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Emergency Contraception (EC) For Victims of Rape: Ten Myths

by

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Emergency Contraception (EC) in the form of the “morning-after pill” is a current major conflict in the “Culture Wars,” as some describe it. Unquestionably, John Paul the Great saw the essence of the conflict even more clearly: “This situation, with its lights and shadows, ought to make us all fully aware that we are facing an enormous and dramatic clash between good and evil, death and life, the ‘culture of death’ and the ‘culture of life.’ We find ourselves not only ‘faced with’ but necessarily ‘in the midst of’ this conflict; we are all involved and we all share in it, with the inescapable responsibility of **choosing to be unconditionally pro-life**. (No 28)”¹ [Italics by John Paul II to whose memory this work is dedicated.]

Pharmacists are losing their jobs in defense of Pro-Life ethics, over-the-counter (OTC) EC status is intensely debated by the FDA, and states are passing mandates that in essence force Catholic hospitals to dispense these chemical abortifacients.^{2,3} Both secular and Church leaders are confused as to the science and ethics at stake. This reflection reviews five scientific and five ethical myths, and then concludes that EC cannot licitly be distributed, prescribed or taken by those who profess to respect the sanctity of human life from conception to natural death. This is especially true for devout Roman Catholics.

Myth #1: EC cannot cause abortion.

Frances Kissling of “Catholics for Free Choice,” (CFFC) has bluntly proclaimed that: “Seemingly at the heart of the Vatican’s opposition to EC are its continued claims – in the face of overwhelming evidence to the contrary – that EC causes an abortion. For the record, such experts as the American College of Obstetrics and Gynecology (ACOG) say that

pregnancy starts when a fertilized ovum implants in the lining of the uterus, about six days after fertilization.”⁴ This rebuttal will examine first this messenger and then her message. The Catholic League states the following:

[CFFC] is not Catholic and it is not an organization. It has been openly denounced by both the Vatican and the U.S. bishops as being a fraud, and it has no members. Funded almost entirely by pro-choice foundations, CFFC is not only an oxymoron, it is the establishment's most persistently anti-Catholic letterhead. CFFC was founded in 1973, setting up shop in the headquarters of New York's Planned Parenthood (PP) office building.⁵

Also in defense of EC, a *New England Journal of Medicine (NEJM)* opinion article by Anna Glasier asserts: “Use of emergency contraception is limited largely by ignorance.”⁶ Glasier does, however, concede, “This confusion is compounded when mifepristone [RU-486] is advocated for EC since, when taken after pregnancy is established, it can be and is used for induction of abortion. The prevention of pregnancy before implantation is contraception not abortion.”⁶ The key to a proper assessment and a credible repudiation of these claims is a true understanding of human embryology, and the modern attempts to corrupt this science.

Albert Rosenfeld wrote in his pre-*Roe* book, *Second Genesis* (1969): “Because these substances do not prevent the sperm from penetrating and fertilizing the ovum – the classic definition of conception – they are not strictly contraceptives. What they do is prevent the newly fertilized egg from implanting itself in the uterus. Since the interference occurs after conception, some hold that such practice constitutes abortion. A way around this impasse has been suggested by Dr. A. S. Parkes of Cambridge: ‘Equate conception with the time of implantation rather than the time of fertilization – a difference of only a few days.’”⁷

Only one year later (September, 1970), an editorial in *California Medicine* proposed a hypothetical new game called “semantic gymnastics.” The first rule of the game was the “avoidance of the scientific fact, which everyone already knows, that human life begins at conception and is continuous whether intra- or extra- uterine until death.” The goal was to replace “the traditional western ethic” respecting “the intrinsic worth and equal value of every human life regardless of its state or condition” with “a new ethic for medicine and society” in order “to separate the idea of abortion from the idea of killing.”⁸

These small, unnoticed and unopposed, but profoundly foundational lies were rapidly followed by the cultural/ethical cataclysms of *Roe* and *Doe* in 1973. The 21st edition of the *Stedman's Medical Dictionary* was a

standard reference in 1971, the year I began my medical training. *Conception* and *pregnancy* were terms of clear, consistent and obvious meaning. *Conception* was “the act of conceiving, or becoming pregnant; the fecundation of the ovum.” *Pregnancy* was similarly defined: “Gestation,... the state of the female after conception until the birth of the child. ..., nine calendar months, or 280 days.” The term *implantation*, that would later become so central to the new agenda-based pseudoscience, was not even then present in this text’s 1,836 pages. The deceit was clandestine.⁹

The foundational terms of life, *conception* and *pregnancy*, are redefined or use more “Semantic Gymnastics.” J.C. Wilke, M.D. has published an authoritative, accurate and concise pamphlet that summarizes many of the points made thus far:

In the early 1960s it was determined that this newly available birth control pill will block ovulation and it was a “contraceptive.”

It was correctly judged that the public would accept this. But there was an anti-implantation effect also, which clearly was an abortion. They worried that if the general public found this out, the pill would be rejected. What to do?

There was a meeting of officials of the ACOG, the US Food and Drug Administration, some drug companies and a prominent doctor, Alan Guttmacher.¹⁰ They solved this “dilemma” by officially, but very quietly, ruling that henceforth the word *conception* would no longer mean the union of sperm and egg. Its new meaning was to be *implantation*, one week later.

The word “*pregnancy*” was also a problem so they changed its definition from beginning at fertilization to beginning at *implantation*. Their stated reason was that her body was not pregnant until *implantation*.

Almost no one was told about this then, nor do even most doctors know about it now, but this enabled the drug companies to call the “pill” and the IUD contraceptives. Today, using their new definitions, they say that the “emergency contraceptive” pill prevents *conception* and prevents *pregnancy*.

This obvious problem is that “the elite” say these things with a straight face, using their own definitions, while 99% of everyone else, including most clergy and doctors, believe “*conception*” and “*pregnancy*” still carry their traditional meanings of union of sperm and egg.

