Proposed Rescission of Provider Conscience Rule
74 Fed. Reg. 10,207 (Mar. 10, 2009)**

Dear Office of Public Health and Science:

On behalf of the American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG"), this responds to the above-captioned notice of proposed rulemaking ("NPRM") in which the Department of Health & Human Services ("HHS") proposed to rescind the "Provider Conscience Rule," 45 C.F.R. pt. 88, that HHS issued to implement the rights of conscience protected by the Church, Coats, and Weldon Amendments. 42 U.S.C. §§300a-7, 238n; Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2008). As indicated under the signature block below, six additional groups have joined these comments. When the new HHS administration has reviewed the record on the Provider Conscience Rule, AAPLOG and the groups joining these comments are confident that HHS will recognize that the rule requires HHS's ongoing implementation and vigorous enforcement.

Consistent with their Hippocratic Oath to do no harm and not to provide abortions, AAPLOG members are physicians who oppose elective abortions for two interrelated reasons, which follow from their medical training and ethics and from their individual consciences. First, as physicians, AAPLOG members are responsible to their female patients and their unborn children. Although proponents portray elective abortion as a liberating right and good medicine, AAPLOG and the groups joining these comments submit that elective abortions can have serious adverse long-term health effects on the women who undergo those abortions. Second, not only as individuals of faith or conscience but also as physicians, AAPLOG members oppose the unjustified taking of human life by elective abortions.

In joining, members affirm AAPLOG's mission statement:

- That we, as physicians, are responsible for the care and well being of both our pregnant woman patient and her unborn child.
- That the unborn child is a human being from the time of fertilization.
- That elective disruption/abortion of human life at any time from fertilization onward constitutes the willful destruction of an innocent human being, and that this procedure will have no place in our practice of the healing arts.
- That we are committed to educate abortion-vulnerable patients, the general public, pregnancy center counselors, and our medical colleagues regarding the medical and psychological complications associated with induced abortion, as evidenced in the scientific literature.
- That we are deeply concerned about the profound, adverse effects that elective abortion imposes, not just on the women, but also on the entire involved family, and on our society at large.

With at least six hundred (600) dues-paying members and over fifteen hundred (1,500) associated doctors, AAPLOG is one of the largest constituent groups within the American College of Obstetricians and Gynecologists. Like pro-life physicians generally, AAPLOG members overwhelmingly would leave the medical profession – or relocate to a more conscience-friendly jurisdiction – before they would accept coercion to participate or assist in procedures that violate their consciences.

BACKGROUND

Acting quickly after the U.S. District Court for the District of Montana's decision in *Taylor v. St. Vincent's Hospital*, 369 F.Supp. 948 (D. Mont. 1972) (sterilization), as well as the U.S. Supreme Court's decision in *Roe v. Wade*, 410 U.S. 113, *reh'g denied*, 410 U.S. 959 (1973) (abortion), Congress enacted the first Church Amendment to protect the nation's health care providers from having courts or public officials use the receipt of federal funds to coerce participation in abortion and sterilization procedures that violate providers' religious beliefs and moral convictions, as well as to prohibit employment discrimination based on abortion or sterilization. Pub. L. No. 93-45, §401, 87 Stat. 91, 95 (1973). The following year, the second Church Amendment expanded individuals' anti-discrimination rights, primarily against coerced participation in any "health service program" against their religious beliefs or moral convictions. Pub. L. No. 93-348, §214, 88 Stat. 342, 353 (1974). Significantly, that amendment defined "health service program" broadly to include "all programs administered by the Secretary except the Social Security Act." S. REP. NO. 93-381 (1974), reprinted in 1974 U.S.C.C.A.N. 3634,

3677. Finally, in 1979, the third Church Amendment protected applicants and students in certain HHS-funded health education programs. Pub. L. No. 96-76, §208, 93 Stat. 579, 583 (1979).

In 1996, the Accrediting Council on Graduate Medical Education sought to require training in abortion techniques as a condition for accreditation of hospitals and medical residency programs. Senator Dan Coats responded with legislation to prohibit discrimination against a “health care entity” for refusal “to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions.” Pub. L. No. 104-134, §515(a)(1), 110 Stat. 1321, 1321-245 (1996); 42 U.S.C. §238n(a)(1). The Coats Amendment defines “health care entities” broadly to “include[] an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.” *Id.* §238n(c)(2) (emphasis added).¹ Because the prohibitions of subsection (a)(1) extend beyond the academic setting (*e.g.*, it prohibits requirements to perform or refer for abortions generally as well as requirements to provide or undergo training in abortions), it is significant that the definition of “health care entity” is not exclusive. Unlike the Church Amendments, however, the Coats Amendment does not require institutions or individuals to rely on moral convictions or religious beliefs as their reason to avoid abortion-related activity. *See* 42 U.S.C. §238n(a)(1). Any subjective reason suffices.

Since 2005, the Weldon Amendment has appeared in the HHS appropriations bill. *See* Pub. L. No. 108-447, § 508(d), 118 Stat. 2809, 3163 (2004); Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2008). The Weldon Amendment confirms the broad definition of “health care entities” and prohibits receipt of federal funds by entities that discriminate on the basis of not paying for, referring for, providing, or covering abortions. *Id.* As with the Coats Amendment, the Weldon Amendment’s abortion-related restrictions apply to all abortion-related discrimination, not merely discrimination based on individuals’ or institutions’ religious beliefs or moral convictions. *Id.*

Throughout the history of these related statutes, Congress has responded quickly to instances where courts, public officials, or quasi-public officials have sought to coerce individual and institutional health care providers to engage in activities contrary to religious beliefs or moral convictions. In that context, it is significant that the American College of Obstetrics and Gynecology (“ACOG”) and the American Board of Obstetrics and Gynecology (“ABOG”) took actions that threatened to put obstetricians and gynecologists (“OB/GYNs”) in the position of either engaging in abortion-related activity against their religious beliefs and moral convictions or risking loss of their certification. Specifically, in November 2007, ABOG finalized its annual

¹ Although not relevant here, the Coats Amendment also deems as accredited for federal, state, and local purposes, any “health care entity” that loses its accreditation based solely on its failure to follow an accrediting board’s abortion-related requirements. 42 U.S.C. §238n(b)(1).

bulletin on the maintenance of certification for 2008, which listed “violation of ABOG or ACOG rules and/or ethics principles” as a basis for losing ABOG certification. American Board of Obstetrics & Gynecology, *Bulletin for 2008: Maintenance of Certification*, at 10, ¶5.b (Nov. 2007) (Ex.1). Also in November 2007, ACOG issued an ethics opinion that limits the right of refusal in reproductive medicine. American College of Obstetrics & Gynecology, Committee on Ethics, “*Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*,” at 3-5 (Nov. 2007) (Ex. 2). Taken together, these two contemporaneous actions threatened conscientious-objector OB/GYNs with losing their ABOG certification for refusing to follow ACOG’s coercion, couched in the form of an ethics opinion.

Because the existing Church, Coats, and Weldon Amendments already provided the necessary statutory protections, but lacked a regulatory enforcement mechanism, HHS proposed and promulgated the Provider Conscience Rule in 2008. 73 Fed. Reg. 50,274 (2008) (proposed rule); 73 Fed. Reg. 78,072 (2008) (final rule). In response both to requests from AAPLOG and to the Provider Conscience Rule, ABOG’s 2009 bulletin removed noncompliance with ACOG ethical standards as a basis for losing ABOG certification in its 2009 bulletin. American Board of Obstetrics & Gynecology, *Bulletin for 2009: Maintenance of Certification*, at 11, ¶6.b (Dec. 2008) (Ex. 3). By contrast, ACOG refused an AAPLOG request to revisit the ethics opinion.

On March 10, 2009, under the new administration, HHS proposed to rescind the Provider Conscience Rule, 74 Fed. Reg. 10,207 (2009), but first sought comments on four questions. The following four sections answer HHS’s questions.

I. WIDESPREAD NONCOMPLIANCE REQUIRES A PROTECTIVE RULE

HHS’s first question seeks information on the scope and nature of the problems giving rise to the need for federal rulemaking and how the current rule would resolve those problems. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that prejudice against pro-life views pervades various institutions within the field of reproductive medicine. Notwithstanding the enactment of the Church, Coats, and Weldon Amendments, that prejudice and the resulting discrimination demonstrate the need for HHS to maintain and vigorously to enforce the Provider Conscience Rule.

In the prior rulemaking, HHS itself cited “the development of an environment in sectors of the health care field that is intolerant of individual objections to abortion or other individual religious beliefs or moral convictions.” 73 Fed. Reg. at 78,073; *accord id.* at 78,088 (hundreds of comments in prior rulemaking demonstrated lack of awareness of the protections found in the Church, Coats, and Weldon Amendments). An article issued today in a prestigious medical journal demonstrates the bias against conscience rights, arguing that those with “[q]ualms about abortion, sterilization, and birth control” should “not practice women’s health.” Julie D. Cantor, *Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine*, NEW

ENG. J. MED. (Apr. 9, 2009). With a prominent journal's giving public voice to prejudice and intolerance that – if it occurred in medical practice or in education – would violate the statutory protections that the Provide Conscience Rule implements, HHS cannot seriously doubt that similar prejudice and intolerance pervade the medical profession.

According to polling of pro-life physicians entered into the record by the Christian Medical Association (“CMA Poll”), 39 percent of pro-life physicians experienced coercion to violate their consciences during their medical education by faculty (with 23 percent experience such discrimination in the application process alone) or administrators, and 32 percent experienced coercion to participate in or refer for procedures that violate their conscience during their professional careers. If HHS needs individual stories, the Freedom2Care.org website has received the following health care personnel stories:

- “25 years ago; as a medical student on my OB/GYN rotation I was randomly assigned to an OR one morning to assist in a procedure. No information was given to me by the intern or resident on service. I found myself witnessing an early second trimester abortion on a women in her late thirties who was obviously distressed. No consideration for my rights of conscience was ever discussed with me; before or after this unfortunate circumstance. Medical students then; and even more so now; are expected to put up or shut up when faced with interventions and therapies they consider morally illicit. This underscores the need for the recent HHS ruling which mandates proper consideration of a health care provider's rights of conscience.”
- “I am a Registered Nurse currently employed at an outpatient podiatry surgery center. Last week; I was told by my administrator that OB/GYN Doctors had signed on to perform surgeries at our center. There is a very large Catholic Hospital across the street that specializes in OB/GYN services. So it was very strange that these doctors would come to our small podiatry center. Our administrator stated there was a [possibility] abortions would be performed at our surgery center. Three of the four nurses stated they wouldn't assist with abortions due to convictions/ethical beliefs. Our administrator responded with ‘if you have a problem assisting with abortions; we have NO PLACE FOR YOU here.’ She stated ‘As nurses; you don't have a CHOICE!’”
- “In May 2005 my professional career as a community pharmacist in the state of Illinois took a dramatic change. I worked for a retail grocery store chain which included a pharmacy for almost 20 years. Following Gov. Blagojevich executive order which forced pharmacies to dispense emergency contraception (Plan B); my practice of pharmacy was forced to change by an action which contradicted the State of Illinois Conscience law. For a year following the executive order I worked to [overturn] the action in the courts in Illinois. I was blocked from doing so because I had not experienced a consequence of the action. I eventually had to leave the State of Illinois and leave community pharmacy

practice because of the inability to exercise my conscience rights. Many of my fellow pharmacists in Illinois were fired and after 4 years are still fighting legal battles in the courts. All this despite the law in Illinois protecting health care professionals. Please protect medical professionals from having to violate their conscience in order to practice in their chosen professions.”

The Provider Conscience Rule’s enforcement process empowers individuals and entities to enforce their rights through HHS, without needing to directly take on their employers, accreditors, certifying boards, or state and local government.

Nonetheless, some have argued that regulations are not necessary because the statutes suffice, by themselves. To the contrary, without the Provider Conscience Rule, conscientious objectors would face daunting economic pressure to conform their conduct to quasi-official coercion. That the coercion occurs demonstrates the need for regulation not only to educate the regulated community but also the beneficiaries.

Comment: HHS regulations are needed both to restrict the illegal actions and inclinations of regulated entities and to protect the civil rights of conscientious objectors.

II. RULE DOES NOT REDUCE ACCESS TO HEALTH CARE SERVICES

HHS’s second question seeks information on whether the current rule reduces access to health care services and information, particularly by low-income women. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that conscience rights deny very few, if any, patients access to health care services and information. Pro-abortion groups provide only anecdotal evidence that the Provider Conscience Rule will cause a meaningful denial of access to abortion-related information and services for women, including low-income women. Moreover, because HHS’s legitimate concern is for the quality of health-care services and information, HHS must weigh against any lost services or information two negative impacts of rescission: (1) pro-life health-care personnel will leave the field, which will reduce access to health-care services and information, particularly in rural and in economically disadvantaged urban area; and (2) increased access to abortion services and information will lead to increased negative health effects associated with abortion. In addition, while freedom of conscience is a statutorily and constitutionally protected right, there is no right to an abortion and *a fortiori* no right to have a particular health-care provider participate in an abortion.

A. In Balancing Rule’s Impact on Access to Health Care, HHS Must Assess the *Loss* of Access that HHS Would Cause by Rescinding the Rule

In related litigation, AAPLOG’s president has provided sworn testimony that AAPLOG’s members are committed to the sanctity of human life and that it is likely that they would leave

the profession or relocate to more conscience-friendly jurisdictions in response to coercion to participate in medical procedures – such as abortion – that violate their consciences. Polling by the Christian Medical Association of pro-life health-care personnel confirms that view, with more than 95 percent (and even higher rates for OB/GYNs) indicating that they would stop practicing before they would accept coercion to violate their consciences.

Significantly, pro-life physicians represent a disproportionately large cohort of the physicians serving poor, rural, and underserved communities. According to the CMA Poll, 82 percent of pro-life health-care personnel said it was either “very” or “somewhat” likely that they personally would limit the scope of their practice of medicine as the result of rescission; for medical professionals who work full time in serving poor and medically-underserved populations, 86 percent considered it very or somewhat likely that they would limit the scope of their practice. By analogy, coercion of religious – and especially Catholic – hospitals threatens to displace medical institutions from the poor, rural, inner-city, and underserved areas that they now serve, but which they might abandon in response to coercion to violate pro-life tenets of their religious faiths.

Finally, because Americans value having physicians and medical caregivers that share their views, the wholesale elimination of pro-life health-care personnel would damage the diversity of the medical profession. *See* 73 Fed. Reg. at 78,081 (“[a] health care system that is intolerant of individual conscience, certain religious beliefs, ethnic and cultural traditions, or moral convictions serves to discourage individuals with diverse backgrounds and perspectives from entering the health care professions, further exacerbating health care access shortages and reducing quality of care”). For all of the foregoing reasons, AAPLOG and the groups joining these comments respectfully submit that denying conscientious objectors a means to enforce their statutory protections would result in a net loss of access to health-care services and the resulting information in both health care generally and reproductive health specifically. Moreover, given the special-purpose abortion and family-planning groups like Planned Parenthood, HHS’s maintaining the Provider Conscience Rule is unlikely to deny meaningful access to abortion-related services and information for those who seek that information.

Comment: In assessing the increased access to abortion services and information that rescission would provide, HHS must weigh the negative effects on not only OB/GYN care but also medical care generally from the loss of pro-life health-care personnel and institutions that leave the health care field as a result of coerced participation in abortions and work environments hostile to pro-life views.

B. In Assessing the Health-Care Impacts of Losing Access to Abortion Services, HHS Must Balance the Negative Impacts of Abortion Services

In assessing the public-health impacts of denial of access to abortion services and information, HHS must balance the harms to medical and mental health caused by access to elective abortions. Such harms include suicide, mood disorders, substance abuse disorders, premature births in subsequent pregnancies, breast cancer, and placenta previa, as well as additional harms for mifepristone abortions:²

- **Suicide:** Abortion carries a sixfold (600 percent) increased risk of suicide compared with birth and a threefold (300 percent) increased risk over the general population. M. Gissler et al., *Pregnancy-Associated Deaths in Finland 1987-1994 – Definition Problems and Benefits of Record Linkage*, 76 ACTA OBSTETRICA & GYNECOLOGICA SCANDINAVICA 651-57 (1997); see also D. Reardon et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95:8 SO. MED. J. 834-41 (2002). Significantly for the low-income women for whom HHS has requested special focus, the Reardon study analyzed Medicaid records for women who either received an induced abortion or delivered children, which showed significantly increased risk of suicide (age-adjusted odds ratio of 3.12) for low-income women who received an induced abortion.
- **Mood disorders:** Women who undergo elective abortions have higher incidence of mood and anxiety disorders than either the general population or women who deliver children. David M. Fergusson, L. John Horwood & Joseph M. Boden, *Abortion and mental health disorders: evidence from a 30-year longitudinal study* 193 BRIT. J. PSYCHIATRY 444-51 (2008); see also D. Reardon et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95:8 SO. MED. J. 834-41 (2002). Significantly for the low-income women for whom HHS has requested special focus, the Reardon study analyzed data for low-income women in California and found that women who had abortions had a higher incidence of psychiatric admissions across all age groups compared with women who delivered children (odds ratio of 2.34) and more depressive psychosis (odds ratio of 3.92) and other psychiatric disorders.
- **Substance Abuse:** Women who undergo elective abortions have higher incidence of substance abuse than either the general population or women who deliver children. Priscilla K. Coleman, David C. Reardon, Vincent M. Rue & Jesse Cogle, *Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of*

² The body of this section cites several leading or recent articles for each of these public-health harms caused by abortions. Additional authorities are collected in Exhibit 4.

abortion in the national comorbidity survey, __ J. PSYCHIATRIC RES. __ (in press/published online).

- **Premature births:** Prior abortions increase the risk of premature births in later pregnancies, including a significantly elevated risk (64 percent) of “very preterm” births prior to 32 weeks gestation. Jay D. Iams, Roberto Romero, Jennifer F. Culhane & Robert L. Goldenberg, *Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth*, 371 THE LANCET 164-75 (Jan. 2008); Hanes M. Swingle, Tarah T. Colaizy, M. Bridget Zimmerman & Frank H. Morriss, Jr., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. REPRODUCTIVE MED. 95-108 (2009); Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention*, 519 (National Academy of Science Press, July 2006) (listing abortion as an immutable risk factor for preterm birth). Moreover, among very preterm newborns, the risk of cerebral palsy increases fifty-five fold (5500 percent) over full-term newborns. E. Himpens, C. Van den Broeck, A. Oostra, P. Calders & P. Vanhaesebrouck, *Prevalence, type, and distribution and severity of cerebral palsy in relation to gestational age: a meta-analytic review*, 50 DEVELOPMENTAL MED. CHILD NEUROLOGY 334-40 (2008).
- **Breast cancer:** Induced abortions significantly increase the risk of breast cancer. Kim E. Innes & Tim E. Byers, *First Pregnancy Characteristics and Subsequent Breast Cancer Risk among Young Women*, 112 INT. J. CANCER 306-11 (2004); Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White & Noel S. Weiss, *Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion*, 86 J. NAT’L CANCER INST. 1584 (1994).
- **Placenta previa:** Induced abortions correlate with a sevenfold (700 percent) increase in the risk of placenta previa, J. M. Barrett, F. H. Boehm & A. P. Killam, *Induced abortion: a risk factor for placenta previa*, 141(7) AM. J. OBSTET. GYNECOL. 769-72 (1981), the leading cause of uterine bleeding in the third trimester and medically indicated preterm birth. Women who have placenta previa face markedly higher risks of preterm birth, low birth weight, and perinatal death in subsequent pregnancies, as well as increased risk of hemorrhaging (of which placenta previa is a major cause). John M. Thorp, Jr., Katherine E. Hartmann & Elizabeth Shadigian, *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OB GYN SURVEY 67-79 (2002).
- **Mifepristone:** Even the Food & Drug Administration has acknowledged that mifepristone patients had “significantly more blood loss than did surgical patients,” FDA, *Medical Officer’s Review of Amendments 024 and 033, Final Reports for the U.S. Clinical Trials Inducing Abortion up to 63 Days Gestational Age and Complete*

Responses Regarding Distribution System and Phase 4 Commitments, (finalized November 22, 1999; dated January 27, 2000), which understates mifepristone's documented problems with significantly higher post-procedural rates of persistent bleeding, bleeding requiring post-procedure surgery, and hemorrhaging. J. T. Jensen, S. J. Astley, E. Morgan & M. D. Nichols, *Outcomes of suction curettage and mifepristone abortion in the United States: a prospective comparison study*, 59 CONTRACEPTION 153-59 (1999); M. M. Gary & D. J. Harrison, *Analysis of severe adverse events related to the use of mifepristone as an abortifacient*, 40 ANNALS OF PHARMACOTHERAPY 191-97 (2006). Mifepristone also increases the risk of septic shock and increases the risk of death tenfold (1000 percent) over surgical abortion. M. F. Greene, *Fatal infections associated with mifepristone-induced abortion*, 353(22) N. ENGL. J MED. 2317-18 (2005); M. Fischer, *Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion*, 353 N. Engl. J Med. 2352-60 (2005); R. P. Miech, *Disruption of the innate immune system by mifepristone and lethal toxin of Clostridium sordellii*, at 1-5, JOURNAL OF ORGAN DYSFUNCTION (2007); R. P. Miech, *Pathophysiology of Mifepristone-Induced Septic Shock Due to Clostridium sordellii*, 39(9) ANNALS OF PHARMACOTHERAPY 1483-88 (2005) The Miech studies discuss the pathophysiological basis both for the increase in hemorrhage and for the profound immunological suppression with mifepristone abortions.

