November 1999

Birth Control Pill: Abortifacient and Contraceptive

William F. Colliton

Follow this and additional works at: <https://epublications.marquette.edu/lnq>

Recommended Citation

Colliton, William F. (1999) "Birth Control Pill: Abortifacient and Contraceptive," *The Linacre Quarterly*. Vol. 66: No. 4, Article 2.

Available at: <https://epublications.marquette.edu/lnq/vol66/iss4/2>

Birth Control Pill: Abortifacient and Contraceptive

by

William F. Colliton, Jr., M.D., FACOG

The author is Clinical Professor of Obstetrics and Gynecology at George Washington University Medical Center.

Dear sister and brother signatories of the document entitled *Birth Control Pills: Contraceptive or Abortifacient*. We love you. We recognize our own sinful natures and are not insensitive to the real difficulty of admitting that one might possibly be wrong. One of us (WFC., Jr.) was for several years convinced that labeling birth control pills as abortifacient was the work of an extremist right wing medical conspiracy. Only on entering into a serious study of the matter did he become convinced of the error of his ways. We also believe that we have a God whose love for all of us is immeasurable, unqualified, and unchanging. If you are good enough for Him, you surely must qualify for our love.

At the 1998 midwinter meeting of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), Pamela Smith, M.D., president of the organization, called for the production of a *Principles of Pro-Life Medical and Public Health Practice* manual. When doing this she said:

...it has become glaringly apparent that now is the time for us, as an organization, to sail into the dangerous and uncharted waters that we have, perhaps intentionally, avoided. These are the "waters" of pro-life principles as they relate to fertility control.

I have intentionally used the words "fertility control" rather than contraception for a number of reasons. Foremost of which is the raging moral, biological and scientific debate, almost exclusively within the pro-life community, as to whether the

mechanisms of certain fertility control measures are contraceptive or abortifacient at a microscopic level.

The undersigned wish to commend Dr. Smith for her insight and courage in bringing this issue to the attention of the Board of AAPLOG. We also desire to contribute to the debate and witness to the medical and scientific facts that demonstrate the abortifacient nature of the hormonal contraceptives. The signatories are all specialists in obstetrics and gynecology, many with sub-specialty interests. Many are or have been on the faculties of teaching institutions.

At the same midwinter meeting a draft document entitled *Birth Control Pills: Contraceptive or Abortifacient?* was circulated. While this was advertised as not a project of AAPLOG, eight of the signers were or are members of the board of directors. Near the beginning of their document, the authors state: "We begin with the recognition that within the Christian community there is a point of view which holds that artificial birth control per se is wrong. We would consider this a personal matter of conscience and belief, and this paper is not intended to argue for or against this issue." While admiring the Christian philosophy of the authors, there is another truth to be considered. There is an unarguable logic connecting the contraceptive act and the abortive act. They are both anti-life. To fully articulate this proposition, the contraceptive action is anti-the-formation of a new life. One does not pop a pill, slip on a condom, take a shot in the buttocks, etc. in preparation for a game of Chinese Checkers. The only logical reason for these actions is to prevent the formation of a new life while positing voluntary coital acts. One might employ condoms in the illusory hope of avoiding sexually transmitted diseases (STDs), but this is Russian roulette revisited with twice the risk of dying if AIDS is the object of one's concern. The greatest witness to the logic of this truth is Planned Parenthood (PP). PP has progressed from being the Western world's number one promoter and provider of contraception to being the number one provider and promoter of induced abortion.

In addition, simple logic demands that those who respect the sanctity of human life from fertilization until natural death should also respect those actions which give rise to that life. They were designed by the same Creator who infuses the soul into each and every new conceptus. As 1 Samuel 2:6 informs us: "The Lord puts to death and gives life."

Now to address the question, "Are BCPs abortifacient?" First, it is important to realize that there exists a large cohort of physicians currently leading our profession in the big lie. These doctors are writing and speaking across the whole nation, selling the idea that the BCP, the IUD,

the "morning after pills", so-called "emergency contraception", are not abortifacient. Dr. Daniel Mishell, writing in response to a question from a pregnancy aid center about the possible abortifacient nature of Depo-Provera, replied that there was no way. That agent, he stated, blocks ovulation 100% of the time. This agent is probably the most effective contraceptive available today, prevention of pregnancy ranging from 99.5 to 99.7%. When taken as advised every 3 months, approximately 50% of users cease menstruating. This indicates that they are not ovulating and are thus at no risk for pregnancy. The other half bleed irregularly and at times heavily. The question that must be answered is: How is this remarkable success rate achieved? The 0.5 to 0.3% failure rate represents pregnancies. If pregnancies occur, obviously ovulation is occurring. Might not all three mechanisms of action traditionally reported for hormonal contraceptives and noted by Dr. Mishell when, writing contemporaneously and more candidly, for medical students and physicians come into play? (*Williams Obstetrics*, 20th Edition, p. 1353, 1997). Others have researched this issue and concluded that all hormonal contraceptives have an abortifacient potential. (*Preventing Pregnancy, Protecting Health: A New Look at Contraceptive Choices in the United States*, Susan Harlap, Kathryn Kost and Jacqueline Darroch Forrest, The Alan Guttmacher Institute, 1991, pp. 17-28. *Does the Birth Control Pill Cause Abortions?* Randy Alcorn, Eternal Perspective Ministries, 2229 East Burnside #23, Gresham, OR 97080, 1998). Neither of these resources has anything to do with the Roman Catholic Church.