Pretty clever? You bet!”¹¹

Thus, seemingly minor attempts to alter the science of human embryology had the ultimate and profound effect of putting in jeopardy early human life, life that would later be destroyed in a myriad of ways: cloning, embryonic stem cell research, in vitro fertilization, and with the multiple abortifacients, disingenuously called "contraceptives," (i.e., IUDs, low dose pills, Norplant, EC, etc.). Perhaps it is worth noting that there is apparently no Christian textbook of human embryology, much less a Roman Catholic one. Ultimately, however, the greatest enemy of the culture of death is truth. Appendix A contains quotes from multiple texts that demonstrate the steadfast resistance to the attempted corruption of human embryology, as well as the tangled web of inconsistency, incoherence and ultimate lack of scientific credibility of a study guide trying to accommodate corrupted redefinitions (*Editor's note: Please see the end of this article for information about all appendices and references.*) Professor of human embryology, C. Ward Kischer Ph.D., states that: "Virtually every human embryologist and every major textbook of human embryology states that fertilization marks the beginning of the life of the new individual human being."¹² Appendix A affirms the truth of these words.

The scientific information in Appendix A demonstrates that the claim that EC does not cause abortion requires the acceptance of a corrupted form of the science of early human life, embryology. To accept the dehumanization of the early embryo is to accept a diminished moral status – "life unworthy of life" or at a minimum, life expendable without consequence. It is important to remember that the holocaust victims lost their names before their lives. The deception of dehumanization preceded, then as now, the structures of quiet and massive killing.

As demonstrated in Appendix A, these redefinitions have not been accepted by human embryologists. "Contraceptive now [after the FDA, ACOG, Guttmacher meeting] meant anything that prevented implantation of the blastocyst, which occurs 6-7 days after fertilization. The hidden agenda in ACOG's redefinition of contraceptive was to blur the distinction between agents preventing fertilization and those preventing implantation of the week-old embryo. Specifically abortifacients such as IUDs, combination pills...Norplant, all are contraceptives by this definition."¹³

John's Gospel reminds us that the "murderer from the beginning" is the "father of lies."¹⁴ The "culture of death" is rooted in lies. And, one huge and hidden lie has been the one that attempts to redefine the very beginning of human life. Frances Kissling is so certain of her view that EC does not cause abortion, because she is so close to the PP source, as was its president, Alan Guttmacher, who so effectively promoted acceptance of this hidden, but lethal lie. St. Thomas Aquinas' admonition that, "A small

error in the beginning leads to a multitude of errors at the end,” is essentially a prophecy of our times.¹⁵

Lastly, in a clear repudiation of the agenda – motivated pseudoscience of Frances Kissling et al., the 28th Edition (2006) of the classic *Stedman's Medical Dictionary*, under the proper consultative expertise of a human embryologist, has re-embraced the traditional and scientifically accurate definitions of life's foundational medical terms, *conception* and *pregnancy* (See Appendix A).¹⁶

Myth #2: The risk of pregnancy after rape is high.

In fact, the risk of pregnancy after rape is very low. Among several large studies, Diamond reports a prospective series of 4,000 rapes in Minnesota, in which no pregnancies occurred. Similarly, Diamond reports zero pregnancies during a nine-year period of prosecution for rape in Cook County, IL (Chicago); likewise a 30-year retrospective study of rape prosecutions in Erie County, NY (Buffalo) and a 10-year report from Cuyahoga County, OH (Cleveland) did not find a single pregnancy. Finally, Diamond reports a prospective study of 117 rapes that found no pregnancies among the 100 women who received no post-rape hormones. One report, however, of fertile women who were raped on their ovulation day, did find a 10% risk of pregnancy.¹⁷

The reported zero pregnancies among 4,000 rapes may seem implausible, but the following findings add to its credibility: a) 70% of the women are already on a “contraceptive” or have been sterilized; b) sperm are recovered in only 50% of cases; c) 57% of rapists have erectile or ejaculatory dysfunction; d) retarded ejaculation is 180 times more common in rapists than the general population; e) and fertility that may average 15-20% is present for perhaps 5 days of the cycle.¹⁷

Thus, the theoretical risk of pregnancy could be calculated very roughly as: $.30 \times .50 \times .43 \times .03 = 1.9/1000$. The actual reports of zero probability are therefore not so implausible. This rough calculation approximates the reported estimate that if two (presumably normal) individuals have consensual intercourse, they have a 3/1000 probability of producing pregnancy. Consequently, this estimate of 1.9/1000 is likely to be well above the actual probability of pregnancy due to rape. Additionally, false accusations, although hopefully infrequent, do occur. Norma McCorvey, the “Jane Roe” of the infamous 1973 *Roe v. Wade* case, now readily admits her claim of a gang rape was completely fabricated.¹⁸ There was neither a gang nor a rape.

Myth #3: A pregnancy test can positively determine pregnancy due to rape in sufficient time to administer EC.

A "Guideline" for treating sexual assault victims by one state Catholic Conference endorses a urine pregnancy test as sufficient clinical evidence to exclude a pregnancy due to rape.¹⁹ Nonetheless, the *NEJM* has firmly refuted the validity of this clinical approach, "Even the most sensitive pregnancy test will not be positive until after the implantation of a fertilized egg in the uterus, an event that occurs about seven days after fertilization."²⁰ Pregnancy tests currently in clinical usage are based on the detection of human chorionic gonadatropin (hCG), which is a hormone that is secreted by the placenta. The placenta does not exist until after implantation of the blastocyst on day six or seven.²¹ The "fertilized egg" neither implants or even exists on day 6-7; it became a zygote on day 1 at the completion of fertilization.

The laboratory manual of St. Joseph Hospital (Lexington, KY) states that the urine pregnancy test becomes positive about "7-10 days after a missed menstrual period."²² Thus, this test is not positive until a minimum of 3 weeks (i.e., 21-24 days) post conception! A negative pregnancy test within 72 hours of assault says nothing about the possibility of pregnancy due to rape. A positive pregnancy test within 3 days (i.e., 72 hours) of rape clearly means that the victim was already pregnant before the assault. Whether the urine test is positive or negative, the test simply provides no information relative to the clinical attempt to detect a rape-induced pregnancy. And, no test in medicine, as clinicians are reminded daily and the next paragraph reaffirms, is 100% accurate. Would the reader bet his/her life on the result of single lab result? If not, should you bet the life of another?