All of the foregoing adverse public-health impacts would undercut the public-health harm from a decreased access to abortion-related services and information, if the Provider Conscience Rule caused such decreased access. Although AAPLOG and the groups joining these comments doubt that HHS will receive credible evidence that the Provider Conscience Rule has decreased access to abortion services and information, HHS must consider abortion's adverse public-health impacts when considering the impact of the Provider Conscience Rule. In considering these issues, moreover, HHS should consider that there is no mandatory reporting of abortion-related complications in the United States. While opponents of the Provider Conscience Rule likely will overstate the rule's impact, the publicly available data certainly understate abortion's adverse public-health impact.

Comment: In assessing the public-health benefit from increased access to abortion services and information, HHS must weigh the negative medical and psychological effects of abortion.

C. Loss of Access to Abortion Services Does Not Deny a Right to Abortions

Pro-abortion groups claim that the HHS rule and similar efforts to protect the conscience rights of health care providers violate women's federal constitutional right of privacy (*i.e.*, that conscience protections deny their "right" to an abortion). In essence, they claim that the U.S. Constitution preempts the HHS rule. The claim lacks merit.

The rights protected by the Church, Coats, and Weldon Amendments are not preempted by *Roe v. Wade*, 410 U.S. 113, 162-64 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 855-59 (1992), which by their terms do not purport to provide women a right to an abortion performed by whomever a woman chooses. *Poelker v. Doe*, 432 U.S. 519, 520-21 (1977). As HHS noted in its original rulemaking, to the extent that a health care provider's refusal to provide sterilization or abortion services "infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals with religious or moral scruples against sterilizations and abortions." 73 Fed. Reg. at 50,276 (quoting *Taylor v. St. Vincent's Hospital*, 523 F.2d 75, 77 (9th Cir. 1975)) (interior quotations omitted); 73 Fed. Reg. at 78,088 n.4 (same). *Roe* and *Casey* "do[] not create or identify a corresponding duty on the part of any provider to be involved in the procedure in any way." 73 Fed. Reg. at 78,088. Because nothing in *Roe* or *Casey* outweighs health care providers' religious beliefs and moral convictions, nothing in those decisions preempts the Provider Conscience Rule or the Church, Coats, and Weldon Amendments.

Comment: The federal "right" to an abortion does not preempt the Provider Conscience Rule because the right of conscience protected by the Provider Conscience Rule outweighs the right to compel any specific individual or institutional health care provider to participate in abortions.

D. Loss of Access to Abortion Services Does Not Discriminate by Gender

Pro-abortion groups claim that the HHS rule and similar efforts to protect the conscience rights of health care providers violate women's federal constitutional rights of equal protection (*i.e.*, that conscience protections constitute unlawful gender discrimination). In essence, they claim that the U.S. Constitution preempts the proposed regulations. These claims lack merit.

Under federal law, discrimination because of pregnancy (or the ability to get pregnant) constitutes discrimination because of sex only in the employment context. *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 684 (1983) ("Pregnancy Discrimination Act has now made clear that, for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex"); 42 U.S.C. §2000e(k) ("For the purposes of [Title VII]... [t]he terms 'because of sex' or 'on the basis of sex' include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions"). Outside the employment context, disparate treatment of a potentially pregnant person because one opposes abortion is not discrimination *because of that person's gender*. *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 271-72 (1993) (citing cases). "While it is true... that only women can become pregnant, it does not follow that every... classification concerning pregnancy is a sex-based classification." *Bray*, 506 U.S. at 271 (interior quotations omitted, citing *Geduldig v. Aiello*, 417 U.S. 484, 496, n.20 (1974)); accord *Harris v. McRae*, 448 U.S.

297, 322 (1980) (restrictions on abortion funding are not discrimination because of gender); *Poelker v. Doe*, 432 U.S. 519, 520-21 (1977) (no equal-protection violation for city to provide public funding for childbirth but not for elective abortions). Instead, to find the required “[d]iscriminatory purpose” one must find that “the decisionmaker... selected or reaffirmed a particular course of action at least in part *because of*, not merely *in spite of*, its adverse effects upon an identifiable group.” *Bray*, 506 U.S. at 271-72 (interior quotations omitted, emphasis added, citing *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 279 (1979)). The refusal to participate in what conscientious objectors consider the unjustified taking of human life has nothing to do with the gender of the victim’s consenting mother and everything to do with the conscientious objector’s religious beliefs and moral convictions.

Comment: The Equal Protection Clause does not preempt the Provider Conscience Rule because no action taken under the rule qualifies as action taken *because of* gender.

III. LACK OF CLARITY OR CONFUSION WARRANTS CLARIFICATION, NOT RESCISSION

HHS’s third question asks whether the current rule provides sufficient clarity to minimize harmful ambiguity and confusion. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that the Provider Conscience Rule would benefit from HHS’s clarification of issues that HHS declined to consider in the initial rulemaking in 2008 (Sections III.A-III.C, *infra*), but that the contents of the Provider Conscience Rule itself are neither ambiguous nor confusing (Sections III.E-III.H, *infra*). To the extent that HHS or regulated entities find the certification process unwieldy, HHS could revise the enforcement mechanism to comport with the time-tested HHS regulatory enforcement mechanism for other civil rights legislation (Section III.D, *infra*).

A. HHS Should Clarify that the Rule Does Not Require Administrative Exhaustion or Displace Constitutional Remedies

In addition to the federal statutory protections at issue in this rulemaking, conscientious health care providers have rights under the First Amendment, *see, e.g., Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972) (religious freedom is a fundamental right), as well as the laws of most states. Maureen Kramlich, *The Abortion Debate Thirty Years Later: from Choice to Coercion*, 31 FORDHAM URB. L.J. 783, 802-03 & n.125 (2004) (citing conscience protections under the laws of 46 states). Indeed, under 42 U.S.C. §1988(a), conscientious objectors may rely on state-law protections in defending and defining the scope of their civil rights under federal law, provided that the state-law protections are “not inconsistent” with federal law. *Wilson v. Garcia*, 471 U.S.

261, 267 (1985).³ Under the Ninth and Tenth Amendments, respectively, a federal enumeration of rights does not “deny or disparage others retained by the people” and powers neither delegated to nor prohibited to the federal government “are reserved to the States... or to the people.” U.S. CONST. amend. IX, X. Finally, in the related area of enforcing the statutory protections of other funding-based federal civil rights laws such as Title IX and Title VI, the availability of an administrative remedy with a federal agency does not preclude a party’s proceeding directly to court to enforce statutory protections, without first exhausting the administrative remedy. *Cannon v. Univ. of Chicago*, 441 U.S. 694, 706-08 (1979). All of these provisions provide important alternate avenues for health care providers to enforce their rights of conscience.

Comment: HHS should clarify that its provider conscience regulations neither preempt whatever rights providers have to enforce their rights of conscience under federal and state law nor require that providers exhaust their administrative remedy with HHS before filing suit.

B. HHS Should Clarify the Scope of Protected Activity for Abortions and Pregnancy

Because the Church, Coats, and Weldon Amendments all refer to abortion, they beg the question of when an abortion (or a pregnancy) takes place. In the prior rulemaking, commenters supported rival definitions, based on fertilization or implantation of the embryo, but HHS declined to promulgate a definition of when pregnancy begins for these statutory protections. *See* 73 Fed. Reg. at 78,077 (“Department declines to add a definition of abortion to the rule”). As explained in the following three subsections, medical science and religious thought counsel for a fertilization-based definition, not an implantation-based definition, but substantial policy reasons counsel for a definition that defers to individuals’ reasonable subjective beliefs.

1. Pregnancy Begins at Fertilization

To have an abortion (*i.e.*, to end a pregnancy), a woman first must be pregnant. Consistent with the weight of both medical and religious authority, HHS should adopt a fertilization-based definition of pregnancy (and thus abortion).

The standard definitions have pregnancy starting at the union of an ovum and spermatozoon, with that union described as both fertilization and conception. *See, e.g.*, DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (25th ed. 1974) (pregnancy means “condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon”); DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (31st ed. 2007) (same); MOSBY’S MEDICAL DICTIONARY (7th ed. 2006) (pregnancy means “gestational process, comprising the growth and

³ The “Title 24” in §1988(a) includes 28 U.S.C. §1343 and 42 U.S.C. §1983. *See Lynch v. Household Fin. Corp.*, 405 U.S. 538, 544 n.7 (1972).

development within a woman of a new individual from conception through the embryonic and fetal periods to birth,” and conception means “beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote... the act or process of fertilization”). Other medical dictionaries have flirted with an implantation-based definition and returned to the fertilization-based definition. *Compare* STEDMAN’S MEDICAL DICTIONARY (21st ed. 1966) (conception means “act of conceiving, or becoming pregnant; the fecundation of the ovum”) *with* STEDMAN’S MEDICAL DICTIONARY (22nd ed. 1972) (conception means “Successful implantation of the blastocyst in the uterine lining”); *see also* STEDMAN’S MEDICAL DICTIONARY (24th ed. 1982) (conception means “act of conceiving, or becoming pregnant; the fertilization of the oocyte (ovum) by a spermatozoon”); STEDMAN’S MEDICAL DICTIONARY (28th ed. 2006) (conception means “Fertilization of oocyte by a sperm”). At least one medical dictionary appears to have switched from fertilization to an implantation-based definition. *Compare* TABER’S CYCLOPEDIA MEDICAL DICTIONARY (18th ed. 1997) (conception means “union of the male sperm and the ovum of the female; fertilization”) *with* TABER’S CYCLOPEDIA MEDICAL DICTIONARY (19th ed. 2001) (conception means “onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall”). As HHS is aware, no new scientific discoveries explain the changes in definition. Zygotes are as alive today as their predecessors were in the 1970s. While some definitional semantics supports an implantation-based definition, those changes reflect political manipulations,⁴ not scientific developments, and do not represent the weight of authority or common understanding. *See* Christopher M. Gacek, J.D., Ph.D., *Conceiving “Pregnancy:” U.S. Medical Dictionaries and their Definitions of “Conception” and “Pregnancy”* (Family Research Council Apr. 2009) (Ex. 5).

A fertilization-based definition also is consistent with the religious beliefs and moral convictions that the Church, Coats, and Weldon Amendments seek to protect. For example, although Southern Baptists and Catholics do not command the obedience of other faiths, their position on this subject suffices to demonstrate the reasonableness of a fertilization-based definition for religious purposes: “The Bible affirms that the unborn baby is a person bearing the image of God from the moment of conception.” Southern Baptist Convention, Resolution on Thirty Years of *Roe V. Wade* (June 2003) (citing Psalm 139:13–16 and *Luke* 1:44) (Ex. 6); *see also* Southern Baptist Convention, Resolution on Human Embryonic and Stem Cell Research (June 1999) (“Bible teaches that... protectable human life begins at fertilization”) (Ex. 7).

In this context, it is not possible to anaesthetize consciences, for example, concerning the effects of particles whose purpose is to prevent an embryo’s implantation or to shorten a person’s life....
In the moral domain, your Federation is invited to address the issue

⁴ *See, e.g.,* Robert G. Marshall & Charles A. Donovan, *Blessed Are the Barren: the Social Policy of Planned Parenthood*, 291-302 (1991) (Ex. 8).

of conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia.

Pope Benedict XVI, *Address of His Holiness Benedict XVI to Members of the International Congress of Catholic Pharmacists* (Oct. 29, 2007) (Ex. 9); *see also* Pontifical Academy for Life, *Statement on the So-Called ‘Morning-After Pill’* (Oct. 31, 2000) (“the proven ‘anti-implantation’ action of the *morning-after pill* is really nothing other than a chemically induced abortion [and] from the ethical standpoint the same absolute unlawfulness of abortifacient procedures also applies to distributing, prescribing and taking the *morning-after pill*”) (emphasis in original) (Ex. 10). Religious and moral opposition to abortion provides the driving force behind the Church, Coats, and Weldon Amendments and thus should guide HHS in regulating under those laws.⁵

Comment: HHS should adopt the prevailing fertilization-based definition of pregnancy and abortion.

2. Implantation-Based Definitions Are Inapposite

Contrary to a fertilization-based definition of pregnancy (and thus abortion), pro-abortion groups seek to impose a definition that has pregnancy begin at implantation of the fertilized egg in its mother’s uterine wall. To support an implantation-based definition, these groups cite medical dictionaries, federal regulations, and “science.” None of these authorities supports an implantation-based definition of pregnancy.

First, as indicated in the prior section, the weight of medical definitions supports a fertilization-based definition of pregnancy and, thus, abortion. Indeed, even HHS has used fertilization-based definitions, both before and after enactment of the statutes at issue here:

All the measures which impair the viability of the zygote at any time between the instant of fertilization and the completion of labor constitute, in the strict sense, procedures for inducing abortion.

⁵ Although the religious views supported here fall squarely within mainstream religious faiths and morality, that is not necessary to trigger our nation’s fundamental First Amendment rights or the rights protected by the Church, Coats, and Weldon Amendments. *See, e.g., Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 524 (1993) (finding unlawful restriction of a faith with animal sacrifice as a principal form of devotion).

U.S. Dep't of Health, Education & Welfare, Public Health Service Leaflet No. 1066, 27 (1963); *accord* 45 C.F.R. §457.10 (for SCHIP, “*Child* means an individual under the age of 19 including the period from conception to birth”); *see also* 67 Fed. Reg. 61,956, 61,963-64 (2002) (finding it unnecessary to define “conception” as “fertilization” in SCHIP because HHS did “not generally believe there is any confusion about the term ‘conception’”). Having itself acknowledged in some contexts that pregnancy begins with fertilization, HHS cannot credibly deny the right of health care providers to have their religious beliefs and moral convictions guide them to that same conclusion.

Second, pro-abortion groups often cite HHS’s definition of pregnancy at 45 C.F.R. §46.202(f) for the proposition that pregnancy begins at implantation, rather than fertilization. That federal regulation simply does not support the weight that pro-abortion groups place on it to define “pregnancy” for all purposes under federal law. At the outset, the regulation expressly applies by its terms only to “this subpart,” namely Subpart B of the HHS regulations at 45 C.F.R. pt. 46. More importantly, HHS’s predecessor did not reject a fertilization-based definition for all purposes and retained the implantation-based definition only “to provide an administerable policy” for a specific purpose (namely, obtaining informed consent for participation in federally funded research) under technology then present:

It was suggested that pregnancy should be defined (i) conceptually to begin at the time of fertilization of the ovum, and (ii) operationally by actual test unless the women has been surgically rendered incapable of pregnancy.

While the Department has no argument with the conceptual definition as proposed above, it sees no way of basing regulations on the concept. Rather in order to provide an administerable policy, the definition must be based on existing medical technology which permits confirmation of pregnancy.

39 Fed. Reg. 30,648, 30,651 (1974). Thus, HHS’s predecessor had “no argument” on the merits against recognizing pregnancy at fertilization, but declined for administrative ease and then-current technology. The resulting “administerable policy” merely sets a federal floor for obtaining the informed consent of human subjects in federally funded research.⁶ In its response

⁶ To the extent that HHS finds that its human-subject protection rules require HHS to use 45 C.F.R. §46.202(f)’s implantation-based definition for the Church, Coats, and Weldon Amendments, HHS must also recognize that the Dickey-Wicker Amendment provides protection from fertilization. *See* Pub. L. No. 110-161, §509(b), 121 Stat. 1844, 2209 (2007) (“For purposes of this section, the term ‘human embryo or embryos’ includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by

to comments on the final rule, HHS's predecessor acknowledged that another of its pregnancy-related definitions served "interests of both consistency and clarity, although it may vary at times from legal, medical, or common usage." 40 Fed. Reg. 33,526 (1975). A decision to set an arguable floor (based on 1970s technology) for administrative expedience obviously cannot translate to the conscience context, where the question is whether individuals or institutions want to avoid participating in activities against *their* religious beliefs or moral convictions. Finally, the enacting Congress expressly indicated that these definitions would not trump religious beliefs and moral convictions under the Church Amendment. S. REP. NO. 93-381 (1973), *reprinted in* 1974 U.S.C.C.A.N. 3634, 3655 ("It is the intent of the Committee that guidelines and regulations established by... the Secretary of HEW under the provisions of the Act do not supersede or violate the moral or ethical code adopted by the governing officials of an institution in conformity with the religious beliefs or moral convictions of the institution's sponsoring group").

Third, pro-abortion groups often appeal to "science" as supporting their view that pregnancy begins at implantation. In doing so, these groups do not specify what "science" they reference, other than the foregoing definitional semantics, which reflect neither medical science nor medical consensus. The pre-implantation communications or "cross talk" between the mother and the pre-implantation embryo establish life before implantation, *see, e.g.*, Eytan R. Barnea, Young J. Choi & Paul C. Leavis, "Embryo-Maternal Signaling Prior to Implantation," 4 EARLY PREGNANCY: BIOLOGY & MEDICINE, 166-75 (July 2000) ("embryo derived signaling... takes place prior to implantation"); B.C. Paria, J. Reese, S.K. Das, & S.K. Dey, "Deciphering the cross-talk of implantation: advances and challenges," SCIENCE 2185, 2186 (June 21, 2002); R. Michael Roberts, Sancai Xie & Nagappan Mathialagan, "Maternal Recognition of Pregnancy," 54 BIOLOGY OF REPRODUCTION, 294-302 (1996), as do the embryology texts. *See, e.g.*, Keith L. Moore & T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology*, 15 (8th ed. 2008) ("Human development begins at fertilization when a male gamete or sperm unites with a female gamete or oocyte to form a single cell, a zygote. This highly specialized, totipotent cell marked the beginning of each of us as a unique individual."). Moreover, non-uterine pregnancies such as ectopic pregnancies demonstrate that uterine implantation cannot mark the beginning of pregnancy.

Even if the term "conception" is redefined in human beings to mean "the point of implantation," defying all other known biological use of the term in other living creatures, that redefinition cannot change the reality that biological life begins at fertilization. Since the mechanism by which mammals reproduce has been known for at least the last 150 years, any biologist in the world can tell you that a mammal's life begins when the sperm from the father unites with the egg from the mother. This process is called fertilization, and when the DNA from

fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells"); Pub. L. No. 111-8, §509(b), 123 Stat 524, 803 (2009) (same).

a human father and a human mother combine, the egg is called a “fertilized egg” or “zygote.” When the zygote splits into two cells, it is called a “two celled embryo.” When it splits into four cells, it is called a “four celled embryo,” etc. The definition of “embryo” is “the youngest form of a being.” If this being is nourished and protected, it will proceed uninterrupted through the developmental stages of embryo, fetus, newborn, toddler, child, adolescent, adult, and aged adult: one continuous existence. This being never develops into a pig, a frog, or a tree, but only into a human. This being is therefore, by definition, a living human being.

In summary, none of the bases for an implantation-based definition support the claim that the pro-abortion groups’ preferred definition has any application in defining the religious beliefs or moral convictions of individuals and institutions who do not share the pro-abortion groups’ views. The right to conscience would be a poor thing if limited to the right to believe what someone else tells us.

Comment: Even if it declines to adopt a fertilization-based definition, HHS should clarify that neither 45 CFR §46.202(f) nor any other federal or medical definition justifies the use of an implantation-based definition of “abortion” for the Church, Coats, and Weldon Amendments.

3. HHS Should Allow Rights-Holder’s Reasonable Subjective View

Although HHS clearly must adopt the fertilization-based definition of pregnancy if HHS elects to define pregnancy, a formal definition is perhaps unnecessary. Honest people undoubtedly differ on the meaning of life, the timing of life, and the permissibility of ending life in certain contexts. In other contexts – such as the lawfulness of abortion – government must take sides in the debate on when life begins. In this context, however, HHS need only recognize that the reasonable subjective view of the individual or institution should govern any assessment of that individual’s or institution’s invocation of religious beliefs or moral convictions.

The Provider Conscience Rule itself does not require HHS to define pregnancy and abortion for itself, for Congress, and for each citizen. Indeed, HHS may find it inappropriate to go any further than to recognize the reasonableness of a subjective belief in a fertilization-based definition:

If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.

West Virginia State Board of Education v. Barnette, 319 U.S. 624, 642 (1943); cf. *Harris v. McRae*, 448 U.S. 297, 321 (1980) (free-exercise claim “requires the participation of individual members” because “it is necessary in a free exercise case for one to show the coercive effect of

the enactment as it operates against him in the practice of his religion”) (citations and interior quotations omitted). Under these authorities, HHS might conclude that it need not conclusively define the terms. For the reason set forth in Section III.B.1, *supra*, a fertilization-based definition unquestionably is reasonable on both religious and medical grounds.