It may seem implausible to the reader that a nation that could put a man on the moon 37 years ago cannot detect pregnancy earlier. Nonetheless, multiple Medline and internet searches found no clinical contradiction to the above *NEJM* statement (paragraph 1 of this section). At the 50th Annual Convention of the American Association of Equine Practitioners (Denver, 2004) a report was given on the test for equine early conception factor (ECF). The sensitivity of this investigational test to detect early equine conception was only 53.8% at 7-8 days post ovulation (i.e., apparently the meaning of the term "early conception" is only confusing when applied to humans). These researchers state that, "For such a test to be useful in detecting conception, the sensitivity would have to approach 99%." Thus, they conclude, "...ECF does not yet have the accuracy needed for commercial use in the equine breeding industry."²³ This can be roughly translated from national convention science-speak to, "a coin flip just doesn't cut it," not even for horse embryos.

The performance of a urine test to exclude a rape-induced pregnancy is a sham, not science. But, as is discussed in the next section (Myth #4) this discussion is rendered moot by Kahlenborn's et al. review that has shown that the post-fertilization effect (i.e., early abortion) of EC is moderately strong whether it is administered before, after and during the ovulatory phase.²⁴

Myth #4: The mechanism of EC is not abortifacient.

Multiple scientifically credible refutations to this myth are given here.

- a) *A scientific review.* The review by Kahlenborn et al. of EC published in *The Annals of Pharmacotherapy* cites 57 references and concludes that the post-fertilization effect is "moderately strong whether the hormonal EC is used in the preovulatory, ovulatory, or postovulatory phase of the menstrual cycle."²⁴
- b) *A textbook of human embryology.* A standard medical school textbook, whose first author is a member of *International Nomina Embryologica Committee* (INEC) (See Appendix A-2 to Myth #1), in a student Q&A section, poses questions regarding "a young woman who feared she might be pregnant...asked you about the so-called 'morning after pills'...What would you tell her? Would termination of such an early pregnancy be considered an abortion?" The answer to this question #5 states quite clearly: "These hormones prevent implantation, not fertilization. Consequently, they should not be called contraceptive pills. Conception occurs but the blastocyst does not implant. It would be more appropriate to call them 'contraimplantation pills'. Because the term 'abortion' refers to a premature stoppage of a pregnancy, the term 'abortion' could be applied to such an early termination of pregnancy."²⁵
- c) *Another textbook of human embryology.* A textbook of human embryology and developmental biology states, "After fertilization, the pre-implantation embryo remains extremely vulnerable. The 'morning after' pill with its high estrogen content, alters the endometrium so that implantation fails to occur..."²⁶
- d) *A respected medical journal.* Similarly, a high-profile team of investigators who are obvious proponents of EC have written in the respected journal *Obstetrics & Gynecology*, "Emergency contraceptive pills reduce the risk of pregnancy by at least 75% and appear to work primarily by inhibiting implantation of a fertilized ovum through their effect on the endometrium." These researchers further state, "Fertilization may take place almost immediately after intercourse if ovulation has occurred or perhaps up to 2 days after intercourse if intercourse precedes ovulation."²⁷

These same researchers admit that, "The 72-hour cutoff, however, is neither evidence based nor convincing biologically." In fact, these researchers found effectiveness on days 4 & 5 "did not statistically differ from failure rates for the standard Yuzpe regimen" and "The 72-hour cutoff for the Yuzpe regimen of EC appears needlessly restrictive."²⁷ Furthermore, recall that these authors state that fertilization may occur "up to 2 days after intercourse." Therefore, the EC effect on day 3, 4, 5 or beyond is implied by these investigators to be via the prevention of implantation (i.e., an early abortion) rather than the prevention of ovulation.

- e) *Limited pre-ovulatory inhibition of ovulation.* Recent evidence for a pre-ovulatory EC abortifacient effect, has been reported by Croxattao et al. Levonorgestrel (aka "Plan B") 0.75 mg administered on the days preceding ovulation did not prevent ovulation (i.e., follicular rupture) during the ensuing 5-day period in nearly one half of cycles. Rupture occurred in 74% of those human subjects given placebo; 50% of those given the standard two doses of LNG and 56% of those given a single dose.²⁸
- f) *EC as late as 10 days post-coitus.* In May, 2006 an editorial critique of the refusal of some pharmacists to dispense EC appeared in the official journal of ACOG. The authors stated, "The fact that pregnancy rates are much lower the earlier after intercourse the medications are taken strongly suggests that emergency contraception operates through prefertilization mechanisms..."²⁹ It is curious that the editors allowed this sentence to be published without qualification in the very same journal, *Obstetrics & Gynecology*, as had been the contradicting 120-hour information contained two paragraphs above. Moreover, EC authorities Trussell et al. in an article entitled, "The role of emergency contraception" state that the IUD is "significantly more effective" and "could prevent pregnancy if inserted up to 10 days after intercourse."³⁰ What a concession! The insertion of an IUD on day 10 cannot possibly prevent either conception (fertilization) or implantation. Not only is the word "contraception" a complete and obvious deception for the embryo killing 10 days post-coitus, but the "emergency" designation is a huge stretch as well.
- g) *Ovulation not prevented in 19 of 19 subjects.* Likewise, evidence for an ovulatory and postovulatory EC abortifacient effect has been reported by Raymond et al.³¹ In this study of the standard EC hormonal (i.e., "Yuzpe") regimen, these researchers found no

significant induced changes in five endometrial factors, but did find changes in five other factors including endometrial thickness.