HHS’s “SCHIP” rulemaking on the allowable definition of “child” provides precedent for this approach. In defining “child” to allow states to go back to conception, HHS “disagree[d] with [the] contention that there is only one appropriate interpretation of the statutory term at issue, and [HHS] believe[d] the range of comments supports [its] view that States should have the option to include unborn children as eligible targeted low income children.” 67 Fed. Reg. at 61,960. Moreover, when a commenter suggested that the SCHIP regulations define “conception” to mean “fertilization” because “there are other potentially confusing definitions being used,” HHS responded that it did “not generally believe there is any confusion about the term ‘conception’” but that “[t]o the extent that there is... [HHS] believe[s] States should have flexibility to adopt any reasonable definition of that term.” 67 Fed. Reg. at 61,963-64. At a minimum, individuals and institutions deserve that same flexibility.

Comment: HHS should make clear that the definition of abortion (and thus the protections afforded by the Church, Coats, and Weldon Amendments) lies in the reasonable subjective religious beliefs or moral convictions of each health care provider.

C. HHS Should Add Federal Entities to §88.4(e)

The first Church Amendment prohibits both courts and public officials from using receipt of funding under three federal statutes, including the Public Health Service Act, as the basis for requiring an individual or an entity to participate or make its facilities available for sterilization or abortion against the individual’s or entity’s religious belief or moral convictions. 42 U.S.C. §300a-7(b); *see also* H.R. REP. NO. 93-227 (1973), *reprinted in* 1973 U.S.C.C.A.N. 1464, 1464 (“H.R. 7806 as amended would... deny *any* court, public official, or public authority the right to require individuals or institutions to perform abortions or sterilizations contrary to their religious beliefs or moral convictions because an individual or institution had received assistance under the Public Health Service Act [and two other statutes]”) (emphasis added); *id.*, *reprinted at* 1973 U.S.C.C.A.N. 1464, 1473 (“Subsection (b) of 401 would prohibit a court or a public official, *such as the Secretary of Health, Education, and Welfare*, from using receipt of assistance under the three laws amended by the bill (the Public Health Service Act [and two other statutes]) as a basis for requiring an individual or institution to perform or assist in the performance of sterilization procedures or abortions, if such action would be contrary to religious beliefs or moral conviction”) (emphasis added). Although the Church Amendment’s definition of “public official” is in no way limited to state and local government, and the legislative history expressly includes HHS’s predecessor, §88.4(e) expressly lists state or local governments, without expressly listing HHS and the federal government.

Comment: HHS should add itself and other federal agencies to the entities subject to §88.4(e).

D. HHS Could Cure Any Perceived Confusion from Certifications by Conforming the Provider Conscience Rule with Civil Rights Statutes

Several groups opposed to the Provider Conscience Rule have focused on the rule's certification requirements. In this respect, Congress did not enact the funding-based restrictions of the Church, Coats, and Weldon Amendments against a blank slate. Instead, going back to Title VI of the Civil Rights Act of 1964, Congress has required recipients of federal funds to refrain from discriminatory conduct on a variety of bases (*e.g.*, race in Title VI, gender in Title IX of the Education Amendments of 1972, etc.). As the Supreme Court has recognized, Congress would have intended these civil rights statutes to be interpreted in light of each other. *See, e.g., Grove City College v. Bell*, 465 U.S. 555, 575 (1984) ("Regulations authorizing termination of assistance for refusal to execute an Assurance of Compliance with Title VI had been promulgated and upheld long before Title IX was enacted, and Congress no doubt anticipated that similar regulations would be developed to implement Title IX"), *abrogated by statute on other grounds*, 20 U.S.C. §1687; *CBOCS West, Inc. v. Humphries*, 128 S.Ct. 1951, 1958-59 (2008) (Congress would have expected similar anti-discrimination statutes to be interpreted similarly); *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 176 (2005) (same). In general, if HHS finds any confusion or burden from the Provider Conscience Rule's certification process, HHS could amend the rule to conform the regulatory enforcement regime for the Church, Coats, and Weldon Amendments to the regulatory enforcement mechanisms for other federal civil-rights legislation under the Spending Clause.

1. HHS Could Adopt the Title VI Enforcement Process

In adopting the implementing regulations for Title IX, HHS's predecessor simply incorporated by reference the enforcement mechanism that it had adopted for Title VI in 1964. *See* 45 C.F.R. §86.71 (incorporating 45 C.F.R. §§80-6 through -11 and 45 C.F.R. pt. 81 into 45 C.F.R. pt. 86); 45 C.F.R. §§80-6 through -11; 45 C.F.R. pt. 81. Given the essentially contemporaneous enactment of the Church Amendments with these other funding-based anti-discrimination statutes, HHS should consider taking the same approach for the enforcement mechanism for the Church, Coats, and Weldon Amendments. The approach would have several advantages for HHS, regulated entities, and beneficiaries alike. First, the enforcement mechanism is time tested and well understood by all concerned. Second, the approach has been very successful in negotiating voluntary compliance with regulated entities and provides a relatively simple complaint process for beneficiaries to utilize without the need to engage counsel. Third, the Title VI enforcement mechanism includes third-party retaliation protections:

No recipient or other person shall intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering

with any right or privilege secured by [the Act] or this part, or because he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding or hearing under this part. The identity of complainants shall be kept confidential except to the extent necessary to carry out the purposes of this part, including the conduct of any investigation, hearing, or judicial proceeding arising thereunder.

45 C.F.R. §80.7(e). All of these reasons would combine to streamline the process, to ensure expeditious compliance, and to protect the important civil rights at issue here.

Comment: If HHS has new-found concerns about the Provider Conscience Rule's certification requirements, HHS should consider incorporating by reference Title VI's administrative-enforcement process as HHS's regulatory enforcement mechanism for the Church, Coats, and Weldon Amendments.

2. HHS Should Rely on Existing Civil Rights Educational Methods

HHS's notice of final rulemaking recognized the need for an education and outreach program *in addition* to the promulgation of a regulatory enforcement mechanism. *See* 73 Fed. Reg. at 78,079; *see also* Section IV, *infra*. HHS should implement its conscience-protection regulations in the same manner as other civil rights regulatory regimes. For example, 45 C.F.R. §80.6(d) requires recipients to make information available to beneficiaries regarding Title VI's protections in such a manner as HHS finds necessary to apprise them of the statutory and regulatory protections against discrimination. In addition, 45 C.F.R. §86.3(c)-(d) requires Title IX recipients to prepare a self evaluation within one year to ensure compliance with the Title IX regulations and further requires them to correct anything that does not comply. To the extent that entities already have affirmative-action officers, departments, websites, training, and/or handbooks to implement other civil rights statutes, those same organs should address the civil rights protections afforded by the Church, Coats, and Weldon Amendments and their implementing regulations.

Comment: HHS should implement and enforce the Provider Conscience Rule in the manner that federal agencies implement and enforce other civil rights laws.

E. Title VII's "Reasonable Accommodation" Standard Is Neither Relevant Nor Applicable to the Church, Coats, and Weldon Amendments

Opponents of the Provider Conscience Rule have argued that HHS should incorporate into the rule (and thus into the Church, Coats, and Weldon Amendments) the reasonable-accommodation/undue-hardship framework from Title VII of the Civil Rights Act of 1964:

For the purposes of this subchapter [*i.e.*, Title VII] -- ... The term “religion” includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee’s or prospective employee’s religious observance or practice without undue hardship on the conduct of the employer’s business.

42 U.S.C. §2000e(j). As the plain language of Title VII’s §701(j) makes clear, however, that provision applies to Title VII.

Although Congress enacted all of the conscience protections at issue here after Congress enacted Title VII generally in 1964 and §701(j) in 1972,⁷ Congress did not include a similar limitation in the conscience-protection statutes. As HHS recognized, “Congress in this context imposed a choice not between reasonable accommodations and undue burden, but between accommodation of religious belief or moral convictions and federal funding.” 73 Fed. Reg. at 78,085. HHS has long recognized that Congress has made similar choices in other civil rights laws imposed under the Spending Clause, *see, e.g.*, 45 C.F.R. §86.6(a) (“obligations imposed by this part are independent of, and do not alter, obligations not to discriminate on the basis of sex imposed by ... Title VII of the Civil Rights Act of 1964 ... and any other Act of Congress or Federal regulation”), and HHS could no more import Title VII’s limitations on employer size into these statutes than it can import the undue-burden test.

Agencies, like “courts[,] are not at liberty to pick and choose among congressional enactments, and when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective.” *Morton v. Mancari*, 417 U.S. 535, 551 (1974) (“specific statute will not be controlled or nullified by a general one, regardless of the priority of enactment”). As it happens, *Morton v. Mancari*’s hornbook principle of law arose in a case that involved Title VII and a statute enacted *prior* to Title VII. Moreover, in its 1972 amendments to Title VII, Congress indicated that “Title VII was envisioned as an independent statutory authority,” which (with respect to public entities liable to discrimination suits under 42 U.S.C. §1983 and the Equal Protection Clause) did “not affect existing rights that [plaintiffs] have already been granted by previous legislation.” H.R. REP. NO. 92-238 (1971), *reprinted in* 1972 U.S.C.C.A.N. 2137, 2154. If Title VII did not limit *previous*, independent legislation that did not include Title VII’s limiting features, it borders on the frivolous to argue that *future*, independent legislation should include those limitations, notwithstanding that Congress choose not to add or reference them.

⁷ Congress added §701(j) to Title VII in the Equal Employment Opportunity Act of 1972, Pub. L. No. 92-261, §2(7), 86 Stat. 103 (1972), which also imposed public entities to Title VII.

Comment: Like the Church, Coats, and Weldon Amendments, the Provider Conscience Rule is not limited by an undue-burden or reasonable-accommodation test. Recipients of federal funds have the choice of complying with these laws or foregoing federal funds.

F. Provider Conscience Rule Is Neither Overbroad Nor Vague

Groups opposed to conscience rights have claimed that the Provider Conscience Rule is overbroad in its reach and impermissibly vague. These objections are misplaced. Contrary to a cramped reading of the conscience rights under the Church, Coats, and Weldon Amendments, Congress would expect courts and agencies to interpret those anti-discrimination statutes broadly under the “familiar canon of statutory construction that remedial legislation should be construed broadly to effectuate its purposes.” *Tcherepnin v. Knight*, 389 U.S. 332, 336 (1967). As to vagueness, AAPLOG and the groups joining these comments respectfully submit that neither the Provider Conscience Rule nor the underlying statutes are vague, but even if they were, that vagueness would go to the lack of a private cause of action to enforce the regulations and the statutes under 42 U.S.C. §1983, *see, e.g., Suter v. Artist M.*, 503 U.S. 347, 356 (1992), not to HHS’s regulatory regime for enforcing the statutes in an administrative proceeding.

In addition to failing on these general legal principles, the over-breadth and vagueness arguments also fail on their specifics. For example, as to the individuals covered by the Provider Conscience Rule, some have claimed hyperbolically that the rule could extend to cashiers in a supermarket. As HHS made clear, however, the rule requires that protected “individuals ... have a reasonable connection to the procedure, health service or health service program, or research activity to which they object.” 73 Fed. Reg. at 78,090. Similarly, although some have claimed that the Coats Amendment does not reach hospitals generally, the statutory language and legislative history support HHS’s longstanding interpretation. *See* 73 Fed. Reg. at 78,091; 42 USCA § 238n(c)(2).

Comment: The Provider Conscience Rule is neither vague nor overbroad, and vagueness and over-breadth arguments would not preclude HHS’s enforcing the Provider Conscience Rule in administrative enforcement proceedings.

G. Regulations Do Not Conflict with Title X

Some opponents of conscience rights have cited the HHS’s regulations under Title X of the Public Health Service Act, which require recipients to counsel and refer for abortions, 45 C.F.R. §59.5(a)(5)(i)(C), (ii), (b)(1), (8), as conflicting with the Provider Conscience Rule. As HHS acknowledged, 73 Fed. Reg. at 78,087, 78,088, these Title X regulatory provisions violate statutory provisions of the Coats and Weldon Amendments. 42 U.S.C. §238n(a); Pub. L. No. 110-161, §508(d), 121 Stat. at 2209. As HHS further acknowledged, “requirements and prohibitions contained in a regulation cannot be enforced in derogation of conflicting statutes.”

73 Fed. Reg. at 78,088; *accord Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 828 (D.C. Cir. 2006) (“the government notes, and plaintiff doesn’t contest, that in the event of conflict the regulation must yield to a valid statute”). Thus, any confusion is created by the unlawful Title X requirements, not by the Provider Conscience Rule.

Comment: Although the Title X regulations concededly include unlawful requirements, the Provider Conscience Rule does not conflict with any *lawful* requirements of the Title X regulations.

H. Provider Conscience Rule Should Not Require Prior Registration of Conscientious Objections

Some states have claimed that the Provider Conscience Rule conflicts with state laws that require conscientious objectors to “register” their objections in writing. In promulgating the Provider Conscience Rule, HHS declined to adopt registration requirement, noting the “vast array of circumstances and settings” covered by the rule. 73 Fed. Reg. at 78,083. Certainly, in some of those circumstances and settings, the underlying statutes would preempt state-law requirements, as for example in medical education, which the Church and Coats Amendments would protect.

Although the Supreme Court found that the Hippocratic Oath did not evidence universal opposition to abortion, even in Hippocrates’ time, *Roe*, 410 U.S. at 715-16, the Court nonetheless recognized the Oath that “I will not give to a woman an abortive remedy” or that “I will not give to a woman a pessary to produce abortion” as a “long-accepted and revered statement of medical ethics.” *Id.* The various adverse health impacts from abortion cited in Section II.B, *supra*, as well as the religious and scientific issues cited in Section III.B, *supra*, provide ample reason for an individual to decline to participate in abortions. Medicine is a healing art, which many believe is inconsistent with abortion. Given the heavily politicized nature of the abortion debate, HHS should not require health-care professionals in any field to wear a badge that would single them out for religious, moral, philosophical, or ethical persecution.

Comment: HHS should not amend the Provider Conscience Rule expressly to allow or to require pre-registration of conscientious objections.

IV. NON-REGULATORY OUTREACH AND EDUCATION CANNOT ACCOMPLISH RULE’S OBJECTIVES

HHS’s fourth question asks whether non-regulatory means, such as outreach and education, might accomplish the current rule’s objectives. 74 Fed. Reg. at 10,210. Given the pervasiveness of prejudice and discrimination against pro-life views documented in the record and summarized in Section I, *supra*, AAPLOG and the groups joining these comments

respectfully submit that education and outreach are necessary, but not sufficient by themselves, to enforce the Church, Coats, and Weldon Amendments.

At the outset, the CMA Poll found that 87 percent of the statutory beneficiaries – *i.e.*, those health-care personnel on the ground, in hospitals and clinics across the country – felt that non-regulatory “outreach and education” alone would be insufficient to protect their rights of conscience. Because Congress intended to protect these health-care personnel, their belief that the statutes alone would not suffice confirms that rescission will have a chilling effect on their asserting their statutory rights. On the other hand, ABOG’s retreat in its 2009 bulletin from the position taken in its 2008 bulletin provides evidence that a credible threat of enforcement will protect beneficiaries like AAPLOG’s members.

Regulatory enforcement and non-regulatory education and outreach are not mutually exclusive. Indeed, HHS itself recognized the need for an education and outreach campaign *in conjunction* with the Provider Conscience Rule. 73 Fed. Reg. at 78,079. A regulatory enforcement regime provides numerous advantages for all stakeholders over the purely non-regulatory means suggested by HHS’s fourth question. First, for beneficiaries, a regulatory enforcement mechanism provides a low-cost way to enforce statutory rights within HHS’s existing civil-rights framework. For its part, HHS remains free to seek prospective compliance and the cessation of ongoing discrimination, rather than the termination of federal funding. Although recipients that violate federal law face loss of federal funding, equitable relief, and other consequences for their noncompliance, they face those consequences in a framework that values compliance over than punishment. Under the non-regulatory means suggested by HHS’s fourth question, recipients would face few if any consequences unless a beneficiary brought suit in state or federal court, which would be demonstrably less favorable to recipients than HHS’s regulatory enforcement.

Even if HHS rescinds the Provider Conscience Rule, the preamble to the notice of final rulemaking and HHS’s post-rescission education and outreach campaign should make clear that beneficiaries may file administrative complaints against recipients with HHS’s Office of Civil Rights. In filing those complaints, HHS should allow interested groups to file on behalf of their members and should keep a complainant’s identity from the recipient unless such disclosure is required by the nature of the complaint. *Cf.* 45 C.F.R. §80.7(b) (individual or class complaints filed in individual or representative capacity); *see also* §81.21 (HHS enforces complaints); §§81.22-.23 (complainants may participate as *amici curiae*). In addition, rescission of the regulations would heighten, not lessen, the need to address issues – such as the definition of abortion – in the preamble to the notice of final rulemaking or in post-rescission guidance under the outreach and education program envisioned by HHS’s fourth question.

Comment: HHS should encourage the Administration expeditiously to approve the Paperwork Reduction Act Information Collection Request for the Provider Conscience Rule’s


certification requirement, and HHS should undertake an extensive education and outreach campaign – without rescinding the Rule – to ensure a smooth transition that allows recipients to comply fully with their obligations under the Church, Coats, and Weldon Amendments.

CONCLUSION

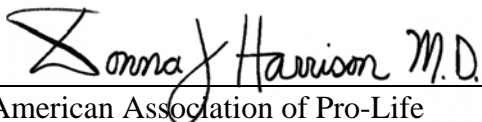
In summary, the Church, Coats, and Weldon Amendments provide important protections that sectors of the health care industry and pro-abortion groups seek to circumvent. The health care industry urgently needs HHS to begin to enforce the Provider Conscience Rule not only to assist and ensure compliance by regulated entities but also to protect the beneficiaries' fundamental rights of religious belief and moral conviction.

Please contact us with any questions about this matter.

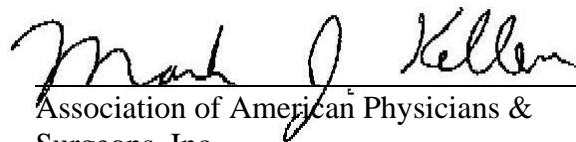
Yours sincerely,



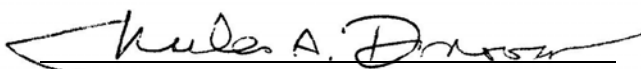
Lawrence J. Joseph



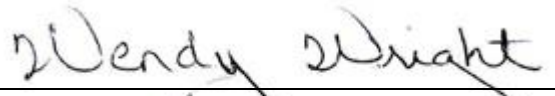
American Association of Pro-Life
Obstetricians and Gynecologists
Donna J. Harrison, M.D., President



Association of American Physicians &
Surgeons, Inc.
Mark J. Kellen, M.D., President



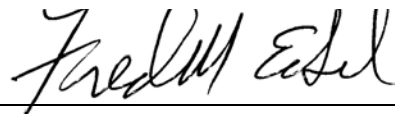
Family Research Council
Charles A. Donovan, Executive Vice President



Concerned Women for America
Wendy Wright, President



Safe Drugs for Women
Christopher M. Gacek, President



Christian Pharmacist Fellowship International
Fred M. Eckel, Executive Director

Enclosures

BULLETIN

for 2008

MAINTENANCE OF CERTIFICATION

Voluntary Recertification

Certificate Renewal



The American Board of
Obstetrics & Gynecology
The Vineyard Centre
2915 Vine Street
Dallas, TX 75204

First in Women's Health

**The American Board of
Obstetrics and Gynecology, Inc.**

This Bulletin, issued in November, 2007,
represents the official statement of the
requirements in effect for the 2008 examinations.

Rev. 11/2007

take this action will result in an Expired Certificate status for an individual holding a time-limited certificate which has expired. In order to reestablish certification, these individuals must contact the American Board of Obstetrics and Gynecology to ascertain what is required. All new certificates will be time-limited.

5. Revoked Certificate

- a. An individual has had their Diplomate status revoked by the American Board of Obstetrics and Gynecology for cause.
- b. Cause in this case may be due to, but is not limited to, licensure revocation by any State Board of Medical Examiners, violation of ABOG or ACOG rules and/or ethics principles or felony convictions.
- c. Such individuals will have the reason(s) for the restriction(s) made available for public review if requested and in requests for status letters.
- d. It is the responsibility of such individuals to inform the American Board of Obstetrics and Gynecology when, and if, ALL such restrictions have been removed by ALL sources.
- e. In order to reestablish certification, these individuals must contact the ABOG to ascertain what is required. All new certificates will be time-limited.

6. Restricted

- a. An individual with a restricted license (as defined in *Revocation of Diploma or Certificate*, page 28) may not participate in any ABOG examination or recertification/MOC process.
- b. Such individuals may be considered for revocation of Diplomate status (see number 5, above).
- c. Such individuals will have the reason(s) for the restriction(s) made available for public

Number 385 • November 2007

The Limits of Conscientious Refusal in Reproductive Medicine

Committee on Ethics

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency

contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.



**The American College
of Obstetricians
and Gynecologists**
*Women's Health Care
Physicians*

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. *Conscience* has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her *moral integrity*—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an

external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider-patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clear-

ly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a *prima facie* value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide

appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to “first, do no harm,” their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations “in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second” (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice.

Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory

manner. One conception of justice, sometimes referred to as the *distributive paradigm*, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, *per se*. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and

professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions “act affirmatively to protect patients from unexpected and disruptive denials of service” (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals’ refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals’ consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient’s well-being must be paramount. Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in con-

science provide the standard reproductive services that their patients request.

5. In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients’ rights to health care services.
7. Lawmakers should advance policies that balance protection of providers’ consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

References

1. Charo RA. The celestial fire of conscience—refusing to deliver medical care. *N Engl J Med* 2005;352:2471–3.
2. Denial of rape victim’s pills raises debate: moral, legal questions surround emergency contraception. New York (NY): Associated Press; 2004. Available at: <http://www.msnbc.msn.com/id/4359430>. Retrieved July 10, 2007.
3. L D. What happens when there is no plan B? Washington Post; June 4, 2006. p. B1. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2006/06/02/AR2006060201405.html>. Retrieved July 10, 2007.
4. Weil E. Breeder reaction: does everyone now have a right to bear children? *Mother Jones* 2006;31(4):33–7. Available at: http://www.motherjones.com/news/feature/2006/07/breeder_reaction.html. Retrieved July 10, 2007.
5. American Civil Liberties Union. Religious refusals and reproductive rights: ACLU Reproductive Freedom Project. New York (NY): ACLU; 2002. Available at: <http://www.aclu.org/FilesPDFs/ACF911.pdf>. Retrieved July 10, 2007.
6. Childress JF. Appeals to conscience. *Ethics* 1979;89:315–35.
7. Wicclair MR. Conscientious objection in medicine. *Bioethics* 2000;14:205–27.
8. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. New York (NY): Oxford University Press; 2001.
9. Benjamin M. Conscience. In: Reich WT, editor. *Encyclopedia of bioethics*. New York (NY): Simon & Schuster Macmillan; 1995. p. 469–73.
10. Ziv TA, Lo B. Denial of care to illegal immigrants. Proposition 187 in California. *N Engl J Med* 1995;332:1095–8.
11. American College of Obstetricians and Gynecologists. Code of professional ethics of the American College of Obste-

- tricians and Gynecologists. Washington, DC: ACOG; 2004. Available at: http://www.acog.org/from_home/acogcode.pdf. Retrieved July 10, 2007.
12. American Medical Association. Principles of medical ethics. In: Code of medical ethics of the American Medical Association: current opinions with annotations. 2006–2007 ed. Chicago (IL): AMA; 2006. p. xv.
 13. Dresser R. Professionals, conformity, and conscience. *Hastings Cent Rep* 2005;35:9–10.
 14. Blustein J. Doing what the patient orders: maintaining integrity in the doctor-patient relationship. *Bioethics* 1993;7:290–314.
 15. Brody H, Miller FG. The internal morality of medicine: explication and application to managed care. *J Med Philos* 1998;23:384–410.
 16. Dickens BM, Cook RJ. Conflict of interest: legal and ethical aspects. *Int J Gynaecol Obstet* 2006;92:192–7.
 17. Faden RR, Beauchamp TL. A history and theory of informed consent. New York (NY): Oxford University Press; 1986.
 18. Maternal decision making, ethics, and the law. ACOG Committee Opinion No. 321. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2005;106:1127–37.
 19. International Federation of Gynecology and Obstetrics. Ethical guidelines regarding interventions for fetal well being. In: Ethical issues in obstetrics and gynecology. London (UK): FIGO; 2006. p. 56–7. Available at: <http://www.figo.org/docs/Ethics%20Guidelines.pdf>. Retrieved July 10, 2007.
 20. Cantor J, Baum K. The limits of conscientious objection—may pharmacists refuse to fill prescriptions for emergency contraception? *N Engl J Med* 2004;351:2008–12.
 21. Davidoff F, Trussell J. Plan B and the politics of doubt. *JAMA* 2006;296:1775–8.
 22. Induced abortion and breast cancer risk. ACOG Committee Opinion No. 285. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2003;102:433–5.
 23. Grimes DA. Emergency contraception: politics trumps science at the U.S. Food and Drug Administration. *Obstet Gynecol* 2004;104:220–1.
 24. Young IM. Justice and the politics of difference. Princeton (NJ): Princeton University Press; 1990.
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BULLETIN

for 2009

MAINTENANCE OF CERTIFICATION

Voluntary

Time Limited

The American Board of
Obstetrics & Gynecology
The Vineyard Centre
2915 Vine Street
Dallas, TX 75204

First in Women's Health

The American Board of Obstetrics and Gynecology, Inc.

This Bulletin, issued in December 2008 represents the official statement of the requirements in effect for the 2009 examinations.

Rev. 12/2008

- a. A physician is registered with the Board when, upon application, the Board rules that they have fulfilled the requirements to enter or re-enter the Maintenance of Certification process.
- b. A physician has met the requirements for the special written examination and been approved.

5. Retired Diplomate

- a. This is an individual who has retired from clinical practice at a time when they were still an active Diplomate.
- b. Individuals in this category are retired Diplomates. If they return to active practice after their time-limited certificate has expired, they must contact the ABOG for specific requirements. This may require taking a proctored written examination. All new certificates will be time-limited.
- c. Individuals choosing to be a retired Diplomate must notify the Board in writing prior to their expiration date. Failure to take this action will result in no status with the Board upon the certification expiration date. In order to reestablish certification, these individuals must contact the American Board of Obstetrics and Gynecology to ascertain what is required. All new certificates will be time-limited.

6. Revoked Certificate

- a. An individual has had their Diplomate status revoked by the American Board of Obstetrics and Gynecology for cause.
- b. Cause in this case may be due to, but is not limited to, licensure revocation by any State Board of Medical Examiners, violation of ABOG rules and/or ethics principles or felony convictions.
- c. Such individuals will have the reason(s) for the restriction(s) made available for public review if requested and in requests for status letters.

- d. It is the responsibility of such individuals to inform the American Board of Obstetrics and Gynecology when, and if, ALL such restrictions have been removed by ALL sources.
- e. In order to reestablish certification, these individuals must contact the ABOG to ascertain what is required. All new certificates will be time-limited.

7. Restricted

- a. An individual with a restricted license (as defined in *Revocation of Diploma or Certificate*, page 11) may not participate in any ABOG examination or Maintenance of Certification process.
- b. Such individuals may be considered for revocation of Diplomate status (see number 6, above).
- c. Such individuals will have the reason(s) for the restriction(s) made available for public review if requested and in requests for status letters.
- d. It is the responsibility of such individuals to inform the American Board of Obstetrics and Gynecology when, and if, ALL such restrictions have been removed by ALL sources.

RIGHTS AND OBLIGATIONS OF APPLICANTS

Jurisdiction and Venue. The Corporation shall require, as a condition precedent for any person or entity to become or maintain status as a Member, Director, Officer, Employee, Agent, Applicant for Examination, a Diplomate certified by the Corporation, a Committee or Division Member, whether paid or volunteer (hereinafter, individually and collectively "Person or Entity"), that such person or entity agree as follows.

In any dispute of any kind with the Corporation or any Person or Entity such Person or Entity shall be subject to suit, if at all, only in the County and State where the Corporation maintains its principal place

Exhibit 4
Studies on or Relating to Public-Health Impacts of Abortions

SUICIDE

- D. M. Fergusson, J. Horwood & E. M. Ridder, *Abortion in young women and subsequent mental health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16-24 (2006)
- A. C. Gilchrist et al., *Termination of pregnancy and psychiatric morbidity*, 167 BRIT. J. PSYCHIATRY 243 (1995)
- M. Gissler et al., *Suicides after pregnancy in Finland, 1987-94: Register linkage study*. 313 BRIT. MED. J. 1431-34 (1996)
- M. Gissler et al., *Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000*, 15 EUROPEAN J. PUB. HEALTH, 459-63 (2005)
- D. C. Reardon et al., *Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study*, 95 SO. MED. J. 834-41 (2002)
- V. M. Rue, P. K. Coleman, J. J. Rue, & D. C. Reardon, *Induced abortion and traumatic stress: A preliminary comparison of American and Russian women*, 10 MEDICAL SCIENCE MONITOR SR 5-16 (2004)
- D. M. Fergusson, J. H. Horwood, & J. M. Boden, *Abortion and mental health disorders: Evidence from a 30-year longitudinal study*, 193 BRIT. J. PSYCHIATRY, 193, 444-451 (2008)

MOOD DISORDERS

- David M. Fergusson, L. John Horwood & Joseph M. Boden, *Abortion and mental health disorders: evidence from a 30-year longitudinal study* 193 BRIT. J. PSYCHIATRY 444-51 (2008)
- David H., Rasmussen N., Holst E. *Post-partum and Post-abortion Psychotic Reactions*, 13 FAMILY PLANNING PERSPECTIVES 88-91 (1981)
- David M. Ferguson, L. John Horwood & Elizabeth M. Ridder, *Abortion in young women and subsequent mental health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16-24 (2006)
- C. F. Bradley, *Abortion and subsequent pregnancy*, 29 CANADIAN J. PSYCHIATRY, 494 (1984)
- P. K. Coleman E. S. Nelson, *The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes*, 17 J. SOCIAL & CLINICAL PSYCHOLOGY, 17, 425-442 (1998)

- P. K. Coleman, D. C. Reardon, V. Rue, & J. Cogle, *State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years*, 72 AM. J. ORTHOPSYCHIATRY 141-52 (2002)
- G. Congleton & L. Calhoun, *Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations*, 39 INT'L J. SOCIAL PSYCHIATRY 255-65 (1993)
- J. Cogle, D. C. Reardon & P. K. Coleman, *Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort*, 9 MEDICAL SCIENCE MONITOR CR105-12 (2003)
- C. Cozzarelli, *Personality and self-efficacy as predictors of coping with abortion*, 65 J. PERSONALITY & SOCIAL PSYCHOLOGY 1224-36 (1993)
- F. O. Fayote, A. B. Adeyemi & B. Y. Oladimeji, *Emotional distress and its correlates*, 5 J. OBSTETRICS & GYNECOLOGY 504-09 (2004)
- D. M. Fergusson, J. Horwood & E. M. Ridder, *Abortion in young women and subsequent mental health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16-24 (2006)
- B. L. Harlow, L. S. Cohen, M. W. Otto, D. Spiegelman & D. W. Cramer, *Early life menstrual characteristics and pregnancy experiences among women with and without major depression: the Harvard Study of Mood and Cycles*, 79 J. AFFECTIVE DISORDERS 167-76 (2004)
- B. Major et al., *Psychological responses of women after first trimester abortion*, 57 ARCHIVES OF GENERAL PSYCHIATRY 777-84 (2000)
- B. Major, C. Cozzarelli, A. M. Sciacchitano, M. L. Cooper, M. Testa, & P. M. Mueller, *Perceived social support, self-efficacy, and adjustment to abortion*, 59 J. PERSONALITY & SOCIAL PSYCHOLOGY 186-97 (1990)
- W. B. Miller, D. J. Pasta & C. L. Dean, *Testing a model of the psychological consequences of abortion*, in L. J. Beckman and S. M. Harvey (eds), *The new civil war: The psychology, culture, and politics of abortion* (Washington, DC: American Psychological Association 1998)
- W. Pedersen, *Abortion and depression: A population-based longitudinal study of young women*, 36(4) SCANDINAVIAN JOURNAL OF PUBLIC HEALTH 424-28 (2008)
- L. M. Pope, N. E. Adler, & J. M. Tschann, *Post-abortion psychological adjustment: Are minors at increased risk?* 29 J. ADOLESCENT HEALTH 2-11 (2001)
- D. C. Reardon & J. Cogle, *Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A cohort Study*, 324 BRIT. MEDICAL J. 151-52 (2002)

- D. C. Reardon, J. Cougle, V. M. Rue, M. Shuping, P. K. Coleman & P. G. Ney, *Psychiatric admissions of low-income women following abortion and childbirth*, 168 CANADIAN MEDICAL ASS'N J. 1253-56 (2003)
- D. I. Rees & J. J. Sabia, *The relationship between abortion and depression: New evidence from the Fragile Families and Child Wellbeing Study*, 13(10) MEDICAL SCIENCE MONITOR 430-36 (2007)
- Sarah Schmiede & Nancy Felipe Russo, *Depression and unwanted first pregnancy: Longitudinal cohort study*, 331 BRIT. MEDICAL J. 1303-06 (2005)
- P. Slade, S. Heke, J. Fletcher & P. Stewart, *A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care*, 105 BRIT. J. OBSTETRICS & GYNECOLOGY 1288-95 (1998)
- H. Söderberg, L. Janzon, & N. O. Sjöberg, *Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden*, 79 EUROPEAN J. OBSTETRICS & GYNECOLOGY & REPRODUCTIVE BIOLOGY 173-78 (1998)
- R. Suri, L. Altshuler, V. Hendrick et al., *The impact of depression and fluoxetine treatment on obstetrical outcome*, 7 ARCHIVES OF WOMEN'S MENTAL HEALTH 193-200 (2004)
- D. R. Urquhart & A. A. Templeton, *Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion*, 98 BRIT. J. OBSTETRICS & GYNECOLOGY 396-99 (1991)
- K. Dingle, R. Alta, A. Clavarino et al., *Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study*, 193 BRIT. J. PSYCHIATRY 455-60 (2008)
- D. M. Fergusson, J. H. Horwood & J. M. Boden, *Abortion and mental health disorders: Evidence from a 30-year longitudinal study*, 193 BRIT. J. PSYCHIATRY 444-451 (2008)
- P. K. Coleman., C. T. Coyle, M. Shuping, & V. Rue, *Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey*, __ J. PSYCHIATRIC RESEARCH __ (in press/published online)

SUBSTANCE ABUSE

- Priscilla K. Coleman, David C. Reardon, Vincent M. Rue & Jesse Cougle, *Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey*, J. PSYCHIATRIC RES. (2008)
- H. Amaro, B. Zuckerman & H. Cabral, *Drug use among adolescent mothers: profile of risk*, 84 PEDIATRICS 144-51 (1989)

- P. K. Coleman, *Resolution of Unwanted Pregnancy during Adolescence through Abortion versus Childbirth: Individual and Family Predictors and Consequences*, J. YOUTH & ADOLESCENCE (2006)
- Coleman, P. K., Reardon, D. C., Rue, V., & J. Cogle, *History of induced abortion in relation to substance use during subsequent pregnancies carried to term*, 187 AM. J. OBSTETRICS & GYNECOLOGY 1673-78 (2002)
- P. K. Coleman, D. C. Reardon & J. Cogle, *Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy*, 10 BRIT. J. HEALTH PSYCHOLOGY 10, 255-268 (2005)
- D. C. Reardon, P. K. Coleman & J. Cogle, *Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study*, 26 AM. J. DRUG & ALCOHOL ABUSE, 369-83 (2004)
- D. M. Fergusson, J. Horwood, & E. M. Ridder, *Abortion in young women and subsequent mental health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16-24 (2006).
- T. L. Hope, E. I. Wilder & T. T. Watt, *The relationships among adolescent pregnancy, pregnancy resolution, and juvenile delinquency*, 44 SOCIOLOGICAL QUARTERLY 555-76 (2003)
- W. Pedersen, *Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study*, 102(12) ADDICTION 1971-78 (2007)
- D. C. Reardon & P. G. Ney, *Abortion and subsequent substance abuse*, 26 AM. J. DRUG & ALCOHOL ABUSE 61-75 (2002)
- D. Yamaguchi & D. Kandel, *Drug use and other determinants of premarital pregnancy and its outcome: A dynamic analysis of competing life events*, 49 J. MARRIAGE & FAMILY 257-70 (1987)
- K. Dingle, R. Alta A. Clavarino et al., *Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study*, 193 BRIT. J. PSYCHIATRY 455-60 (2008)
- D. M. Fergusson, J. H. Horwood & J. M. Boden, *Abortion and mental health disorders: Evidence from a 30-year longitudinal study*, 193 BRIT. J. PSYCHIATRY 444-51 (2008)
- P. K. Coleman, D. C. Maxey, M. Spence & C. Nixon, *The choice to abort among mothers living under ecologically deprived conditions: Predictors and consequences*, __ INT'L J. MENTAL HEALTH & ADDICTION __ (in press)

PREMATURE BIRTHS

- Jay D Iams, Roberto Romero, Jennifer F Culhane & Robert L Goldenberg, *Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth*, 371 THE LANCET 164-75 (Jan. 2008)

- Hanes M. Swingle, Tarah T. Colaizy, M. Bridget Zimmerman & Frank H. Morriss, Jr., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. REPRODUCTIVE MED. 95-108 (2009)
- Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention*, 519 (National Academy of Science Press, July 2006)
- E. Himpens, C. Van den Broeck, A. Oostra, P. Calders & P. Vanhaesebrouck, *Prevalence, type, and distribution and severity of cerebral palsy in relation to gestational age: a meta-analytic review*, 50 DEVELOPMENTAL MED. CHILD NEUROLOGY 334-40 (2008).
- B. Reime, B. A. Schuecking & P. Wenzlaff, *Reproductive Outcomes in Adolescents Who Had a Previous Birth or an Induced Abortion Compared to Adolescents' First Pregnancies*, 8 BMC PREGNANCY AND CHILDBIRTH 4 (2008)
- M. Voigt, D. Olbertz, C. Fusch, D. Krafczyk, V. Briese & K. T. Schneider, *The influence of previous pregnancy terminations, miscarriages, and still-birth on the incidence of babies with low birth weight and premature births as well as somatic classification of newborns*, 212 Z. GEBURTSHILFE NEONATOL. 5-12 (2008)
- G. C. S. Smith, I. Shah, I. R. White, J. P. Pell, J. A. Crossley & R. Dobbie, *Maternal and biochemical predictors of spontaneous preterm birth among nulliparous women: a systematic analysis in relation to degree of prematurity*, 35(5) INT'L J. EPIDEMIOLOGY 1169-77 (2006)
- P. Stang, A. O. Hammond & P. Bauman, *Induced Abortion Increases the Risk of Very Preterm Delivery; Results from a Large Perinatal Database*, FERTILITY STERILITY, S159 (Sept. 2005)
- C. Moreau, M. Kaminski, P. Y. Ancel, J. Bouyer, et al. *Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study*, 112(4) BRIT. J. OBSTETRICS GYNAECOLOGY 430-37 (2005)
- P. Y. Ancel, N. Lelong, E. Papiernik, M. J. Saurel-Cubizolles & M. Kaminski, *History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey*, 19(3) HUMAN REPRO. 734-40 (2004)
- P. Y. Ancel, M-J Saurel-Cubizolles, G. C. D. Renzo, E. Papiernik & G. Breart, *Very and moderate preterm births: are the risk factors different?* 106 BRIT. J. OBSTETRICS & GYNAECOLOGY 1162-70 (1999)
- Byron C. Calhoun & Brent Rooney, *Induced Abortion and Risk of Later Premature Birth*; 8:2 J. AM. PHYSICIANS & SURGEONS 46 (2003)
- W. Zhou, H. T. Sorenson & J. Olsen, *Induced Abortion and Subsequent Pregnancy Duration*, 94 OBSTETRICS & GYNECOLOGY 948-53 (1999)

- J. A. Martius, T. Steck, M. K. Oehler & K. H. Wulf, *Risk factors associated with preterm (<37+0 weeks) and early preterm (<32+0 weeks): univariate and multi-variate analysis of 106 345 singleton births from 1994 statewide perinatal survey of Bavaria*, 80 EUROPEAN J. OBSTETRICS & GYNECOLOGY REPRODUCTIVE BIOLOGY 183-89 (1998)
- J. Lumley, *The association between prior spontaneous abortion, prior induced abortion and preterm birth in first singleton births*, 3 PRENAT. NEONAT. MED. 21-24 (1998)
- J. Lumley, *The epidemiology of preterm birth*, 7(3) BAILLIERE'S CLIN OBSTET GYNECOLOGY. 477-98 (1993)
- C. Algert, C. Roberts, P. Adelson & M. Frammer, *Low birth weight in New South Wales, 1987: a Population-Based Study*, 33 AUST. NEW ZEALAND J. OBSTET. GYNAECOL. 243-48 (1993)
- J. Zhang & D. A. Savitz, *Preterm Birth Subtypes among Blacks and Whites*, 3 EPIDEMIOLOGY 428-33 (1992)
- E. Mueller-Heubach & D. S. Guzick, *Evaluation of risk scoring in a preterm birth prevention study of indigent patients*, 160 AM. J. OBSTETRICS & GYN. 829-37 (1989)
- J. Lumley, *Very low birth-weight (less than 1500g) and previous induced abortion: Victoria 1982-1983*, 26 AUST. NZ J. OBSTET. GYNECOL. 268-72 (1986)
- D. Schuler & A. Klinger, *Causes of low birth weight in Hungary*, 24 ACTA PAEDIATRICA HUNGARICA 173-85 (1984)
- A. Levin, S. Schoenbaum, R. Monson, P. Stubblefield & K. Ryan, *Association of Abortion With Subsequent Pregnancy Loss*, 243(24) JAMA 2495-99 (1980)
- J. W. Van Der Slikke & P. E. Treffers, *Influence of induced abortion on gestational duration in subsequent pregnancies*, 1 BMJ 270-72 (1978)

BREAST CANCER

- Holly L. Howe, Ruby T. Senie, Helen Bzduch & Peter Herzfeld, *Early Abortion and Breast Cancer Risk among Women under Age 40*, 18 INT. J. EPIDEMIOLOGY 300-04 (1989)
- Patrick S. Carroll, *The Breast Cancer Epidemic: Modeling and Forecasts Based on Abortion and Other Risk Factors*, 12:3 J. AM. PHYSICIANS & SURGEONS 72 (2007)
- Kim E. Innes & Tim E. Byers, *First Pregnancy Characteristics and Subsequent Breast Cancer Risk among Young Women*, 112 INT. J. CANCER 306-11 (2004)
- Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White & Noel S. Weiss, *Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion*, 86 J. NAT'L CANCER INST. 1584 (1994)

- M. Melbye, J. Wohlfahrt, A-M. N. Andersen, T. Westergaard & P. K. Andersen, *Preterm Delivery and risk of breast cancer*, 30(3/4) BRIT. J. CANCER 609-13 (1999)

PLACENTA PREVIA

- V. M. Taylor, M. D. Kramer, T. L. Vaughan & S. Peacock, *Placental previa in relation to induced and spontaneous abortion: a population-based study*, 82(1) OBSTET. GYNECOL. 88-91 (1993)
- J. M. Barrett, F. H. Boehm & A. P. Killam, *Induced abortion: a risk factor for placenta previa*, 141(7) AM. J. OBSTET. GYNECOL. 769-72 (1981)
- M. S. Hendricks, Y. H. Chow, B. Bhagavath & K. Singh, *Previous cesarean section and abortion as risk factors for developing placenta previa*, 25(2) J. OBSTET GYNAECOL RES. 137-42 (1999)
- A. S. Faiz & C. V. Ananth, *Etiology and risk factors for placenta previa: an overview and meta-analysis of observational studies*, 13(3) J. MATERN. FETAL NEONATAL. MED. 175-90 (2003)
- C. V. Ananth, J. C. Smulian & A. M. Vintzileos, *The association of placenta previa with history of cesarean delivery and abortion: a metaanalysis*, 177(5) AM J OBSTET GYNECOL. 1071-78 (1997)
- C. V. Ananth, D. A. Savitz & M. A. Williams, *Placental abruption and its association with hypertension and prolonged rupture of membranes: a methodologic review and meta-analysis*, 88(2) OBSTET. GYNECOL. 309-18 (1996)
- M. G. Zlatnik, Y. W. Cheng, M. E. Norton, M. P. Thiet & A. B. Caughey, *Placenta previa and the risk of preterm delivery*, 20(10) J. MATERN. FETAL NEONATAL MED. 719-23 (2007)
- John M. Thorp, Jr., Katherine E. Hartmann & Elizabeth Shadigian, *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OB GYN SURVEY 67-79 (2002)

MIFEPRISTONE

- J. T. Jensen, S. J. Astley, E. Morgan & M. D. Nichols, *Outcomes of suction curettage and mifepristone abortion in the United States: a prospective comparison study*, 59 CONTRACEPTION 153-59 (1999)
- B. Winikoff, I. Sivin, K. J. Coyaji, et al., *Safety, efficacy, and acceptability of medical abortion in China, Cuba, and India: a comparative trial of mifepristone and misoprostol versus surgical abortion*, 176 AM J OBSTET. GYNECOL. 431-37 (1997)
- E. Cabezas, *Medical versus surgical abortion*, 63 INT'L J. GYNAECOL. & OBSTET. Supp. 1, S141-6 (1998)

- B. Elul, C. Ellertson, B. Winikoff & K. Coyaji, *Side effects of mifepristone-misoprostol abortion versus surgical abortion: Data from a trial in China, Cuba, and India*, 59(2) CONTRACEPTION 107-14 (1999)
- The FDA and RU-486: lowering the standard for women's health. Staff report prepared for the Hon. Mark Souder, Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, October 2006.
- Medical Officer's Review of Amendments 024 and 033, Final Reports for the U.S. Clinical Trials Inducing Abortion up to 63 Days Gestational Age and Complete Responses Regarding Distribution System and Phase 4 Commitments, Finalized November 22, 1999 (dated January 27, 2000)
- Y. F. Chan, P. C. Ho, H. K. Ma, *Blood loss in termination of early pregnancy by vacuum aspiration and by combination of mifepristone and gemeprost*, 47 CONTRACEPTION 85-95 (1993)
- M. M. Gary & D. J. Harrison, *Analysis of severe adverse events related to the use of mifepristone as an abortifacient*, 40(2) ANNALS OF PHARMACOTHERAPY 191-97 (2006)
- M. F. Greene, *Fatal infections associated with mifepristone-induced abortion*, 353(22) N. ENGL. J. MED. 2317-18 (2005)
- M. Fischer, *Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion*, 353 N. ENGL. J. MED. 2352-60 (2005)
- R. P. Miech, *Disruption of the innate immune system by mifepristone and lethal toxin of Clostridium sordellii*, J. ORGAN DYSFUNCTION, 1-5 (2007)
- B. Couzin, N. Le Strat, A. Ulmann, E. E. Baulieu & G. Schaison, *Termination of early pregnancy by the progesterone antagonist RU 486 (mifepristone)*, 315 N. ENGL. J. MED. 1565-70 (1986)

CONCEIVING “PREGNANCY:”

U.S. MEDICAL DICTIONARIES AND THEIR DEFINITIONS OF “CONCEPTION” AND “PREGNANCY”

Christopher M. Gacek

“When I use a word,” Humpty Dumpty said, in rather a scornful tone,
“it means just what I choose it to mean – neither more nor less.”

“The question is,” said Alice, “whether you *can* make words mean so
many different things.”

“The question is,” said Humpty Dumpty, “which is to be master –
that’s all.”

~ *Through the Looking Glass*
by Lewis Carroll

Given the hyper-politicized nature of the times we live in, it is not surprising that determining when human life begins has become the focus of an intense political struggle. It is a struggle of great importance because many people believe that human life begins at fertilization and that pregnancy follows from that developmental starting point. Many who hold this position work in the medical professions, and they object to using technologies that would destroy such nascent life and abort pregnancies. In effect, these individuals are conscientious objectors to the use of certain birth control technologies.

The validity of their objections rests on the plausibility of the objectors’ claims about the beginning of human life, conception, and pregnancy. Given our current state of scientific and medical knowledge, can such claims be held with credibility? That is, can one credibly claim that pregnancy begins at conception which is traditionally defined as occurring at fertilization? It is the purpose of this paper to provide some clarity on this subject by surveying the American medical profession’s reference dictionaries to ascertain the range of opinion that exists regarding these questions. The paper will demonstrate that these conscientious objectors’ scientific analysis is not only reasonable but that it reflects the predominant worldview presented by the dictionaries and the historical usage they represent.



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Exhibit 05

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I. Background

Since the 1960s battle lines have been drawn over the definitions of “conception” and “pregnancy.” In English, analysis of the medical dictionaries over the course of a century reveals that conception is identified as the point at which pregnancy begins. Consequently, whether conception occurs at “fertilization” – when the male and female gametes fuse in the Fallopian Tubes creating a zygote – or about a week later upon uterine “implantation” has enormous moral and policy implications.

Acceptance of an implantation-based definition of “conception” (and “pregnancy”) would allow for the use of medical technologies that might destroy a living, developing embryo in the seven days that follow fertilization but precede implantation. Some believe that birth-control pills may have this effect. The FDA-approved package insert (label) for the morning-after-pill or emergency contraceptive, Plan B® (Levonorgestrel), states:

Plan B® is believed to act as an emergency contraceptive principally by preventing ovulation or fertilization (by altering tubal transport of sperm and/or ova). In addition, *it may inhibit implantation (by altering the endometrium)*. It is not effective once the process of implantation has begun.¹

Intra-uterine devices (“IUDs”), in general, are believed to have multiple means of action including the blocking of implantation.²

Since the 1960s, organizations like the Guttmacher Institute, the research arm of Planned Parenthood,³ and the pro-abortion American College of Obstetricians and Gynecologists (ACOG) have pushed hard to gain acceptance of the implantation-based definition of “conception” in the scientific, public health, and political communities.⁴ In 1965 ACOG stated in its first *Terminology Bulletin* that “CONCEPTION is the implantation of a fertilized ovum.”⁵ Forty years later, Rachel Benson Gold flatly asserts in a 2005 article for the *Guttmacher Report on Public Policy*, that, with respect to the definition of pregnancy “.... the medical community has long been clear: Pregnancy is established when a fertilized egg has been implanted in the wall of a woman’s uterus.”⁶ Given the political leaning of governmental agencies, academic institutions, and the scientific publishing industry it would not be surprising if Ms. Gold were correct.

However, important redoubts of scientific integrity remain, and Gold’s claim is actually not correct. As the research below will demonstrate, *there is certainly no medical-scientific consensus in favor of implantation-based definitions of “conception” or “pregnancy.”* This is an important fact because individual pharmacists, physicians, and health-providing organizations have become concerned that their prescribing or

dispensing certain drugs or devices might abort a pre-implantation pregnancy – by preventing uterine implantation of the developing embryo. Furthermore, this research indicates that the medical dictionaries provide considerable support for the proposition that a fertilization-based approach to defining “conception” and “pregnancy” finds substantial support in the medical-scientific community. In fact, the fertilization-based perspective is predominant in the medical dictionaries.

II. Medical Dictionaries as Purveyors of Scientific-Medical Consensus

After becoming aware of the debate over how best to define “conception” and “pregnancy,” I thought about ways to determine whether a scientific-medical consensus existed for these terms. Having access to the Library of Congress and other important federal government health libraries, I decided to simply track down as many *medical* dictionaries as possible, record their definitions, and analyze them.⁷ With the assistance of dedicated research assistants, we were able to accumulate a nearly complete inventory of American medical dictionary definitions of these terms.

The Four Major Medical Dictionaries

Medical dictionaries provide important information to practitioners of the healing arts so they can conduct their medical work. Additionally, these same dictionaries provide us with a snapshot of the common wisdom of the medical-scientific community at particular points in time. By tracking definitions over an extended period of time one is able to see how scientific research and analysis have or have not changed the conceptual building blocks of medical discourse.

One reassuring feature of the medical dictionaries is that they are not overtly political as are Guttmacher and ACOG publications.⁸ In the opening pages of the dictionaries one finds the names and credentials of the editors and contributing authors. None of the medical dictionaries are associated with *any* pro-life organization or professional body. Rather, the editorial panels appear to contain a cross-section of opinion across the medical fields. The editors are distinguished members of the medical-scientific community.

Four major medical dictionaries are used in the United States: *Dorland's*, *Stedman's*, *Taber's*, and *Mosby's*. *Dorland's* and *Stedman's* were begun in the early years of the 20th Century – both prior to World War I. *Taber's* hails from the Depression-World War II era, and *Mosby's*, the most recently created, was first published in the early 1980s. The remainder of this paper presents the findings of in-depth research designed to examine any patterns in the definitions of “conception” and

“pregnancy” relevant to the current policy debates and assertions of rights of conscience.

III. Definitions of “Conception” and “Pregnancy”

This medical dictionary survey demonstrates that there is *no* consensus supporting *either* the position that conception begins at implantation *or* that pregnancy begins at implantation. The survey results are summarized below in this section, but the raw data is contained in the two appendices to this paper. Appendix A presents the four dictionaries’ definitions of “conception” in tabular form, and Appendix B does the same for “pregnancy.”

A.

Dorland’s on Conception. *Dorland’s Illustrated Medical Dictionary* is the oldest of the major American medical dictionaries. The first edition was published in 1900. From 1900 to 1974 (25th ed.), *Dorland’s* defined “conception” as “[t]he fecundation of the ovum.” In the 25th edition, fecundation was defined as “impregnation or fertilization.” “Fecundate” is a verb defined as “to impregnate or fertilize.”

In the 26th (1981), the 27th (1988), and the 28th (1994) editions, *Dorland’s* altered its definition of “conception.” The new definition contained two parts – one based on implantation and another that was fertilization-based. The definition described “conception” as the “onset of pregnancy, marked by implantation of the blastocyst in the endometrium; the formation of a visible zygote.” There was a tension in this definition. The first part of the definition clearly described the implantation in the lining of the uterus (endometrium). On the other hand, the definition’s reference to the “formation of a visible zygote” probably referred to the syngamy or fusion of the two (male and female) gametes to produce a zygote. Whatever was meant precisely, this second part of the definition of “conception” was not based on implantation but on earlier events.

In the 29th edition (2000), there was shift to a wholly fertilization-based definition where “conception” was defined as “the onset of pregnancy, marked by fertilization of an oocyte by a sperm or spermatozoon; formation of a visible zygote.” This *Dorland’s* edition stepped away from any reliance on an implantation-based definition of “conception.”

The definition used in *Dorland’s* 30th (2003) and 31st editions (2007) notes oddly that “conception” is “an imprecise term denoting the formation of a viable zygote.” (The 2007 edition is the current or latest edition of *Dorland’s*.) The switch from “visible” to “viable” may signal a slight shift in focus by the editors. A “visible zygote”

probably reflected consideration of the single zygotic cell and the fact that such a cell could contain two pro-nuclei before syngamy and then a clearly delineated, single nucleus after syngamy. The move to the use of “viable zygote” may point to a single-cell zygote that has the capability to progress along the developmental pathway to form a fetus. In either case, these definitions are not implantation-focused given the early point at which the zygote is the key player in the developmental story – that is, before implantation.

Dorland's on Pregnancy. Since 1900 *Dorland's* has used only two definitions of “pregnancy” that are relevant for our purposes. From the 1st edition (1900) until the 21st (1947), “pregnancy” was defined as “[t]he condition of being with child; gestation.” The definition contains no reference to either fertilization or implantation. In the 22nd edition (1951), *Dorland's* modified the definition as follows: “The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon [continuing without further reference to fertilization or implantation].” Such union places the beginning of pregnancy not at the point of uterine implantation but after fertilization. This definition has been used by *Dorland's* through its current version in 2007 (31st ed.).

Dorland's: Analysis. *Dorland's* has provided a fertilization-based definition of “conception” in every edition. This was true even in the 26th through 28th editions which always offered a fertilization-based definition of “conception” in addition to an implantation-based definition. After the publication of the 29th edition (2000), *Dorland's* definition of “conception” reverted to a fertilization focus and did not reference implantation again. Additionally, *Dorland's* definition of “pregnancy” has been explicitly fertilization-centric since 1951 without exception. Thus, it is accurate to say that *Dorland's* has never presented a purely implantation-based definition of either “conception” or “pregnancy.” *Dorland's* definitions are heavily weighted to a fertilization-based viewpoint.

B.

Stedman's on Conception. *Stedman's Medical Dictionary* is the second oldest of the medical dictionaries surveyed in this study. *Stedman's* defined “conception” from its 5th edition (1918) to its 19th (1957) as “[t]he act of conceiving, or becoming pregnant.” These editions contained no explicit reference to fertilization or implantation as the point of conception. However, the 20th edition (1961) and 21st (1966) added the fertilization-focused phrase “[t]he fecundation of the ovum.” Fecundate is defined as “[t]o impregnate, to fertilize.”

In the 1970s, *Stedman's* moved to an implantation-based definition. The 22nd edition (1972) defines “conception” as follows: “Successful implantation of the blastocyst in

the uterine lining.” The next edition (23rd ed.), published in 1976, states: “Implantation of the blastocyst; see implantation.”⁹

Since 1982, *Stedman’s* has used fertilization-based definitions with one exception in 2000 (27th ed.). The 24th edition (1982) and 25th edition (1990) define “conception” as: “The act of conceiving, or becoming pregnant; the fertilization of the oocyte (ovum) by a spermatozoon.” In 1995, the 26th edition alters the final wording of the second phrase to read “...by a spermatozoon to form a viable zygote.”¹⁰

In 2000 with its 27th edition, *Stedman’s* once again used an implantation-based definition of “conception” which reads: “Act of conceiving; the implantation of the blastocyte in the endometrium.” *Stedman’s* has published only one edition since then, and in 2006 (28th ed.) *Stedman’s* reverted to a fertilization-based definition, defining “conception” as “[f]ertilization of oocyte by a sperm.”

Stedman’s on Pregnancy.

Stedman’s has defined “pregnancy” with remarkable consistency since its 2nd edition in 1912 – the earliest *Stedman’s* we could obtain. The definition contained a list of synonyms for “pregnancy” accompanying two descriptive sentences or clauses. The 1912 definition read: “Gestation, fetation; gravidity; the state of a female after conception until the birth of the child.” This was followed by a sentence describing human pregnancy’s duration as “[t]he duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.” The definition remained unchanged through the 19th edition (1957). In 1961 (20th ed.), “or 280 days” was added, and this phrase was retained in 1966.

From 1912 to 2008 the following terms were included, at one time or another, in the *Stedman’s* definitions as synonyms for “pregnancy:” gestation, fetation, graviditas, gravidity, cyesis, and cyophoria.¹¹ An online medical dictionary (<http://www.drugs.com/dict/>), using *Stedman’s* definitions, indicates that these terms are all synonyms for “pregnancy” with one term, cyophoria, found in a source other than *Stedman’s* due to its very rare usage.¹²

In 1972 (22nd ed.) the definition read: “Gestation, fetation; gravidity; the state of a female after conception until the birth of the child.”[†] Additionally, the second sentence describing a pregnancy’s duration was dropped going forward. In 1976 (23rd ed.), 1982 (24th ed.), and 1990 (25th ed.) the list of “pregnancy” synonyms was

[†] See Appendix B to track the described changes more easily. Also, after 1972, “baby” replaced “child.”

lengthened in 1976 as follows: “Gestation; fetation, cyesis, cyophoria; graviditas; gravidity.” In 1982 and 1990 “cyophoria” was deleted from the list.

In the last three editions (1995, 26th ed.; 2000, 27th ed.; 2006, 28th ed.) the list of synonymous terms was moved to follow the main sentence. For example, the 26th ed. (1995) reads: “The condition of a female after conception until the birth of the baby. SYN fetation, gestation, gravidism, graviditas.”

In 2000 and 2006 the following disturbingly cold definition of “pregnancy” is presented: “The state of a female after conception and until the termination of the gestation.” While it is true that many pregnancies end with spontaneous or induced abortions, the endpoint of pregnancy is normally thought to be birth. Additionally, “The gestation” replaces “the baby” – another unsettling innovation.

Stedman's: Analysis.

Since 1961, *Stedman's* definitional approach to “conception” and “pregnancy” has been fertilization-based six times and implantation-based three times. Furthermore, four of the last five editions have presented a fertilization-based combination of the two definitions.

TABLE
Stedman's: Implantation or Fertilization-based?
(analyzing “conception” & “pregnancy” together)

Year	Edition	Basis
1961	20 th	Fertilization-based
1966	21 st	Fertilization-based
1972	22 nd	Implantation-based
1976	23 rd	Implantation-based
1982	24 th	Fertilization-based
1990	25 th	Fertilization-based
1995	26 th	Fertilization-based
2000	27 th	Implantation-based
2006	28 th	Fertilization-based

At the very least, one cannot rely on *Stedman's* to support the proposition that implantation-based definitions of “conception” and “pregnancy” represent the consensus view of the medical field.

C.

Taber's on Conception. *Taber's* first edition was published in 1940. From 1940 (1st ed.) until 1997 (18th ed.), the dictionary used a fertilization-based definition of "conception." There have been two formulations. The first definition was used from 1940 to 1955 (6th ed.) and states: "The union of the male sperm and the ovum of the female." The definition was altered slightly in the next edition by adding "fertilization" at the end: "The union of the male sperm and the ovum of the female; fertilization." This definition was used until 1997 (18th ed.).

In 2001, *Taber's* switched to an implantation-based definition of "conception" that was consistent with the dictionary's implantation-based definition of "pregnancy." So, the 19th (2001) and 20th (2005) editions define "conception" as: "The onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall." *Taber's* has not published another edition of its dictionary since 2005.

Taber's on Pregnancy. From 1940 (1st ed.) to 1970 (11th ed.) *Taber's* defined "conception" as: "The condition of being with child." This definition did not reveal whether there was a fertilization or implantation basis for the term. However, from 1973 (12th ed.) to 1997 (18th ed.), *Taber's* used this implantation-based definition of "pregnancy:" "The condition of carrying a developing embryo in the uterus."

This definition was amended in the last two editions – 2001 (19th) and 2005 (20th) – to read: "The condition of having a developing embryo or fetus in the body after successful conception." This might seem to allow for a fertilization-based "pregnancy" definition, but in the 2001 and 2005 editions *Taber's*, as noted above, defined "conception" in terms of uterine implantation.

Taber's: Analysis. *Taber's* definition of "conception" was clearly fertilization-based until 1997, but its definition of "pregnancy" has been implantation-based since 1973. In 2001 and 2005 *Taber's* definitions of "conception" and "pregnancy" were made consistent with each other when the implantation-based approach was imported into the definition of "conception." Before 2001, the dictionary was not consistent in the way it defined "conception" and "pregnancy."