Of particular note, however, the authors stated that the administration of Yuzpe regimen on the day of the urinary LH surge, or the day after, "did not prevent ovulation in any of the [nineteen] participants" as determined "[b]oth by the endometrial histology and the luteal phase serum progesterone concentrations." The claim of a primary anovulatory mechanism is strongly disputed in this report by EC proponents.³¹

- h) *Alan Guttmacher Institute concurs – implantation inhibited.* The US Conference of Catholic Bishops (USCCB) has stated:

The Alan Guttmacher Institute's *Family Planning Perspectives* made the same observation in 1995: "Emergency contraceptive pills, also known as morning-after pills, are a postcoital hormonal treatment that appears to inhibit implantation of the fertilized ovum (C. Harper and C. Ellertson, "Knowledge and Perceptions of Emergency Contraceptive Pills Among a College-Age Population: A Qualitative Approach," 27 *Family Planning Perspectives* 149 [July-August, 1995])."³²

Thus, Kahlenborn et al.'s opening conclusion to this section that a post-fertilization, or abortifacient effect is "moderately strong whether the hormonal EC is used in the preovulatory, ovulatory, or postovulatory phase of the menstrual cycle" is confirmed.²⁴ As noted above, Glasier has stated in the *NEJM*, "The prevention of pregnancy before implantation is contraception not abortion."²⁶ Similarly, the opinion piece in 4-f (just above) from the ACOG journal stated, "Pharmacists who describe these medications [EC] as abortifacients are either scientifically uninformed or are deliberately misusing standard medical terminology to promote a personal moral or political agenda."³⁰ A clear refutation of these claims comes from Glasier herself. In fact, the controlled trial that culminated in Glasier et al.'s concession that no controlled trial of EC "has shown a reduction in unintended pregnancies" had another twist.³³ The EC used in this trial was mifepristone (i.e., RU-486), the abortion pill.³⁴ Thus, the implied claim, with its twisted logic, becomes that usage of the abortion pill for EC, although it is known to be highly effective, does not cause abortions.³³

Obviously, one side is not telling the truth. As noted in Myth #1, human embryologists have uniformly rejected these "semantic gymnastics." Worse yet for its advocates, a study of primary care physicians, that including faculty and residents in obstetrics and gynecology, who were associated with a teaching hospital, found that

decades after the attempt to corrupt embryology, 38% of those questioned believed EC “to be a form of abortion.”³⁵

Lastly and most sadly, more than one year after a Catholic Conference of one state adopted “Guidelines” for the administration of EC to sexual assault victims following the performance of a simple urine pregnancy test, its own website stated, “The so-called “emergency contraceptives” (“morning-after pill”) have an abortifacient effect as their primary mode of action.”³⁶

Myth #5: EC will reduce abortions.

The Planned Parenthood website states that emergency contraception “could prevent 1.7 million unwanted pregnancies and 800,000 abortions each year in the U.S.”³⁷ Moreover, in the above 1997 *NEJM* review, Anna Glasier claimed that “the widespread use of EC in the United States could prevent over 1 million abortions and 2 million unintended pregnancies...”³⁶ Similarly, a July 11, 2005 *Newsweek* editorial by Anna Quindlen proclaims that, “In theory, access to the drug called Plan B should be a no-brainer.” Quindlen summarizes, “If easy access to a pill that has been shown to significantly decrease the number of abortions is not a welcome development, what is the real point of the anti-abortion exercise?”³⁸ A careful re-reading of the above will show a subtle shift from the phrase “could prevent” to an assumed “would prevent,” but the truth is EC has not and will not prevent surgical abortions.

The breathtaking expansiveness and lack of credibility of these PP et al. claims are demonstrated when it is recalled that the most recent official statistics for abortion reported a total of 854,122 for the United States in 2002. A 93.7% (i.e., 800,000) *reduction* is the PP claim, if the chemical abortions are, of course, left out of the counting.

At least five controlled trials were published in 2004 and 2005, and none showed a reduction in abortions (See Appendix B). One controlled trial of advanced EC provision was published in *JAMA* in early 2005 that not only did not show a reduction in pregnancy rate, but instead the report found a 10% higher pregnancy rate.³⁹ The increase was not statistically significant given the report’s sample size, but could represent a huge public health impact for the entire country.

In fact, after publishing a paper entitled, “Advanced provision of emergency contraception to postnatal women in China makes no difference in abortion rates: a randomized control trial” in the journal *Contraception*,³⁴ the same Anna Glasier, who wrote of “preventing one million abortions” with EC in the *NEJM*, now contradicts what she had written in 1997.⁶ In a 2006 co-authored editorial she now concedes, “...randomized trials of advanced provision of EC in a variety of settings have all demonstrated increased use of EC, but none has shown a reduction

in unintended pregnancies.”³³ **Don’t** look for this concession on the PP website.

Concerned Women for America (CWA) in a carefully referenced report, “Uncovering lies,” show that abortions actually increase after easier access to EC: “In Scottish schools, teenage pregnancy among 13 to 15-year-olds rose 10 percent in one year. In 2006, the country reported the highest number of abortions since abortion was legalized in 1967. In the United Kingdom, abortion rates increased by 6,000 in one year with the largest leap among girls younger than 16 years old.”⁴⁰

In general, if a drug is demonstrated to lack the claimed effect, any discussion of risk becomes moot. The assumption would be that the benefit-to-risk ratio could not possibly be positive. The promotion of EC is so prevailing, however, that the risks must be weighed and these include many:

Ectopic pregnancy rate is increased. “When the British discovered that twelve of 201 (5.9 percent) unintended pregnancies following levonelle (levonorgestrel 0.75 mg, the same drug as in Plan B) ingestion was ectopic... [they] issued a warning... which was also picked up by New Zealand’s public health system. To make a drug which has the potential of increasing fourfold the rate of ectopic pregnancy available without medical supervision is the height of medical irresponsibility.”⁴¹ Ironically, the term “ectopic pregnancy” is used without hesitation even though the embryo never implants into the endometrium and therefore does not fulfill the corrupted re-definitions of either *conception* or *pregnancy*.

Sexually Transmitted Disease (STD) rate is increased. In the United Kingdom, where access to EC is easy, chlamydia cases rose from 7,000 in 1999 to 10,000 cases in 2003. Gonorrhea cases climbed nearly 50 percent to nearly 3,000 cases in 2003, up from 2,000 in 1999. The highest increases were among 16-19 year olds.⁴² Similarly, in Washington, in the year EC was first made available through a pilot program in pharmacies, the rate of chlamydia increased from 169 cases per 100,000 in 1997 to 193 per 100,000 in 1998. The increase was a dramatic reversal of a steadily downward trend in chlamydia through 1996. In Washington annual cases of chlamydia numbered 9,523; in 2002 there were 14,936 cases (i.e., a 57% increase).⁴³

Similar and alarming data has been uncovered by CWA: “Countries where the morning-after pill is easily accessible have experienced an increase in sexually transmitted diseases (STDs). In the United Kingdom, specific STDs such as gonorrhea increased by 50 percent in only three years after the morning-after pill was distributed without prescription. In a four-year period, the number of cases of chlamydia went up 76 percent. Gonorrhea went up 55 percent. Syphilis went up 54 percent. Genital warts went up 20 percent.”⁴⁰

Promiscuity is increased. Proponents of EC are, of course, loathe to admit this. Nonetheless, a randomized trial of advance supply of EC to adolescent mothers (AEC) found that teens in the AEC treatment group were more likely to have "unprotected sex" at the 12-month follow-up interview (69% vs. 45%).⁴⁴ Another controlled trial found that the AEC group was significantly more likely (37%) to use EC at least once.⁴⁵ By 2003, 6% of United States women reported using EC; a sixfold increase since 1997 and a threefold increase since the year 2000 (i.e., 2% usage).⁴⁶ By 2004 EC use in the United Kingdom had more than doubled from one in 12 teenagers to one in five.⁴²

Regulations, whether OTC EC status or smoking bans, do influence behavior. The AEC postnatal group in China, like the non-AEC group, was less likely to use any contraceptives during the first 16-weeks postpartum. At only 1-year FU the AEC group was twice as likely to use EC (187 v. 90 women; $p < .001$), were 4X more likely to use EC more than twice (20 v. 5; $p < .001$, calculated by APS) and were 5X more likely to have used EC 4-8 times during the year after delivery.³⁴ A British girl who said that she was 10 years old told the pharmacist that "she had already used it four times."⁴²

Similar concern is being reported in Spain. According to a report in the Spanish daily *La Opinion de la Coruña*, "the morning-after pill, approved for use in Spain for emergency only, has spread out of control in schools in the northern Spanish region of Galicia, with some young women taking the drug up to seven times a month."⁴⁷

Sexual abuse and exploitation are increased. The research arm of PP, the Alan Guttmacher Institute, has reported: "The younger women are when they first have intercourse the more likely they are to have had unwanted or nonvoluntary first sex, seven in 10 of those who had sex before age 13, for example."⁴² Dr. Jocelyn Elders stated in *JAMA* that the rush to choose "pregnancy outcome options" may preempt efforts to rule out sexual abuse. "Sexual abuse is a common antecedent of adolescent pregnancy..."⁴⁸ "Two-thirds of a sample of 535 young women from the state of Washington who became pregnant as adolescents had been sexually abused: Fifty-five percent had been molested, 42 percent had been victims of attempted rape and 44 percent had been raped."⁴⁹

In Bangkok EC has been readily available for fifteen years; random studies there have shown men are the most frequent buyers. "They buy the pills for their girlfriends or wives so that they don't have to wear condoms and feel they're at no risk of becoming a father afterwards. Some women I've spoken to said that they didn't even know what they were taking; that the guy just said it was a health supplement," said Nattaya Bookpakdee, program assistant at the Population Council (an agency dedicated to promoting and developing contraception and abortion methods).⁴²

The *Bangkok Post* continued, "Although many feminists believe that the morning-after pill gives them more control over their own bodies, it would seem, judging from the few studies conducted so far, that it is actually being used by men to exploit women."⁴²

CWA notes further that, "Teenage girls make up the largest percent of the population that has experienced rising abortion and STD rates in conjunction with nonprescription access to Plan B."⁴⁰

Other risks. The 2006 *Physician's Desk Reference* has eight large pages of small print on the risks of the birth control pill Ovral-28® which include an increased risk of blood clots, heart attack and cervical cancer. There are 16 precautions and 47 adverse reactions listed. Oral contraceptives are contraindicated for 18 conditions, including women with diabetes, breast cancer, liver problems, headaches, heart disease or a history of heart disease, deep venous thrombosis or a history of deep thrombosis, and women over 35 who are smokers.⁵⁰

Cancer risk. In 2005 the International Agency for Research on Cancer, the Lyon (France)-based cancer research agency of the World Health Organization, in its press release on the 29th of July, 2005, classified estrogen-progestogen oral contraceptives as Group 1 carcinogenic agents. This agency determined that the use of oral contraceptives increases the risk of breast, cervix and liver cancer.⁵¹

Risks to be determined. The estrogenic hormone, Premarin, was extracted from and named for pregnant mares' urine; it was released in 1942. It did not, however, receive the FDA highest (i.e., "black box") warning of increased risk of myocardial infarction, stroke or invasive breast cancer, pulmonary emboli, etc, for 60 years (i.e., 2002).

In September, 2000, the human pesticide, Mifeprex (i.e., aka, mifepristone, RU-486, abortion pill and "French abortion pill") was fast-tracked to market with the assistance of the Clinton Administration under a category only meant for life-threatening diseases like AIDS and cancer – conditions so serious that the study of risk is perceived to be less imminent.

The morbidity and mortality, however, associated with RU-486 has proved to be quite imminent and not minor. A total of 607 adverse events were reported to the FDA (?FDDA "Federal Deception & Death Administration") by September, 2004 including 237 cases of hemorrhage (68 requiring transfusions, 42 characterized as life-threatening, and one resulting in death). Seventeen of the adverse events were ectopic pregnancies, a potentially life-threatening condition; one death did occur. There were 66 cases of infection with seven cases of septic shock – two resulting in death.⁵²

All total, eight deaths have now been associated with RU-486 (five with toxic shock from *C. sordellii* – three not included in the FDA report and 4 of 5 were from California, a woman in Tennessee died from a

ruptured ectopic pregnancy after taking the abortion drug, a Swedish teen died from a massive hemorrhage, and a woman in the U.K. died for unclear reasons. In December, 2005, the CDC estimated the maternal death rate to be ten times that of surgical abortions.⁵³