D.

Mosby's on Conception. *Mosby's* released several dictionaries in the early 1980s. To date, every *Mosby's* dictionary has presented the same two-part, fertilization-based definition of "conception." "Conception" is defined as: 1) "the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote;" and, 2) "the act or process of fertilization."

Mosby's on Pregnancy. Mosby's medical dictionaries all carry the following definition of "pregnancy:" "The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth."

Mosby's: Analysis. If *Taber's* is the most consistently implantation-based of the dictionaries, *Mosby's* is its opposite counterpart. As noted above, *Mosby's* has not wavered from a fertilization-based analysis of conception or pregnancy. Furthermore, *Mosby's* has never hinted at acceptance of an implantation-based definition for "conception" and "pregnancy."

IV. Loose Ends: Ectopic "Pregnancy" and Embryology

Two additional "loose ends" underscore the argument that implantation-based definitions of "conception" and "pregnancy" are terminologically unusual and problematic. Both considerations shed light on why it may have been impossible for a politically correct medical community, if it had wished to do so, to adopt uniform, implantation-based definitions for both terms.

First, if one uses the adjective "ectopic," what noun immediately comes to mind? "Pregnancy," of course. The National Institutes of Health's MedlinePlus defines an "ectopic pregnancy" as follows:

An ectopic pregnancy occurs when the baby starts to develop outside the womb (uterus). The most common site for an ectopic pregnancy is within one of the tubes through which the egg passes from the ovary to the uterus (fallopian tube). However, in rare cases, ectopic pregnancies can occur in the ovary, stomach area, or cervix.¹³

Similarly, *Taber's* 20th edition (2005) defines an "ectopic pregnancy" as the: "Extra-uterine implantation of a fertilized ovum, usually in the fallopian tubes, but occasionally in the peritoneum, ovary, or other locations." Clearly, the condition described as an "ectopic pregnancy" poses significant problems for the implantation-based terminological approach because the term describes a *pregnancy* that develops *outside the uterus*.[†]

The definitional difficulty is clear. In the current *Taber's* (20th; 2005) "pregnancy" is defined as "[t]he condition of having a developing embryo or fetus in the body, after

[†] Similarly, *Taber's* lists "Ampullar pregnancy" and "abdominal pregnancy" as terms used to more specifically describe certain types of non-uterine ectopic pregnancies. Of course, only fertilization-based definitions of conception and pregnancy are consistent with the use of "pregnancy" for conditions of this kind.

successful conception.” This wording might have avoided collision with “ectopic pregnancy,” but *Taber’s* implantation-based approach requires that “conception” be defined as “the onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall.” Given the unanimity in defining “ectopic pregnancy,” there clearly are *pregnancies* (*i.e.*, ectopic, non-uterine) that do not fall within the scope of any implantation-based definitional framework.

Embryology

Embryologists do not appear to share the ACOG-Planned Parenthood view of human development. Rather, embryology regards fertilization as the beginning of a multi-stage developmental process that does not begin with uterine implantation. For example, a foremost embryology text makes this observation:

Human development begins at fertilization when a male gamete or sperm unites with a female gamete or oocyte to form a single cell, a zygote. This highly specialized, totipotent cell marked the beginning of each of us as a unique individual.¹⁴ (Additional statements support this point.¹⁵)

The 23 Carnegie Stages of human embryological development are well known and run from Day 1 to Day 60 of pregnancy.¹⁶ Implantation occurs on Days 6-12.¹⁷ Of course, uterine implantation is critical to embryological development, but implantation does not mark the beginning of the developmental process.

The inability of medical dictionaries to migrate to an implantation-based, conception-pregnancy definitional pair may rest, at least to some extent, on the problem posed by the embryologists’ recognition that human development begins at fertilization. That is, even if “pregnancy” can be defined with an implantation basis, some term has to recognize that the beginning of the developmental process occurs at fertilization. Thus, we see some confusion, for example, in *Taber’s* having conflicting definitions of “conception” (fertilization-based) and “pregnancy” (implantation-based) from 1973 to 1997 with the last two editions being unable to account for extra-uterine pregnancies.

V. Conclusion

My review of the four American medical dictionary definitions of “conception” and “pregnancy” leads to the conclusion that there is no medical-scientific consensus supporting an implantation-based definition for those terms. A fair reading of the medical dictionaries reveals a broader acceptance of fertilization-based definitions. Of the four, only *Taber’s* leans strongly toward implantation, and its definitions of

“pregnancy” and “conception” were mixed until its last two editions in 2001 and 2005.

As noted at the outset some medical, nursing, and pharmaceutical professionals object to participating in or cooperating with the use of technologies they deem to interfere with an ongoing pregnancy. The technologies that most arouse concern impede or block embryo implantation in the uterine lining. One response to this argument has been to do what ACOG and Planned Parenthood suggest – alter the definition of “pregnancy” to make the problem go away. If conception and then pregnancy begin with embryonic implantation, then interference with or blockage of implantation does not interrupt or terminate a pregnancy.

The conscientious objectors see this as disingenuous – a trick. But what does the medical profession think about how to define the onset of pregnancy? Decades of exposure to the ACOG / Planned Parenthood arguments have *not* led to a consensus supporting the proposition that conception and pregnancy begin with uterine implantation. Fertilization remains the benchmark and the majority position.

Therefore, the conscientious objectors have used the terms “conception” and “pregnancy” in a manner that is consistent with their current usage in contemporary medical and scientific practice. Consequently, the reasonable basis of their scientific perspective should be recognized by our nation’s commercial, political, judicial, and health care authorities. Furthermore, state governments should not be misled into using the minority view, an implantation-based definition of “pregnancy” or “conception” in their statutes and regulations.

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NOTES

- ¹ Package Insert (label), Plan B® (Levonorgestrel), “Clinical Pharmacology” section, p. 1.
- ² For example, the “Clinical Pharmacology” section of the package insert for the ParaGard® T 380A Intrauterine Copper Contraceptive states: “The contraceptive effectiveness of ParaGard® is enhanced by copper continuously released into the uterine cavity. Possible mechanism(s) by which copper enhances contraceptive efficacy include interference with sperm transport or fertilization, and prevention of implantation.”
- ³ Planned Parenthood is the largest abortion provider in the United States.
- ⁴ Robert G. Marshall and Charles A. Donovan, *Blessed Are the Barren: The Social Policy of Planned Parenthood* (San Francisco: Ignatius Press, 1991): ch. 12 (pp. 291-302) (the source containing the best discussion of the effort to change these definitions to eliminate objections to hormonal birth-control technologies as possibly being abortifacients).
- ⁵ Marshall and Donovan, *Blessed Are the Barren*, p. 293.
- ⁶ Rachel Benson Gold, “The Implications of Defining When a Woman Is Pregnant,” *Guttmacher Report on Public Policy* 8 (May 2005): 7.
- ⁷ This research strategy would probably not be available for those living elsewhere – with the possible exception of New York City.
- ⁸ In 1971 ACOG changed its official policy regarding abortion, endorsing abortion upon patient request as acceptable medical practice.
- ⁹ This edition defines implantation as: “The attachment of the fertilized ovum (blastocyst) to the endometrium, and its subsequent embedding in the compact layer, occurring six or seven days after fertilization of the ovum.”
- ¹⁰ Note that *Dorland’s* later use of “viable zygote” may reflect this shift in *Stedman’s* phrasing.
- ¹¹ “Gestation” and “fetation” appeared in every definition of “pregnancy” from 1912 to 2008. Either one or two of these three – gravidity, graviditas, or gravidism – has also been included in the definition.
- ¹² “Cyphoria” is a difficult term to find in any reference source. Using the Yahoo search engine I was able to find a webpage (<http://www.wordinfo.info/words/index/info/view_unit/606/?letter=C&page=31>) that defined it as “[a]n awareness of pregnancy.”
- ¹³ LINK: < <http://www.nlm.nih.gov/MEDLINEPLUS/ency/article/000895.htm> >.
- ¹⁴ Keith L. Moore and T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology* (8th ed., 2008): p. 15. There are additional, helpful definitions from embryology. An earlier edition of Moore and Persaud contains this definition of “zygote”:

Zygote. This cell results from the union of an oocyte and a sperm during fertilization. A zygote is the beginning of a new human being (*i.e.*, an embryo).

Keith L. Moore and T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology* (7th ed., 2007): p. 2.

¹⁵ From *Longman's Medical Embryology* we find this comment on fertilization:

The development of a human begins with fertilization, a process by which the *spermatozoon* from the male and the oocyte from the female unite to give rise to a new organism, the *zygote*."

T.W. Sadler, *Langman's Medical Embryology* (7th ed., 1995): p. 3. Finally, another embryology volume contains this observation about fertilization and human development:

Almost all higher animals start their lives from a single cell, the fertilized ovum (zygote)... The time of fertilization represents the starting point in the life history, or ontogeny, of the individual."

Bruce M. Carlson, *Patten's Foundations of Embryology* (6th ed., 1996): p. 3.

¹⁶ LINK: < http://en.wikipedia.org/wiki/Carnegie_stages >.

¹⁷ LINK: < <http://www.embryology.ch/anglais/iperiodembry/carnegie01.html> >.

Appendix A: "Conception" Defined

A-1

Title	Ed.	Year	Term Defined	Definition
American Illustrated Medical Dictionary (Dorland)	1st	1900	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	2nd	1901	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	3rd	1903	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	6th	1911	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	7th	1913	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	9th	1917	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	10th	1919	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	12th	1923	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	14th	1927	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	15th	1929	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	18th	1938	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	19th	1941	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	20th	1944	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	21st	1947	conception	1. The fecundation of the ovum
American Illustrated Medical Dictionary (Dorland)	22nd	1951	conception	1. The fecundation of the ovum
Dorland's Illustrated Medical Dictionary	23rd	1957	conception	1. The fecundation of the ovum
Dorland's Illustrated Medical Dictionary	24th	1965	conception	1. The fecundation of the ovum
Dorland's Illustrated Medical Dictionary	25th	1974	conception	1. The fecundation of the ovum
Dorland's Illustrated Medical Dictionary	26th	1981	conception	1. onset of pregnancy, marked by implantation of the blastocyst in the endometrium; the formation of a visible zygote.
Dorland's Illustrated Medical Dictionary	27th	1988	conception	1. onset of pregnancy, marked by implantation of the blastocyst in the endometrium; the formation of a visible zygote.
Dorland's Illustrated Medical Dictionary	28th	1994	conception	1. onset of pregnancy, marked by implantation of the blastocyst in the endometrium; the formation of a visible zygote.
Dorland's Illustrated Medical Dictionary	29th	2000	conception	1. the onset of pregnancy, marked by fertilization of an oocyte by a sperm or spermatozoon; formation of a visible zygote.
Dorland's Illustrated Medical Dictionary	30th	2003	conception	1. an imprecise term denoting the formation of a viable zygote.
Dorland's Illustrated Medical Dictionary	31st	2007	conception	1. an imprecise term denoting the formation of a viable zygote.
Mosby's Medical and Nursing Dictionary	1st	1983	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
Mosby's Medical, Nursing, and Allied Health Dictionary	2nd	1987	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
Mosby's Medical, Nursing, and Allied Health Dictionary	3rd	1990	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
Mosby's Medical, Nursing, and Allied Health Dictionary	4th	1994	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization

Appendix A: "Conception" Defined

A-2

Title	Ed.	Year	Term Defined	Definition
Mosby's Medical, Nursing, and Allied Health Dictionary	5th	1998	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
Mosby's Medical Dictionary	6th	2002	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
Mosby's Medical Dictionary	7th	2006	conception	1. the beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote 2. the act or process of fertilization
A Practical Medical Dictionary (Stedman's)	2nd	1912	conception	3. Becoming pregnant.
A Practical Medical Dictionary (Stedman's)	5th	1918	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	6th	1920	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	7th	1921	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	8th	1924	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	9th	1926	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	11th	1932	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	12th	1933	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	13th	1936	conception	3. The act of conceiving, or becoming pregnant.
A Practical Medical Dictionary (Stedman's)	14th	1939	conception	3. The act of conceiving, or becoming pregnant.
Stedman's Practical Medical Dictionary	15th	1942	conception	3. The act of conceiving, or becoming pregnant.
Stedman's Practical Medical Dictionary	16th	1946	conception	3. The act of conceiving, or becoming pregnant.
Stedman's Medical Dictionary	18th	1953	conception	3. The act of conceiving, or becoming pregnant.
Stedman's Medical Dictionary	19th	1957	conception	3. The act of conceiving, or becoming pregnant.
Stedman's Medical Dictionary	20th	1961	conception	3. The act of conceiving, or becoming pregnant; the fecundation of the ovum.
Stedman's Medical Dictionary	21st	1966	conception	3. The act of conceiving, or becoming pregnant; the fecundation of the ovum.
Stedman's Medical Dictionary	22nd	1972	conception	3. Successful implantation of the blastocyst in the uterine lining.
Stedman's Medical Dictionary	23rd	1976	conception	3. Implantation of the blastocyst; see implantation.
Stedman's Medical Dictionary	24th	1982	conception	3. The act of conceiving, or becoming pregnant; the fertilization of the oocyte (ovum) by a spermatozoon.
Stedman's Medical Dictionary	25th	1990	conception	3. Act of conceiving, or becoming pregnant; fertilization of the oocyte (ovum) by a spermatozoon.
Stedman's Medical Dictionary	26th	1995	conception	3. Act of conceiving, or becoming pregnant; fertilization of the oocyte (ovum) by a spermatozoon to form a viable zygote.
Stedman's Medical Dictionary	27th	2000	conception	3. Act of conceiving; the implantation of the blastocyte in the endometrium.
Stedman's Medical Dictionary	28th	2006	conception	3. Fertilization of oocyte by a sperm.
Taber's Cyclopedic Medical Dictionary	1st	1940	conception	The union of the male sperm and the ovum of the female.
Taber's Cyclopedic Medical Dictionary	3rd	1945	conception	The union of the male sperm and the ovum of the female.
Taber's Cyclopedic Medical Dictionary	4th	1946	conception	The union of the male sperm and the ovum of the female.
Taber's Cyclopedic Medical Dictionary	5th	1950	conception	The union of the male sperm and the ovum of the female.
Taber's Cyclopedic Medical Dictionary	6th	1955	conception	The union of the male sperm and the ovum of the female.
Taber's Cyclopedic Medical Dictionary	7th	1957	conception	The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	8th	1959	conception	The union of the male sperm and the ovum of the female; fertilization.

Appendix A: "Conception" Defined

A-3

Title	Ed.	Year	Term Defined	Definition
Taber's Cyclopedic Medical Dictionary	9th	1962	conception	The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	10th	1965	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	11th	1970	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	12th	1973	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	13th	1977	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	14th	1981	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	15th	1985	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	16th	1989	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	17th	1993	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	18th	1997	conception	2. The union of the male sperm and the ovum of the female; fertilization.
Taber's Cyclopedic Medical Dictionary	19th	2001	conception	2. The onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall.
Taber's Cyclopedic Medical Dictionary	20th	2005	conception	2. the onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall.

Appendix B: "Pregnancy" Defined

B-1

Title	Ed.	Year	Term Defined	Definition
American Illustrated Medical Dictionary (Dorland)	1st	1900	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	2nd	1901	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	3rd	1903	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	6th	1911	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	7th	1913	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	9th	1917	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	10th	1919	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	12th	1923	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	14th	1927	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland)	15th	1929	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland's)	18th	1938	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland's)	19th	1941	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland's)	20th	1944	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland's)	21st	1947	pregnancy	The condition of being with child; gestation. [continues w/out reference to fertilization or implantation]
American Illustrated Medical Dictionary (Dorland's)	22nd	1951	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	23rd	1957	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	24th	1965	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	25th	1974	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	26th	1981	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	27th	1988	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	28th	1994	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	29th	2000	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	30th	2003	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Dorland's Illustrated Medical Dictionary	31st	2007	pregnancy	The condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon. [continues]
Mosby's Medical and Nursing Dictionary	1st	1983	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
Mosby's Medical Dictionary	2nd	1987	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
Mosby's Medical, Nursing, and Allied Health Dictionary	3rd	1990	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
Mosby's Medical, Nursing, and Allied Health Dictionary	4th	1994	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]

Appendix B: "Pregnancy" Defined

B-2

Title	Ed.	Year	Term Defined	Definition
Mosby's Medical, Nursing, and Allied Health Dictionary	5th	1998	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
Mosby's Medical Dictionary	6th	2002	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
Mosby's Medical Dictionary	7th	2006	pregnancy	The gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. [continues]
A Practical Medical Dictionary (Stedman's)	2nd	1912	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	5th	1918	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	6th	1920	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	7th	1921	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	8th	1924	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	9th	1926	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	11th	1932	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	12th	1933	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	13th	1936	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	14th	1939	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	15th	1942	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	16th	1946	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
A Practical Medical Dictionary (Stedman's)	18th	1953	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
Stedman's Medical Dictionary	19th	1957	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months.
Stedman's Medical Dictionary	20th	1961	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months, or 280 days.
Stedman's Medical Dictionary	21st	1966	pregnancy	Gestation, fetation; gravidity; the state of a female after conception until the birth of the child. The duration of pregnancy in woman is about forty weeks, ten lunar months, or nine calendar months, or 280 days.
Stedman's Medical Dictionary	22nd	1972	pregnancy	Gestation; fetation; gravidity; the state of a female after conception until the birth of the child.
Stedman's Medical Dictionary	23rd	1976	pregnancy	Gestation; fetation; cyesis; cyophoria; graviditas; gravidity; the state of a female after conception until the birth of the baby.

Appendix B: "Pregnancy" Defined

B-3

Title	Ed.	Year	Term Defined	Definition
Stedman's Medical Dictionary	24th	1982	pregnancy	Gestation; fetation; cyesis, graviditas; gravidism; the state of a female after conception until the birth of the baby.
Stedman's Medical Dictionary	25th	1990	pregnancy	Gestation; fetation; cyesis, graviditas; gravidism; the state of a female after conception until the birth of the baby.
Stedman's Medical Dictionary	26th	1995	pregnancy	The condition of a female after conception until the birth of the baby. SYN fetation, gestation, gravidism, graviditas.
Stedman's Medical Dictionary	27th	2000	pregnancy	The state of a female after conception and until the termination of the gestation. SYN fetation, gestation, gravidism, graviditas.
Stedman's Medical Dictionary	28th	2006	pregnancy	The state of a female after conception and until the termination of the gestation. SYN fetation, gestation, gravidism, graviditas.
Taber's Cyclopedic Medical Dictionary	1st	1940	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	3rd	1945	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	4th	1946	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	5th	1950	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	6th	1955	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	7th	1957	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	8th	1959	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	9th	1962	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	10th	1965	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	11th	1970	pregnancy	The condition of being with child.
Taber's Cyclopedic Medical Dictionary	12th	1973	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	13th	1977	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	14th	1981	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	15th	1985	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	16th	1989	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	17th	1993	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	18th	1997	pregnancy	The condition of carrying a developing embryo in the uterus.
Taber's Cyclopedic Medical Dictionary	19th	2001	pregnancy	The condition of having a developing embryo or fetus in the body after successful conception.
Taber's Cyclopedic Medical Dictionary	20th	2005	pregnancy	The condition of having a developing embryo or fetus in the body, after successful conception.



ON THIRTY YEARS OF ROE v. WADE

June 2003

WHEREAS, Scripture reveals that all human life is created in the image of God, and therefore sacred to our Creator (Genesis 1:27; Genesis 9:6); and

WHEREAS, The Bible affirms that the unborn baby is a person bearing the image of God from the moment of conception (Psalm 139:13–16; Luke 1:44); and

WHEREAS, Scripture further commands the people of God to plead for protection for the innocent and justice for the fatherless (Psalm 72:12–14; Psalm 82:3; James 1:27); and

WHEREAS, January 2003 marked thirty years since the 1973 United States Supreme Court Roe v. Wade decision, which legalized abortion in all fifty states; and

WHEREAS, Resolutions passed by the Southern Baptist Convention in 1971 and 1974 accepted unbiblical premises of the abortion rights movement, forfeiting the opportunity to advocate the protection of defenseless women and children; and

WHEREAS, During the early years of the post-Roe era, some of those then in leadership positions within the denomination endorsed and furthered the “pro-choice” abortion rights agenda outlined in Roe v. Wade; and

WHEREAS, Some political leaders have referenced 1970s-era Southern Baptist Convention resolutions and statements by former Southern Baptist Convention leaders to oppose legislative efforts to protect women and children from abortion; and

WHEREAS, Southern Baptist churches have effected a renewal of biblical orthodoxy and confessional integrity in our denomination, beginning with the Southern Baptist Convention presidential election of 1979; and

WHEREAS, The Southern Baptist Convention has maintained a robust commitment to the sanctity of all human life, including that of the unborn, beginning with a landmark pro-life resolution in 1982; and

WHEREAS, Our confessional statement, The Baptist Faith and Message, affirms that children “from the moment of conception, are a blessing and heritage from the Lord”; and further affirms that Southern Baptists are mandated by Scripture to “speak on behalf of the unborn and contend for the sanctity of all human life from conception to natural death”; and

WHEREAS, The legacy of Roe v. Wade has grown to include ongoing assaults on human life such as euthanasia, the harvesting of human embryos for the purposes of medical experimentation, and an accelerating move toward human cloning; now, therefore, be it

RESOLVED, That the messengers to the Southern Baptist Convention meeting in Phoenix, Arizona, June 17–18, 2003, reiterate our conviction that the 1973 Roe v. Wade decision was based on a fundamentally flawed understanding of the United States Constitution, human embryology, and the basic principles of human

rights; and be it further

RESOLVED, That we reaffirm our belief that the Roe v. Wade decision was an act of injustice against innocent unborn children as well as against vulnerable women in crisis pregnancy situations, both of which have been victimized by a "sexual revolution" that empowers predatory and irresponsible men and by a lucrative abortion industry that has fought against even the most minimal restrictions on abortion; and be it further

RESOLVED, That we offer our prayers, our love, and our advocacy for women and men who have been abused by abortion and the emotional, spiritual, and physical aftermath of this horrific practice; affirming that the gospel of Jesus Christ grants complete forgiveness for any sin, including that of abortion; and be it further

RESOLVED, That we lament and renounce statements and actions by previous Conventions and previous denominational leadership that offered support to the abortion culture; and be it further

RESOLVED, That we humbly confess that the initial blindness of many in our Convention to the enormity of Roe v. Wade should serve as a warning to contemporary Southern Baptists of the subtlety of the spirit of the age in obscuring a biblical worldview; and be it further

RESOLVED, That we urge our Southern Baptist churches to remain vigilant in the protection of human life by preaching the whole counsel of God on matters of human sexuality and the sanctity of life, by encouraging and empowering Southern Baptists to adopt unwanted children, by providing spiritual, emotional, and financial support for women in crisis pregnancies, and by calling on our government officials to take action to protect the lives of women and children; and be it further

RESOLVED, That we express our appreciation to both houses of Congress for their passage of the Partial-Birth Abortion Ban Act of 2003, and we applaud President Bush for his commitment to sign this bill into law; and be it further

RESOLVED, That we urge Congress to act swiftly to deliver this bill to President Bush for his signature; and be it finally

RESOLVED, That we pray and work for the repeal of the Roe v. Wade decision and for the day when the act of abortion will be not only illegal, but also unthinkable.

Phoenix

<http://www.sbc.net/resolutions/amResolution.asp?ID=1130>

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RESOLUTION ON HUMAN EMBRYONIC AND STEM CELL RESEARCH

June 1999

WHEREAS, Developments in human stem cell research have brought into fresh focus the dignity and status of the human embryo; and

WHEREAS, The National Bioethics Advisory Commission has called for the removal of the ban on public funding of human embryo research; and

WHEREAS, The Bible teaches that human beings are made in the image and likeness of God (Gen. 1:27; 9:6) and protectable human life begins at fertilization; and

WHEREAS, Efforts to rescind the ban on public funding of human embryo research rely on a crass utilitarian ethic which would sacrifice the lives of the few for the benefits of the many; and

WHEREAS, Current law against federal funding of research in which human embryos are harmed and/or destroyed reflects well-established national and international legal and ethical norms against misusing any human being for research purposes; and

WHEREAS, The existing law forbidding public funding of human embryo research is built upon universally held principles governing experiments on human subjects, including principles contained in the Nuremberg Code, the World Medical Association's Declaration of Helsinki, the United Nations Declaration of Human Rights, and other statements; and

WHEREAS, The use of human embryos in research would likely lead to an increase in the number of abortions and create a market for aborted embryos and other fetal tissues; and

WHEREAS, Some forms of human stem cell research require the destruction of human embryos in order to obtain the cells for such research and Southern Baptists are on record for their decades-long opposition to abortion except to save the physical life of the mother and their opposition to destructive human embryo research; and

WHEREAS, Exciting advances in human stem cell research are on the horizon which do not require the destruction of embryos, leading the British Medical Journal to state that the use of human embryonic stem cells "may soon be eclipsed by the more readily available and less controversial adult stem cells;" and

WHEREAS, Treatments for Alzheimer's, diabetes, Parkinson's disease, and a host of maladies may soon be within our reach without sacrificing human embryos.

Be it RESOLVED, that we, the messengers to the Southern Baptist Convention, meeting in Atlanta, Georgia, June 15-16, 1999, reaffirm our vigorous opposition to the destruction of innocent human life, including the destruction of human embryos; and

Be it further RESOLVED, that we call upon the United States Congress to maintain the existing ban on the use of tax dollars to support research which requires the destruction of human embryos; and

Be it further RESOLVED, that we call upon those private research centers which perform such experiments to cease and desist from research which destroys human embryos, the most vulnerable members of the human community; and

Be it finally RESOLVED, that we encourage support for the development of alternative treatments which do not require human embryos to be killed.

Atlanta, Georgia

<http://www.sbc.net/resolutions/amResolution.asp?ID=620>

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BLESSED ARE THE BARREN

The Social Policy of Planned Parenthood

By
Robert G. Marshall
and
Charles A. Donovan

IGNATIUS PRESS SAN FRANCISCO

Chapter Twelve

Old Lies and New Labels: When Contraception Is Abortion

Nowhere has the manipulation of the truth by population-control and abortion proponents been more evident than in the area of medical terminology dealing with antifertility drugs, devices, and social policies.

This policy of semantic gymnastics, successfully carried out over a period of decades, included efforts to redefine nearly every term in the lexicon of human reproduction: pregnancy, conception, abortion, and human being or person. These subterfuges were necessary because the prevalent social attitudes were against abortion, but the developing antifertility technology depended heavily upon it. The Pill and IUD, it was discovered, achieved their antifertility effects by methods besides preventing fertilization.

The definitional changes effected by Planned Parenthood and other notables were radical departures from prior, established medical knowledge. The "traditional" and previously noncontroversial understanding of some of these terms was clearly stated in 1952 by Planned Parenthood's own Dr. Abraham Stone, who had noted in a discussion of contraceptive research that

the mechanical and chemical methods currently employed, or any biologic method that would prevent ovulation or fertilization merely prevent life from beginning. . . . Measures designed to prevent implantation fall into a different category. Here there is a question of destroying a life already begun.¹

In the face of lingering antiabortion attitudes, a terminological shift was critically needed to obfuscate the difference between antiovulatory, antifertilization, and anti-implantation fertility control methods. This question was also related in a number of ways to the physiological problem of safely inhibiting fertility. This was evident in an internal memo from Searle and Company, an early leader in birth control research. This memo from the 1950s suggested that chemicals that interrupted the menstrual cycle and that would produce a "false" pregnancy would be rejected for human use.

¹ Abraham Stone, M.D., "Research in Contraception: A Review and Preview", presented at the Third International Conference of Planned Parenthood, Bombay, India, *Report of the Proceedings*, November 24-29, 1952, no copyright, Family Planning Association of India, 101.

I believe the only acceptable compound would be one which does not interfere with the cycle or ovulation but which might prevent either fertilization or possibly implantation [attachment to the uterine wall].²

But those most interested in redefinitions of reproductive terminology during this period were proponents of global population control. At a 1959 Planned Parenthood–Population Council joint symposium, Bent Boving, a Swedish fertility researcher, eloquently identified the importance of using *le mot juste* to mollify public concern about abortifacients: “Whether”, he said, “eventual control of implantation can be reserved the social advantage of being considered to prevent conception rather than to destroy an established pregnancy could depend on something so simple as a prudent habit of speech.”³ Boving himself was not consistently able to manage the “prudent habit of speech” he urged. Earlier in the same discourse, Boving had said that: “Thus, the greatest pregnancy wastage, in fact by far the highest death rate of the entire human life span, is during the week before and including the beginning of implantation, and the next greatest is in the week immediately following.”⁴

A “prudent habit of speech” was nevertheless needed because it was estimated, accurately as it turned out, by these early researchers that the physiological opportunities for developing antifertility drugs were limited, and the likelihood of achieving new ones that were safer, more effective, and totally nonabortive was slim indeed. The initial restructuring of medical terms was engineered to comport with the physiological reality of early abortion and to take advantage of religious/social opposition to abortion, but accommodation of “contraception”. In 1962 Dr. Mary Calderone, the medical director of PPFA at that time, said that “if it turns out that these intrauterine devices operate as abortifacients, not only the Catholic Church will be against them, but Protestant churches as well.”⁵

There were also legal implications in this matter, as can be seen from a 1963 U.S. Department of Health, Education, and Welfare survey that noted:

All the measures which impair the viability of the zygote at any time between the instant of fertilization and the completion of labor constitute,

² Memo to Dr. Drill from Dr. Saunders, re: “Effects of Drugs on Mating in Rats”, December 9, 1954, Gregory Pincus Papers, Manuscript Division, Library of Congress.

³ Bent G. Boving, “Implantation Mechanisms”, in *Mechanisms Concerned with Conception*, ed. C. G. Hartman (New York: Pergamon Press, 1963), 386.

⁴ *Ibid.*, 321.

⁵ Dr. Mary Calderone, discussion, “Mechanisms of Contraceptive Action”, in *Intra-uterine Contraceptive Devices: Proceedings of the Conference*, held April 30–May 1, 1962, New York City, ed. Christopher Tietze and Sarah Lewit, published by Excerpta Medica Foundation, 110.

in the strict sense, procedures for inducing abortion. Administration of such compounds whose mechanism of action is of this character to man as either an investigative procedure or as a practical birth control technique poses technical legal questions that have not yet been resolved.⁶

Eventually an answer to the question of how to effect a "prudent habit of speech" was suggested in 1964 at an International Population Council-sponsored symposium during a discussion between two physicians. Dr. Samuel Wishik stated: "In a Moslem country such as Pakistan, if it's considered that the intra-uterine device is an abortifacient, this obviously would have a bearing on national acceptance or rejection."⁷ Dr. Tietze, affiliated with both Planned Parenthood and the Population Council, suggested not to "disturb those people for whom this is a question of major importance".⁸ Dr. Tietze also indicated that theologians and jurists have always taken into account the prevailing medical and biological consensus of their times, and that "if a medical consensus develops and is maintained that pregnancy, and therefore life, begins at implantation, eventually our brethren from the other faculties will listen."⁹

Planned Parenthood's efforts at hidden persuasion were accepted by the American College of Obstetrics and Gynecology with the publication of its first *Terminology Bulletin* in 1965, which stated "CONCEPTION is the implantation of a fertilized ovum".¹⁰

Was there some shattering and revolutionary development in molecular biology during this period that necessitated ACOG's sudden shift in labeling? Dr. J. Richard Sosnowski, head of the Southern Association of Obstetricians and Gynecologists, a member group of ACOG, gave a clear answer in his 1984 presidential address:

I do not deem it excellent to play semantic gymnastics in a profession. . . . It is equally troublesome to me that, with no scientific evidence to validate the change, the definition of conception as the successful spermatoc penetration of an ovum was redefined as the implantation of a fertilized ovum. It appears to me that the only reason for this was the dilemma produced by the possibility that the intrauterine contraceptive device might function as an

⁶ *A Survey of Research on Reproduction Related to Birth and Population Control* (as of January 1, 1963), U.S. Department of Health, Education and Welfare, Public Health Service, publ. no. 1066, Washington, D.C.: U.S. Government Printing Office, 1963, 27.

⁷ Discussion, *Proceedings of the Second International Conference, Intra-Uterine Contraception*, held October 2-3, 1964, New York City, ed. Sheldon Segal et. al., International Congress Series, Excerpta Medica Foundation, no. 86, 212.

⁸ *Ibid.*, 212.

⁹ *Ibid.*, 213.

¹⁰ ACOG *Terminology Bulletin*, Terms Used in Reference to the Fetus, Chicago: American College of Obstetricians and Gynecologists, no. 1, September 1965.

abortifacient. Now that the intrauterine contraceptive device has lost popularity will we change the definition again?¹¹

As Sosnowski's speech suggests, the ACOG and Planned Parenthood finesses are rejected elsewhere within the medical profession. The *American Journal of Obstetrics and Gynecology*, which is the official publication of nearly forty obstetrical and gynecological societies throughout the United States, publishes articles that use the traditional definition of pregnancy as beginning at fertilization. In a study of the preimplantation human embryo published in 1989, the following is reported:

Early pregnancy factor and other factor(s) produced by the preimplantation embryo may play a role in suppressing maternal cellular immune response, thereby preventing maternal rejection of the embryo.

However, other than the early pregnancy factor (EPF), present in the sera of pregnant women shortly after fertilization (24 hours), there is no other factor produced in significant amounts at time of implantation. Therefore this factor plays a possible role in the prevention of maternal rejection of the oligocellular embryo.¹²

And when different species of mammals are studied, such as rats, and no political agenda is at stake, fertilization and not implantation is readily recognized as the beginning of pregnancy: "Normally, fertilized rat eggs take about 3 days to pass through the oviduct, and on the 4th day of pregnancy they enter the uterus. . . . Day 5, attachment of the blastocyst to the uterine epithelium starts, and this we consider the beginning of implantation."¹³

No One Knows When Human Life Begins

The second facet of Planned Parenthood's redefinition involved the claim that no one really knows when human life begins. Yet, writing in 1933 when he had not yet accepted the doctrine of abortion on demand, Dr. Alan Guttmacher was perplexed that anyone, much less an educated medical doctor, would not know this.

We of today know that man is born of sexual union; that he starts life as an embryo within the body of the female; and that the embryo is formed from

¹¹ Dr. J. Richard Sosnowski, "The Pursuit of Excellence: Have We Apprehended and Comprehended It?", *American Journal of Obstetrics and Gynecology*, vol. 150, no. 2 (September 15, 1984): 117.

¹² Ratna Bose, Ph.D., et al., "Purified Human Early Pregnancy Factor from Preimplantation Embryo Possesses Immunosuppressive Properties", *American Journal of Obstetrics and Gynecology*, vol. 160, no. 4 (April 1989): 955.

¹³ Z. Dickmann and V. J. De Feo, "The Rat Blastocyst during Normal Pregnancy and during Delayed Implantation, Including an Observation of the Shedding of the Zona Pellucida", *Journal of Reproduction and Fertility*, official journal of the Society for the Study of Fertility, the Biological Science Committee of the IPPF, vol. 13 (1967): 3-9.

the fusion of two single cells, the ovum and the sperm. This all seems so simple and evident to us that it is difficult to picture a time when it was not part of the common knowledge.¹⁴

Guttmacher added that at least since 1875 two medical researchers “showed that the essential act of fertilization is not the union of the two cells, ovum and sperm, but the fusion of the two nuclei into one, the offspring beginning its career as a combination of the nuclei of its two parents”.¹⁵

However, after his conversion to the “pro-choice” view and assumption of the Planned Parenthood helm, Guttmacher’s past knowledge seemed to vanish. At a 1968 symposium he said:

Dr. Marchetti and I are rarely together. . . . He believes that an abortion is murder, and under these conditions he does not feel that it can ever be justified.

My feeling is that the fetus, particularly during its early intra-uterine existence, is simply a group of specialized cells that do not differ materially from other cells. I do not think they are made in God’s image. I think they are made in man’s image. . . . If one can justify shooting a burglar who enters your home . . . one can certainly justify the elimination of some cells, which from my point of view, have simply not yet become a human being, but simply have the potentialities of life. Philosophically we are too far apart to try to compromise; it is impossible.¹⁶

And he would add in his 1973 book that: “Scientifically all we know is that a living human sperm unites with a living human egg; if they were not living there could be no union. . . . Does human life begin before or with the union of the gametes, or with birth, or at a time intermediate? I, for one, confess I do not know.”¹⁷

This view had its origins more in attitudes than knowledge. Guttmacher had noted that “many women who are opposed to abortion on request say that they do not regard the taking of a drug that will ‘bring on their period’ as an abortion.

“I believe the opposition of many doctors to abortion would be greatly diminished if there were a safe drug available.”¹⁸

The “ignorance is bliss” posture has received widespread endorsement

¹⁴ Alan F. Guttmacher, *Life in the Making: The Story of Human Procreation* (New York: Viking Press, 1933), 3.

¹⁵ *Ibid.*, 48–49.

¹⁶ Willard Heckel, moderator, “Law, Morality and Abortion Symposium”, held at Rutgers University Law School, March 27, 1968, *Rutgers Law Review*, vol 22 (Spring 1968): 436.

¹⁷ Alan F. Guttmacher, M.D., *Pregnancy, Birth, and Family Planning: A Guide for Expectant Parents in the 1970’s* (New York: Viking Press, 1973), 23

¹⁸ Jane Ross, “Abortion and the Unwanted Child: An Interview with Alan F. Guttmacher, M.D. and Harriet Pilpel”, *Family Planning Perspectives*, vol. 2, no. 2 (March 1970): 16–24.

throughout the medical community. The American College of Obstetricians and Gynecologists in their 1990 abortion "white paper" reported that 167 scientists and physicians told the U.S. Supreme Court in 1989 that "[t]here is no scientific consensus that a human life begins at conception, at a given stage of fetal development, or at birth. . . . When life begins cannot be tested by scientific method, but instead depends on each individual's beliefs and values."¹⁹

In essence, this claim of medical agnosticism is really an attack on the integrity of the biological sciences to which medicine is incontestably subordinate for its basic information regarding human physiology, development, and the healing process. In contrast to this formidable assertion of basic ignorance stands the published research of Erich Bleschschmidt who has stated that

the evidence no longer allows a discussion as to if and when and in what month of ontogenesis a human being is formed. To be a human being is decided for an organism at the moment of fertilization of the ovum. For this reason we have to regard the intrinsic quality of the fertilized ovum as an essential prerequisite, decisive for all future ontogenesis.²⁰

And Professor Landrum Shettles, who has engaged in human in vitro fertilization projects, wrote a letter to the *New York Times* shortly after *Roe v. Wade* about the Supreme Court's indecision concerning the beginning of human life: "To deny a truth should not be made the basis for legalizing abortion."²¹

Over a century ago the *Journal of the American Medical Association* suggested that "this fallacious idea that there is no life until quickening takes place has been the foundation of, and formed the basis of, and has been the excuse to ease or appease the guilty conscience which has led to the destruction of thousands of human lives."²² Every addition to medical knowledge that has occurred since the definitive discovery of fertilization in the first half of the nineteenth century has added to the weight of information in behalf of the humanity of the child in utero. Recent advances in ultrasound imaging should have taken away any vestiges of doubt on this part even among the uneducated (albeit public opinion polls uniformly indicate that it is the educated who have the most difficulty incorporating this knowledge). Abortion providers instinctively know this. Dr. Sally Faith Dorfman of Einstein Medical College has noted that during an abortion

¹⁹ *Public Health Policy Implications of Abortion: A Government Relations Handbook*, Kathryn G. Moore, ed., American College of Obstetricians and Gynecologists, 1990, 38.

²⁰ Erich Bleschschmidt, *The Beginning of Human Life* (New York, Heidelberg, and Berlin: Springer-Verlag, 1977), 17.

²¹ Dr. Landrum Shettles, Letter to the Editor, *New York Times*, February 14, 1973.

²² Isaac M. Quimby, "Introduction to Medical Jurisprudence", *Journal of the American Medical Association*, vol. 9 (August 6, 1887): 164; see also N. C. Markham, "Foeticide and Its Prevention", *Journal of the American Medical Association*, vol. 11 (December 8, 1888): 805.

a compassionate and sensitive sonographer should remember to turn the screen away from the plane of view. Staff too may find themselves increasingly disturbed by the repeated visual impact of an aspect of their work that they need to partially deny in order to continue to function optimally and to concentrate on the needs of the women who come to them for help.²³

Enacting Antiabortion Laws Will Deny "Contraceptives" to Women

Claims that prolife laws will outlaw "contraceptives" are not new. Previously, such discussions could be found only in arcane law journals, but they are becoming more prominent as the "threat" to abortion on demand increases.

For example, consider the amicus brief filed by the Planned Parenthood Federation of America and the Association of Planned Parenthood Physicians (APPP) in the 1973 *Roe* and *Doe* abortion cases. In that brief, PPFA and APPP lawyers noted that the states with antiabortion laws had not "made any effort to outlaw the use of the intrauterine device (IUD) which in fact may function to prevent implantation after fertilization has occurred".²⁴ The brief cited a 1964 law review article that pointed to the then-extant anti-abortion laws that

apply to acts done with an intent to terminate pregnancy at any time, from the moment of conception. . . . The broad language of statutes and cases would suggest that to use pre-implantation means on a pregnant woman would be unlawful . . . under statutes where [proving] pregnancy is an element of the offence . . . manufacturers, distributors or sellers of the pre-implantation means might be prosecuted under 1/4 statutes prohibiting the manufacture, distribution or sale of abortifacients.²⁵

Another law review article makes the point that where state laws such as that of Wisconsin criminalize abortion and refer to the "unborn child" as a human being from the time of conception,

there would certainly be no question that under this enactment the vitalized embryo is legally protected before implantation and thus the use of any pills or intra-uterine devices to keep the fertilized ovum from implanting on the wall of the uterus is a violation of the statute.