Ortho Evra® and 17 deaths. In April, 2005, “a Manhattan fashion student collapsed in a city subway station. An autopsy found a blood clot had moved into the victim’s lung, and the medical examiner ruled that the clot was a side effect of the birth control device. FDA records show that seventeen patch users between the ages of 17 and 30 have suffered fatal heart attacks, blood clots and possible strokes since August, 2002,” so states a website that is handling legal claims against this product. The estrogen content in the bloodstream is only 60% greater than the usual dose from a birth control pill.⁵⁴ On Nov 11, 2005 the FDA warned that the risk of blood clots was threefold higher than women taking the pill, whose risk is already elevated.⁵⁵ Compare this relatively modest 60% higher serum level to the massive combined EC hormonal regimens requiring 4-10 times the usual daily dose to be taken within 12 hours or to the progestin-only EC treatment schedule that requires taking 40 times (i.e., 3,900% higher) the usual daily dose of this hormone within a 12-hour period!^{30,56} The risk of repeated dosing with high levels of EC hormones, especially in high risk groups such as smokers, remains to be defined.

Six months later the Planned Parenthood website said nothing about the 17 deaths or threefold higher risk for blood clots among for the Patch users when compared to the birth control pill risk. The website stated under “Possible Complications” that “Serious problems do not occur very often. In general, using the patch is much safer than pregnancy and childbirth” and “The patch does not interfere with having sex, and may improve a woman’s sex life.”⁵⁷

Clearly, there is more to learn about the risks of these so-called “contraceptives.”

Myth #6: A woman’s right to defend herself against a rapist allows EC to be given.

The Vatican has made it very clear (Myth #9) that the “disadvantage” of an unwanted pregnancy, even if it produces a great burden, does not justify the snuffing out of an innocent early life. Likewise, Mary Meehan comments with truthful and insightful clarity, “Our commitment to equality would be radically compromised if we were to say that children’s right to life depends on the circumstances of their conception.”⁵⁸

Father Frank Pavone, of Priests for Life, likewise states that, “To ‘agree to disagree’ is to concede that a baby is a baby only if the mother thinks it is – that the child has value, only if the mother says it does.”⁵⁹ Do *we the people* honestly believe the words of the Declaration of

Independence that we are endowed by Our Creator with certain unalienable rights – among them the right to life, liberty and pursuit of happiness”? Do we?

Myth #7: EC is compassionate treatment for raped women.

Lee Ezell, who was raped by a co-worker at age 18 has written: “In the nightstand, I found a Gideon Bible...As I read the words of David in *Psalm 139:13-16*, I received a glimpse of God’s love for each of us: ‘You made my whole being; you formed me in my mother’s body. I praise you. ...All the days planned for me were written in your book before I was one day old.’ If these words were true, then I was *not* an unwanted child! ...He [God] must also care for the child inside me. This simple truth transformed my life. I no longer began to look at the child inside me as a curse or an extension of the man who raped me.”

Ezell’s insight is not isolated. Most women who are raped develop a more positive view of their baby as the pregnancy progresses and more than 80% who carry their babies to term explicitly express happiness with their decision.⁵⁹

On the other hand, the same report found that 28 of 30 (93%) women, who became pregnant by rape and chose abortion, later said that it was not a good solution.⁵⁹

Myth #8: The US Conference of Catholic Bishops has approved EC for rape.

The US Catholic Bishops published in July, 2001 the 4th Ed. of the *Ethical and Religious Directives for Health Care Services*. Directive 36 states:

Compassionate and understanding care should be given to a person...A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.⁶⁰

It should be clear from the discussion thus far that: a) No pregnancy test will diagnose a conception due to rape within the customary 72 hour window of EC effectiveness (Myth #3). Therefore, the phrase “appropriate testing” is without scientific meaning; b) There is no EC in standard current clinical usage that does not have as its “purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized

ovum" (Myth #5); c) Sadly, this Directive uses corrupted embryology. The Vatican states the science correctly (Myth #9, b). It is a blastocyst that implants on day six as the fertilized ovum ceases to exist on day one with the formation of the zygote. Neither the stated diagnostic nor the therapeutic stipulations for EC usage in this Directive 36 are met.

As stated above, St. Thomas' admonition that an "error in the beginning" later creating a multitude of errors is essentially a prophecy of our times relative to the ethical debates over EC, cloning, embryonic stem cell research, etc. Examples of such early "errors" are surely the corrupted redefinitions of ethically foundational words such as *conception* and *marriage*.

In November, 2004 an amendment to the Kentucky Constitution appeared on the ballot; this referendum defining marriage as a union of a man and woman passed by a margin of three to one. The debate had been heated, but at the "end of the day" it became clear to many that if the ethical bright line [the definition of marriage] was not drawn at one man and one woman, that no other ethical line would or could hold (i.e., What about bigamy, or polygamy, or marrying one's children [incest], or even marrying oneself or one's pet [bestiality]? etc., etc. down the slippery slope.) Furthermore, a concession to homosexual unions, but not "gay marriage," was concluded to be a distinction without a difference. Thus, at least in this instance and in this place, the natural law trumped a multitude of threatening errors.

So, too, it is with human life. The protection of the embryo is the *foundational ethical issue* in cloning, embryonic stem cell research and EC. Either we protect life from conception to natural death or we have no defensible moral argument against embryonic stem cell research, cloning, physician assisted suicide or Peter Singer's advocacy of newborn (or even infant) euthanasia. If EC is OK for genocidal, terroristic or violent rape, then why isn't it OK for non-violent or statutory rape? What about date rape, or alcohol with seduction, or a condom failure, missed pill or pills, closed pharmacy, lack of quarters, or any other perceived "emergency"? Emergency and urgency are very elastic and subjective terms, as any ER doctor will verify. Would we not want to make EC available to all – even to children via OTC status – who perceive an emergent or urgent need? "No," we say, but oh so softly. Why was the voice of the Catholic Church in America, with rare exception, so muted in opposition to OTC EC? The reason for this sad silence may be the confusion resulting from the acceptance of EC for rape (and "sexual assault") by some Catholic bishops and other ethical leaders. Deep down, however, there is a quiet uneasiness with this inconsistency. The attempt to draw a clinical and ethical bright line that says OK to prescription EC for emergencies, but forbids OTC EC for urgencies is at root incoherent and flawed, another distinction

without a difference, or at least one that is neither convincing nor issue clarifying.

It is said that John Paul the Great did much of his thinking and writing before the Blessed Sacrament at a little table. And, in that little table was a drawer, beneath the writing surface; and, in the drawer was his brother's stethoscope. How strange to combine a monstrance and a stethoscope! But, was not this the same man who combined theology and the human body?! And, how strange is it really to link the Divine Physician to the stethoscope or those made in the *divine image*, the man and woman of Genesis, to their Creator, who saw that the fruit of this creative act was indeed *very good*.

John Paul's brother was Edmund. After graduating *magna cum laude* in his medical studies, he began working at the Children's Clinic in Krakow in cardiology. There he became aware of a young woman suffering from scarlet fever. He chose (there is that word again) to treat her, a patient shunned by the other doctors because contact with her meant contracting her illness and near certain death. Edmund thus died treating one of his very first patients. The personnel at the clinic then gave little brother Edmund's stethoscope – an instrument that had lead to medical diagnoses, but also had lead to his death. Lolek's admiration and respect for older brother transcended his boyhood name and perceptions – truly John Paul never forgot his physician older brother or brother's ultimate Pro-Life witness or brother's professional calling. Perhaps, Edmund's cause for canonization will someday be considered. Luke is the first patron saint of physicians; St. Gianna Beretta Molla is the newest and the first woman physician saint – canonized by JPII in 2004, less than a year before his own death. Her feast day is April 28.

Without doubt, John Paul the Great was no ordinary teacher of medical ethics, nor was his knowledge and appreciation of the body and the ancient profession of medicine ordinary. It is probably true that one can be uneducated in medicine and still get important bioethical questions wrong; but, how is it possible to not understand the relevant clinical facts, the truth of the handiwork of God's greatest creation – the workings of the human body, the creation that was called "very good," and still get important bioethical questions right? There is no clear clinical line that separates a clinical case that is "urgent" from the "emergent." If the "bio" component is flawed, how can the "bioethical" judgement line be rightly drawn? Lastly, by what ethical standard or bright line does one destroy innocent human life in some clinical cases (or crises) and not in others? How does the Hippocratic ethic to "Do no harm," or the Decalogue command – "Do not kill," or the *Catechism* teaching "to protect absolutely" permit this human destruction?

Myth #9: The Vatican has not addressed the ethics of EC for rape.

Nine statements by the Vatican on EC have been identified. Not one approves the use of EC. Seven are contained in Appendix C; two of these statements are quoted here.

Charter for Health Care Workers:

Abortion 139. The inviolability of the human person from conception prohibits abortion as the suppression of prenatal life. This is “a direct violation of the fundamental right to life of the human being” and is “an abominable crime.”...The elimination of unwanted pregnancy has become a wide-spread phenomenon...

141. It is also true that in certain cases, by refusing an abortion, other important goods – which is only normal that one would want to safeguard – are put in jeopardy. They could be: danger to the mother’s health, the burden of another child, a serious malformation of the fetus, a pregnancy caused by rape.

These problems cannot be ignored or minimized, nor the reasons supporting them. But it must also be affirmed that none of them can objectively give the right to dispose of another’s life, even in the initial phase. “Life, in fact, is too fundamental a good for it to be compared with certain disadvantages, even if they be very great.”

...A doctor who would knowingly prescribe or apply such substances or means would cooperate in the abortion.⁶¹

Pontifical Academy of Life: Statement on the so-called “Morning-After Pill”:

As is commonly known, the so-called *morning-after pill*... is a well-known chemical product (of the hormonal type) which has frequently...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).

1. The *morning-after pill* is a hormone-based preparation (it can contain oestrogens, estrogen/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.

...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. ...⁶²

The two above statements are unambiguous declarations of disapproval of EC, as are the seven other statements in Appendix B. These statements are entirely consistent with the teaching of John Paul II, “Contraception is to be judged so profoundly unlawful as never to be, for any reason, justified.” To think so or to say the contrary is equal to

maintaining that in human life, situations may arise in which it is lawful not to recognize God as God.”⁶³ Similarly, the *Catechism* states:

2270 Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognized as having the rights of a person – among which is the inviolable right of every innocent being to life. ⁶⁴

The conclusion that the EC may not always function as an abortifacient is far short of the ethical standard to “protect absolutely.” Authentically Catholic hospitals, physicians and other health care professionals who are faithful to the Magisterium will observe the above moral teaching that “the same absolute unlawfulness” applies to “distributing, prescribing and taking” of the EC.

Myth #10: Contraception and abortion are quite distinct.

In 2005, ironically, Good Friday fell on the customary Feast of the Annunciation (March 25), and this date also marked the tenth anniversary of a towering work by arguably the most respected moral thinker and leader then on the face of the earth. For many Catholics, this was the last time we saw on EWTN our beloved John Paul II alive, however dimly, in front of a TV with his crosier, watching the Stations of the Cross being prayed in the Coliseum. A prophetic insight from the *Gospel of Life* by John Paul the Great is worthy of a re-reflection: “The close connection which exists, in mentality, between the practice of contraception and that of abortion is becoming increasingly obvious...It is being demonstrated [that]...chemical products, intrauterine devices and vaccines which, distributed with the same ease as contraceptives, really act as abortifacients in the very early stages of the development of the life of the new human being. (No 13).”⁶¹

In *Veritatis Splendor* (No 79, 80), John Paul II recalls Sacred Scripture that *it is not licit to do evil that good may come of it* (cf. Rom 3:8) and writes that there are:

...human act[s] which are by their nature “incapable of being ordered” to God, because they radically contradict the good of the person made in his image. These are the acts which, in the Church’s moral tradition, have been termed “intrinsically evil” (*intrinsece malum*): they are such *always and per se*, in other words, on account of their very object, and quite apart from the ulterior intentions of the one acting and the circumstances. ...The Second Vatican Council itself, in discussing the respect due to the

human person, gives a number of examples of such acts: "Whatever is hostile to life itself, such as any kind of homicide, genocide, abortion, euthanasia and voluntary suicide..."⁶⁵

If the use of RU-486 by girls and young women as "EC" is not an action hostile to life, then truth is as devalued as life.