²³ Transcript excerpts from a talk entitled, "Abortion Update" (talk no. 1065), given by Dr. Sally Faith Dorfman, director of Family Planning, Development, and Research at Albert Einstein Medical College in New York, at the American Public Health Conference, November 18, 1985, in Washington, D.C. Recorded by Robert G. Marshall, director of research, Castello Institute.

²⁴ Planned Parenthood Federation of America and the Association of Planned Parenthood Physicians in the 1973 *Roe* and *Doe* abortion cases, 44.

²⁵ *Ibid.*, citing Sybil Meloy, "Pre-Implantation Fertility Control and the Abortion Law", *Chicago-Kent Law Review*, vol. 41 (1964): 183, 205-6.

Since the function of the pre-implantation means of fertility control is to interrupt pregnancy, their use would no doubt violate abortion statutes which do not require proof of pregnancy as an element of the offence. . . .

But with the problems of overpopulation facing us, as it is today, allowing society to legally expand methods of birth control to the instant of implantation does not seem unreasonable.²⁶

In contrast to the *Roe* and *Doe* cases where “contraceptive” abortions were buried deep in legal briefs, the 1989 *Webster v. Reproductive Health Services* Supreme Court case brought the issue of abortion masquerading as “contraception” further out of the closet.

Frank Sussman, the lawyer who argued the pro-abortion side in the *Webster* case, told the Supreme Court that the Missouri antiabortion law would outlaw physician prescription of “contraceptives” such as the IUD and “progesterone only” Pill—the so-called mini-Pill—in public clinics.

Missouri attorney general William Webster flatly told the Court that Missouri’s law was not enacted to restrict women’s contraceptive options.

And Jack Willke, M.D., president of the National Right to Life Committee said that lawyers for his group “believe the Missouri law would not restrict access to birth control unless the state legislature passed another law specifically defining methods like the IUD and the progesterone only pill as abortifacients.”

Such methods “fall in-between in the sense that they have both effects”, he said. “One effect would be legal—contraception—and one effect would be illegal. It’s our opinion that you could very easily defend those as contraceptives.”²⁷

All three of the responses above—Sussman, Webster, and Willke—betray a casual use of terminology that ultimately confuses the listener. After all, if a drug or device operates as both a contraceptive and an abortifacient, it makes little sense to call it one or the other. It is both. The public policy question is clearly one of determining whether the law should permit, fund, or allow research, development, or the use of occasionally or frequently abortifacient drugs or devices. For the birth control activist, the question is simple: Everything is permitted. The question for the defender of the right to life is at once more subtle and significant. If occasional abortifacients are acceptable, what possible objection is there to the frequently or nearly always abortifacient drug or device? This is a moral and political question that must take into account the general inability of the public to appreciate subtle though real

²⁶ John L. King, “Notes and Comment: Criminal Law—Abortion—the ‘Morning After Pill’ and Other Pre-implantation Birth Control Methods and the Law”, *Oregon State Law Review*, vol. 46, no. 2 (February 1967): 211–18.

²⁷ *Washington Post*, May 28, 1989, A-19.

distinctions, and the profound question of possibly taking a life in ignorance, culpably or otherwise. But in any case, no moral or satisfactory practical solution will be forthcoming that ignores inconvenient physiological or pharmacological properties of various antifertility items.

The simple truth is that some of these drugs and devices are called contraceptives, but really cause the death of the human being by abortion shortly after the child's origin. But it is important to note here that Planned Parenthood and its supporters are sheepishly acknowledging their deception to a small proportion of their birth control market. Mr. Sussman and others submitting pro-abortion briefs in *Webster* omit any mention of the most "popular" birth control Pill, the combined estrogen/progesterone regimen, as also being in the abortion classification, even though the FDA patient and physician package inserts describe their mode of action in terms that mean abortion. Perhaps these opponents of Missouri's antiabortion law were unwilling to test the reaction of millions of women to the fact that even the most commonly used Pill, or "oral contraceptive", is sometimes a killer of children.

Each of these approaches looks to what is presumed to be the probable consequences of antiabortion laws in the lives of the "middle ground" public, which has largely accepted the practice of birth control. Each of these approaches seeks to maximize ignorance and confusion in order to maximize political advantage. Neither side is being completely candid. But we harken back to Professor Landrum Shettles' observation that "to deny a truth should not be made the basis for legalizing abortion".²⁸

This curious right to be ignorant that has resulted from the abortion political standoff regarding contraceptives that kill has produced the incredible situation in the United States of doctors having the medical right to abort women without their knowledge or consent. In the 1984 Illinois case of *Diamond v. Charles*, a question in controversy was whether the state of Illinois could require physicians who prescribe or administer abortifacients to women to inform their patients that they have done so. By dismissing the case for procedural reasons, the Supreme Court effectively sustained without comment the decision of the U.S. Circuit Court of Appeals for the Seventh Circuit, which struck down the Illinois informed-consent provision.²⁹ Thus, Illinois women have no right to know what mode of action is responsible for the antifertility effect of the birth control drugs or devices prescribed to them.

Oddly enough, the American Medical Association, the American College of Obstetricians and Gynecologists, and others claimed the Illinois provision interfered with the physician's ability to provide medically relevant information to the patient.

²⁸ Shettles, Letter to Editor.

²⁹ No. 84-1379, Supreme Court, October 1984 term.

This “finesse” regarding the beginning of pregnancy is regularly displayed in medical journals as a matter of course. For example, when pregnancy is discussed in a neutral context, medical journals read as follows: “Highly sensitive early pregnancy tests that are positive at about the time of implantation (seven days after conception) are being used to estimate the extent of pregnancy losses that occur between implantation and the time after the first missed menses when standard pregnancy tests can be employed.”³⁰

But when a nonpregnant state is desired and the red flag of abortion is waving, the finesses recur. The following appeared a mere week later in the medical journal just quoted: “These preliminary studies suggest that RU-486 holds promise as a safe and effective form of fertility control that can be administered once a month.”³¹ The title of the article? “A Potential New Contraceptive Agent”. This, for a drug that is administered postimplantation, after a pregnancy is suspected or definitively established.

Information regarding the abortifacient properties of both the Pill and the IUD are available to the public, even if presented in somewhat disguised language most of the time. When the FDA proposed in 1976 that mandatory physician and patient package inserts accompany the distribution of the Pill, it was stated that

oral contraceptives are of two types. The most common . . . is a combination of an estrogen and a progestin, the two kinds of female hormones . . . this kind of oral contraceptive works principally by preventing release of an egg from the ovary . . . the second type of oral contraceptive, often called the mini-pill, contains only a progestin. It works, in part, by preventing release of an egg from the ovary, but also by keeping sperm from reaching the egg and making the uterus (womb) less receptive to any fertilized egg that reaches it.³²

Note the omission of the word “abortion”, used in 1963 by the same federal department to describe modes of action for antifertility drugs or devices that interfere with development after fertilization, such as the types of birth control pills.

This is all the more significant in light of the directives given by HEW that stated “the patient brochure will contain the latest medical information about ‘the pill,’ written in language understandable by the general public”.³³ Seven years earlier in 1969, an advisory committee to the FDA for the Pill stated in

³⁰ Dorothy Warburton, “Reproductive Loss: How Much Is Preventable”, *New England Journal of Medicine* (January 15, 1987): 158–60.

³¹ Lynnette K. Nieman et al., “The Progesterone Antagonist RU-486: A Potential New Contraceptive Agent”, *New England Journal of Medicine* (January 22, 1987): 187–90.

³² *Federal Register*, vol. 41, no. 236, December 7, 1976, 53640.

³³ Press release, Dept. of Health, Education, and Welfare, December 3, 1976, contact Ed Nida, FDA.

definite if technical terms that, for the Pill: "The second major effect is on the endometrium. The progestin acts as an antiestrogen causing alteration in endometrial glands and as a progestin, causing pseudodecidual reactions. Both of these alter the ability of the endometrium to participate in the process of implantation."³⁴

The FDA's suggested patient brochure on IUDs states that, "IUD's seem to interfere in some manner with the implantation of the fertilized egg in the lining of the uterine cavity. The IUD does not prevent ovulation."³⁵ Note again the avoidance of the word "abortion".

And Planned Parenthood reading materials for the "health consumer" identifies implantation and not fertilization as the beginning of pregnancy, which is clearly false.³⁶

Old Habits Die Hard: The Abortion Pill, Killing as "Contraception"

Gaining public acceptance for the French abortion pill, RU-486, is in part a matter of contriving and using acceptable euphemisms. Hastings Center author Lisa Cahill has written, "The method of reevaluation by redescription has assumed a significant role in the presentation of RU-486 . . ." She notes how the difference between abortion and contraception has been finessed "by the rhetoric designed to make the drug more acceptable to those who already accept conception prevention [i.e., contraception]."³⁷

Indeed, RU-486 inventor Etienne-Emile Baulieu has acknowledged christening RU-486 a contragestive, partly in the hope that the term "may defuse the abortion issue".³⁸ His collaborators are even trying to extend the definition of "pregnancy prevention" to twenty-eight days after fertilization, again under the rubric of "contragestion".³⁹

³⁴ Advisory Committee on Obstetrics and Gynecology, Food and Drug Administration, 1969, *Second Report on the Oral Contraceptives*, app. 4, "Report of the Task Force on Biological Effects", Philip Corfman, chairman.

³⁵ *Second Report on Intrauterine Contraception*, The Medical Drug and Device Advisory Committee on Obstetrics and Gynecology to the U.S. Food and Drug Administration, Department of Health, Education, and Welfare, December 1978, app. 1, 97, 101.

³⁶ PPFA, *Basics of Birth Control* (9-76/150), 1976, no. 150.

³⁷ Lisa Sowle Cahill, "'Abortion Pill' RU 486: Ethics, Rhetoric, and Social Practice", *Hastings Center Report*, October/November 1987, 5-8.

³⁸ Etienne-Emile Baulieu, "Contraception by the Progesterone Antagonist RU 486: A Novel Approach to Human Fertility Control", *Contraception*, supp. to vol. 36 (1987): 1-5.

³⁹ M. R. Van Santen, M.D. and A. A. Haspels, "Interception III: Postleutal Contraception by an Antiprogesterin (Mifepristone, RU 486) in 62 Women", *Contraception*, vol. 35, no. 5 (May 1987): 423-31 (see, "Only after the completion of implantation, i.e., after the 28th day of the menstrual cycle, should RU 486 be considered as an abortion). Moreover, organogenesis begins about two weeks after implantation."

This is a case in which the willingness to be deceived also plays a part. "Psychologically, the patients concerned consider themselves in no way pregnant and therefore do not regard the antiprogestins as abortifacient medication."⁴⁰ Failure to define correctly this pill's mode of action is reinforced by the fact that women can take the pill without a pregnancy test. "The psychological consequences of this uncertainty can be significant. 'We call it contragestion, not abortion', says Couzinet. 'Many women think of it as an induction of a menstrual period.'"⁴¹

Planned Parenthood decided to call RU-486 the "Interceptor Pill", because "it not only intercepts implantation, but it can also intercept further fetal development".⁴²

Even the prestigious *New England Journal of Medicine* succumbed to designating RU-486 as a contraceptive. The study, conducted by researchers at the National Institutes of Health, noted that:

The present studies were designed to test the contraceptive potential of RU 486. The ability of a single midluteal-phase dose to induce menses in women was established. Human chorionic gonadotropin (HCG) was also given concurrently to test whether RU 486 could induce menses in the presence of the enhanced corpus luteal function characteristic of early pregnancy.⁴³

If RU-486 is being tested as a contraceptive why administer HCG in order to mimic the biochemical characteristics of an established pregnancy?

To quote Cahill once again, "The research team explained their project in a manner that presumed the disputed premise that expulsion of the embryo before implantation counts as 'contraception' rather than abortion. . . . This language may represent another attempt to redescribe an activity to make it less morally problematic."⁴⁴

There is one additional major reason to call RU-486 a contragestive, and that is to obviate the impact of any existing antiabortion statutes.⁴⁵ This is semantic gymnastics on a scale to make even Nadia Comaneci envious.

⁴⁰ Ibid.

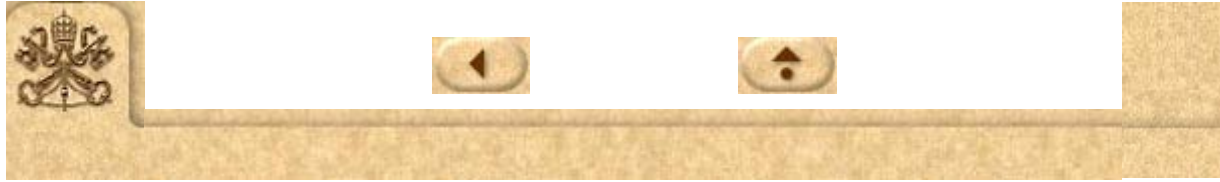
⁴¹ "The Month after Pill", *Medicine, Time*, December 29, 1986.

⁴² Dr. Louise Tyrer (vice president for medical affairs for Planned Parenthood), "General Discussion", *Contraception*, suppl. to vol. 36 (1987): 37-42.

⁴³ Lynnette K. Nieman et al., "The Progesterone Antagonist RU-486: A Potential New Contraceptive", *New England Journal of Medicine*, vol. 316 (January 22, 1987): 187-91.

⁴⁴ Cahill, " 'Abortion Pill' RU 486", 7.

⁴⁵ Tina Agoestina, "Prospective Usefulness of RU-486 in Fertility Control", *Contraception*, suppl. to vol. 36 (1987), 33-36.



***ADDRESS OF HIS HOLINESS BENEDICT XVI
TO MEMBERS OF THE INTERNATIONAL CONGRESS
OF CATHOLIC PHARMACISTS***

*Consistory Hall
Monday, 29 October 2007*

*Mr President,
Dear Friends,*

I am happy to welcome you, members of the International Congress of Catholic Pharmacists, on the occasion of your 25th Congress, whose theme is: "The new boundaries of the pharmaceutical act".

The current development of an arsenal of medicines and the resulting possibilities for treatment oblige pharmacists to reflect on the ever broader functions they are called to fulfil, particularly as intermediaries between doctor and patient; they have an educational role with patients to teach them the proper dosage of their medication and especially to acquaint them with the ethical implications of the use of certain drugs. In this context, it is not possible to anaesthetize consciences, for example, concerning the effects of particles whose purpose is to prevent an embryo's implantation or to shorten a person's life. The pharmacist must invite each person to advance humanity, so that every being may be protected from the moment of conception until natural death, and that medicines may fulfil properly their therapeutic role. No person, moreover, may be used thoughtlessly as an object for the purpose of therapeutic experimentation; therapeutic experimentation must take place in accordance with protocols that respect fundamental ethical norms. Every treatment or process of experimentation must be with a view to possible improvement of the person's physical condition and not merely seeking scientific advances. The pursuit of good for humanity cannot be to the detriment of people undergoing treatment. In the moral domain, your Federation is invited to address the issue of conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia.

It would also be advisable that the different pharmaceutical structures, laboratories at hospital centres and surgeries, as well as our contemporaries all together, be concerned with showing solidarity in the therapeutic context, to make access to treatment and urgently needed medicines available at all levels of society and in all countries, particularly to the poorest people.

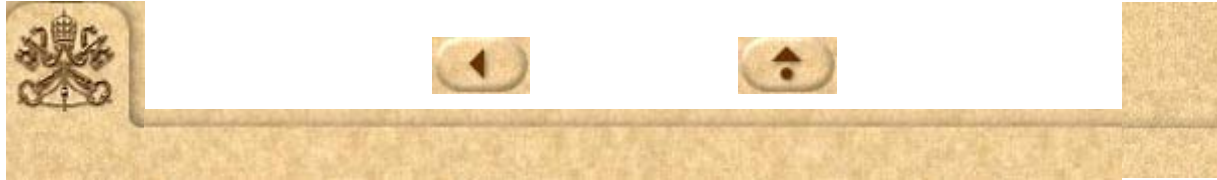
Prompted by the Holy Spirit, may you as Catholic pharmacists find in the life of faith and in the Church's teaching elements that will guide you in your professional approach to the sick,

who are in need of human and moral support if they are to live with hope and find the inner resources that will help them throughout their lives. It is also your duty to help young people who enter the different pharmaceutical professions to reflect on the increasingly delicate ethical implications of their activities and decisions. To this end, it is important that all Catholic health-care professionals and people of good will join forces to deepen their formation, not only at a technical level but also with regard to bioethical issues, as well as to propose this formation to the profession as a whole. The human being, because he or she is the image of God, must always be the centre of research and choices in the biomedical context. At the same time, the natural principle of the duty to provide care for the sick person is fundamental. The biomedical sciences are at the service of the human being; if this were not the case, they would have a cold and inhuman character. All scientific knowledge in the health sector and every therapeutic procedure is at the service of the sick person, viewed in his integral being, who must be an active partner in his treatment and whose autonomy must be respected.

As I entrust you as well as the sick people you are called to treat to the intercession of Our Lady and of St Albert the Great, I impart my Apostolic Blessing to you and to all the members of your Federation and your families.

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PONTIFICAL ACADEMY FOR LIFE

***STATEMENT ON THE SO-CALLED
"MORNING-AFTER PILL"***

As is commonly known, the so-called *morning-after pill* recently went on sale in Italian pharmacies. It is a well-known chemical product (of the hormonal type) which has frequently - even in the past week - been presented by many in the field and by the mass media as a mere contraceptive or, more precisely, as an "emergency contraceptive", which can be used within a short time after a presumably fertile act of sexual intercourse, should one wish to prevent the continuation of an unwanted pregnancy. The inevitable critical reactions of those who have raised serious doubts about how this product works, namely, that its action is not merely "contraceptive" but "abortifacient", have received the very hasty reply that such concerns appear unfounded, since the morning-after pill has an "anti-implantation" effect, thus implicitly suggesting a clear distinction between abortion and *interception* (preventing the implantation of the fertilized ovum, i.e., the embryo, in the uterine wall).

Considering that the use of this product concerns fundamental human goods and values, to the point of involving the origins of human life itself, the Pontifical Academy for Life feels the pressing duty and definite need to offer some clarifications and considerations on the subject, reaffirming moreover already well-known ethical positions supported by precise scientific data and reinforced by Catholic doctrine.

* * *

1. The *morning-after pill* is a hormone-based preparation (it can contain oestrogens, oestrogen/progestogens or only progestogens) which, within and no later than 72 hours after a presumably fertile act of sexual intercourse, has a predominantly "anti-implantation" function, i.e., it prevents a possible fertilized ovum (which is a human embryo), by now in the *blastocyst* stage of its development (fifth to sixth day after fertilization), from being implanted in the uterine wall by a process of altering the wall itself.

The final result will thus be the expulsion and loss of this embryo.

Only if this pill were to be taken several days before the moment of ovulation could it sometimes act to prevent the latter (in this case it would function as a typical "contraceptive").

However, the woman who uses this kind of pill does so in the fear that she may be in her fertile period and therefore intends to cause the expulsion of a possible new conceptus; above all, it would be unrealistic to think that a woman, finding herself in the situation of wanting to use an emergency contraceptive, would be able to know exactly and opportunely her current state of fertility.

2. The decision to use the term "fertilized ovum" to indicate the earliest phases of embryonic development can in no way lead to an artificial value distinction between different moments in the development of the same human individual. In other words, if it can be useful, for reasons of scientific description, to distinguish with conventional terms (fertilized ovum, embryo, fetus, etc.) different moments in a single growth process, it can never be legitimate to decide arbitrarily that the human individual has greater or lesser value (with the resulting variation in the duty to protect it) according to its stage of development.

3. It is clear, therefore, that the proven "anti-implantation" action of the *morning-after pill* is really nothing other than a chemically induced abortion. It is neither intellectually consistent nor scientifically justifiable to say that we are not dealing with the same thing.

Moreover, it seems sufficiently clear that those who ask for or offer this pill are seeking the direct termination of a possible pregnancy already in progress, just as in the case of abortion. Pregnancy, in fact, begins with fertilization and not with the implantation of the blastocyst in the uterine wall, which is what is being implicitly suggested.

4. Consequently, from the ethical standpoint the same absolute unlawfulness of abortifacient procedures also applies to distributing, prescribing and taking the *morning-after pill*. All who, whether sharing the intention or not, directly co-operate with this procedure are also morally responsible for it.

5. A further consideration should be made regarding the use of the *morning-after pill* in relation to the application of Law 194/78, which in Italy regulates the conditions and procedures for the voluntary termination of pregnancy.

Saying that the pill is an "anti-implantation" product, instead of using the more transparent term "abortifacient", makes it possible *to avoid* all the obligatory procedures required by Law 194 in order to terminate a pregnancy (prior interview, verification of pregnancy, determination of growth stage, time for reflection, etc.), by practising a form of abortion that is completely hidden and cannot be recorded by any institution. All this seems, then, to be in direct contradiction to the correct application of Law 194, itself debatable.

6. In the end, since these procedures are becoming more widespread, we strongly urge everyone who works in this sector to make a firm objection of *moral* conscience, which will bear courageous and practical witness to the inalienable value of human life, especially in view of the new *hidden* forms of aggression against the weakest and most defenceless individuals, as is the case with a human embryo.

Vatican City, 31 October 2000.