Four years earlier the Pope had declared in an address at the University of Uppsala (June 9, 1989), "The dignity of the person can be protected only if the person is considered as inviolable from the moment of conception until natural death. ...Unless, a society treats the human person as inviolable, the formulation of consistent ethical principle becomes impossible, as does the creation of a moral climate which fosters the protection of the weakest members of the human family."⁶⁶

It is long past time – nearly four decades since the publication of *Humanae Vitae* (the Feast of St. James, 1968 July 25) – that lay Catholics in America and elsewhere, finally concede that it is ultimately untenable to profess to be Pro-Life while still distributing, prescribing or taking so-called "contraceptives." A more accurate term for these products is indeed "interceptives." True, they do not always destroy their target, but what missile does? Likewise, it is ultimately incoherent for Church leaders to justify EC for rape (which has many forms) and other sexual assault emergencies (which is an even more elastic, ill-defined and ethically slippery term), but oppose OTC EC for "urgencies." A broken condom of an 18-year-old man with a 17-year-old female classmate could fall in either category.

The sanctity of early human life, before implantation, has a biblical basis that is being increasingly recognized. As Rosary scholar K.O. Johnson notes, Jesus was likely in "His first few days of life," and John the Baptist only in his sixth-month, when he leapt in the womb of his mother Elizabeth at the Visitation.⁶⁷ Jesus was likely, therefore, only a tiny pre-implantation embryo. Pope Benedict XVI, in fact, concurs with this insight.

On December 28, 2005, the Feast of the Holy Innocents, Pope Benedict XVI, as Lee Ezell had done before (Myth #7), reflected on *Psalms* 139, and dedicated his last homily of the year to the unborn, saying even the tiniest embryo is the object of God's loving gaze and concern. "The loving eyes of God look on the human being, considered full and complete at its beginning," Pope Benedict said in his address at St. Peter's Square.⁶⁸ Similarly, in his first book, published six months earlier in Italian (*The Europe of Benedict, in the Crisis of Cultures*), the Pope had written, "There is no such thing as small murders."⁶⁹

On February 27, 2006 Pope Benedict gave an address at the two day international conference held to mark the 12th general assembly of Pontifical Academy of Life. The title of the conference was "The Human

Embryo Prior to Implantation – Scientific Aspects and Bioethical Considerations.” The Pope spoke clearly in support of Johnson’s insight:

Indeed, the study topic chosen for your Assembly, the human embryo in the pre-implantation phase, that is, in the very first days subsequent to conception, is an extremely important issue today...It is certainly a fascinating topic, however difficult and demanding it may be, given the delicate nature of the subject...

As it is easy to see, neither Sacred Scripture nor the oldest Christian Tradition can contain any explicit treatment of your theme. St Luke, nevertheless, testifies to the active, though hidden, presence of the two infants. He recounts the meeting of the Mother of Jesus, who had conceived him in her virginal womb only a few days earlier, with the mother of John the Baptist, who was already in the sixth month...

Therefore, the Magisterium of the Church has constantly proclaimed the sacred and inviolable character of every human life from its conception until its natural end (*Evangelium Vitae*, n. 57). This moral judgment also applies to the origins of the life of an embryo even before it is implanted in the mother’s womb, which will protect and nourish it for nine months until the moment of birth: “Human life is sacred and inviolable at every moment of existence, including the initial phase which precedes birth” (*EV.*, n. 61).⁷⁰

The discussion in this paper has focused on scientific and ethical issues. An examination of the legal related issues would be a complete separate work well beyond the competence of the author. Briefly, however, it can be recalled that several U.S. Supreme Court rulings have shown the close relationship between contraception and abortion. As all of Christianity opposed contraception until the ethical crack that appeared at the Anglican Lambeth Conference of 1930, it is not surprising that the 19th century Comstock Laws were not nullified before the 20th century. In 1965 the High Court ruled in the *Griswold v. Connecticut* decision that a law forbidding contraception by married couples was unconstitutional, even though the Constitution was silent on the issue. In 1972 in *Eisenstadt v Baird* the Court banned laws against the sale and distribution of contraceptives. A year later, in *Roe and Doe*, judicial activism accelerated, the ethical levees collapsed, and the same “penumbras” of privacy rationale that had been used in *Griswold*,⁷¹ was then used to wash away all

democratically legislated state abortion laws, and henceforth, by Supreme edict, abortion was a “right” throughout the darkened and defruited plain, by any means of butchery, at any point in pregnancy, without anesthesia, for any reason or no reason, up to the baby’s partial birth. In *Stenberg v. Carhart* (2000) this position was re-affirmed and the ACOG, PP, ACLU et al. agenda prevailed. Most distressing was the defense of partial birth abortion by George Annas in the *NEJM*, who wrote of the need for “the availability of safe abortions to protect women’s lives and liberty.”⁷²

Thus, the Supreme Pontiff of the Catholic Church, John Paul II, wrote of “lights and shadows,” while the U.S. Supreme Court wrote of “penumbras” – shadows of shadows.

In closing, what is the level of certitude that a devout Catholic would want that by some action he was not killing the 3-year-old child Jesus? What about a 1-year-old child Jesus, or a several-day-old Jesus in the Immaculate Womb at the Visitation. Hopefully, a truly devout Catholic or any devout Christian would want an absolute level of certainty. Similarly, should the level of certainty be any lower for a 3-day-old new human being made in the “divine image” of the God-man, Jesus the Christ? Again, the Catechism (2270) states that level of certitude is absolute, “Human life must be respected and protected absolutely from the moment of conception...”⁶⁴ In truth, no one claims that EC never prevents implantation (i.e., never causes an early abortion). Devout Catholics, those choosing to respond to John Paul II’s call “*to be unconditionally pro-life*” and to support his call to a consistent ethical principle of life, will reject EC, with no exceptions.¹

Editor’s Note: Because of the length of the supporting appendices and references for this article, for a copy of this material the readership is referred to the author at:

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