The fact that the hormonal contraceptives have an abortive potential is discussed in the paper circulated at AAPLOG's 1998 midwinter meeting. "Most (virtually all) literature dealing with hormonal contraception ascribes a three-fold action to these agents. 1. inhibition of ovulation, 2. inhibition of sperm transport, and 3. production of a 'hostile endometrium', which presumably prevents or disrupts implantation of the developing baby if the first two mechanisms fail. The first two mechanisms are true contraception. The third proposed mechanism, IF it in fact occurs, would be abortifacient." (editor's addition) What is the precise language appearing in the *Physician's Desk Reference* (PDR) with regard to these agents? "Ortho-Novum: ...a progestational effect on the endometrium, interfering with implantation." "Norinyl: ...alterations in ...the endometrium (which reduce the likelihood of implantation)." The authors follow with a long harangue against the drug manufacturers' use of the term "hostile endometrium." Perhaps they should be calling them to task, rather than the right-to-life community. They do accurately describe the findings in the endometrium of pill users proven in numerous scientific studies. They note that the findings indicate a "less vascular, less

glandular, thinner lining of the uterus produced by these hormones." One of the side effects listed for BCPs is amenorrhea. This means that the endometrium is thinned out completely resulting in no menstrual flow when on the break from the hormones. They then add, perhaps disingenuously, "...not one company will offer data to validate the 'hostile endometrium' presumption."

The authors are obviously not familiar with Randy Alcorn's booklet, *Does the Birth Control Pill Cause Abortions?* Randy Alcorn is a Christian minister and researcher who set out to prove that the BCPs are NOT abortifacient. (see reference on page 31, *supra*) On pages 29-30 he recalls a conversation with a representative of Ortho-McNeil.

"On March 24, 1997, I had a lengthy and enlightening talk with Richard Hill, a pharmacist who works for Ortho-McNeil's product information department. (Ortho-McNeil is one of the largest manufacturers of the Pill.) I took detailed notes.

Hill was unguarded, helpful and straightforward. He never asked me about my religious views or my beliefs about abortion. He did not couch his language to give me an answer I wanted to hear...

I asked him, "Does the Pill sometimes fail to prevent ovulation?" He said "Yes." I asked, "What happens then?" He said, "The cervical mucus slows down the sperm. And if that doesn't work, *if you end up with a fertilized egg, it won't implant and grow because of the less hospitable endometrium.*" (Emphasis in the original)

I then asked Hill if he was *certain* the pill made implantation less likely. "Oh yes," he replied. I said, "So you don't think this is just a theoretical effect of the Pill?" He said the following, which I draw directly from my extensive notes of our conversation.

"Oh, no, it's not theoretical. It's observable. We know what an endometrium looks like when it's rich and most receptive to the fertilized egg. When the woman is taking the Pill, you can clearly see the difference, based both on gross appearance - as seen with the naked eye - and under a microscope. *At the time when the endometrium would normally accept a fertilized egg, if a woman is taking the Pill it is much less likely to do to.*" (Emphasis in the original)

In addition, Randy Alcorn found a paper entitled "The Effect of Oral Contraceptive Pills on Markers of Endometrial Receptivity" (Somkuti, et al, *Fertility and Sterility*, Vol. 65, No. 3, pp. 484-488, 1996). The paper was designed to determine if oral contraceptive usage alters expression of

integrins associated with endometrial receptivity. Integrins are a family of heterodimeric cell adhesion molecules that have been implicated in a number of diverse physiological processes, including a role in fertilization and embryo implantation. The authors found that the expression of those integrins most closely associated with endometrial receptivity is altered in the glandular epithelium of women taking OCs. Stromal integrin expression in OC users also differs from that in cycling women. These alterations in epithelial and stromal integrin expression suggest that impaired uterine receptivity is one mechanism whereby OCs exert their contraceptive actions.

The authors repeatedly state that no scientific proof has appeared in the medical literature demonstrating that the pill is abortifacient. They are correct. The reason is that such proof would require collecting, fixing, staining and serially sectioning all vaginal contents from mid-cycle through menstruation and demonstrating the presence of an early embryo. No one has the time, money or motivation for such an undertaking. In addition, would such a study be morally permissible? We think not. Attempting to prove that any mechanism causes the death of an innocent human individual is an assault on the fifth commandment.

The authors next detail the attributes of the blastocyst, and in support of her or his lack of need for a favorable endometrium, state this thesis: "the blastocyst regularly and successfully implants on tubal ciliated epithelium (commonly referred to as tubal, or ectopic pregnancies)." The authors once again are possibly disingenuous or, at a minimum, unfamiliar with the literature on ectopic pregnancies. It is very important to realize the relatively high frequency and high success rate of expectant management, i.e., careful observation only for the treatment of tubal pregnancies. (Fernandez, et al, "Spontaneous Resolution of Ectopic Pregnancy," *ObstetGynecol.* 1988; 71:171, 10 more references available on request) These papers describe 193 cases with 129 successful outcomes (68.8%). Thus, when an unruptured, non-bleeding ectopic is diagnosed, when the size is small (equal to or smaller than 3.5 cm.), when the beta hCG is 1000 or less and falling, non-intervention or expectant management offers freedom from the toxicity of methotrexate and the morbidity of surgery. The issue of contraception use and the risk of ectopic pregnancy was addressed by an article in *Contraception* 1995; 52:337-341. In the body of the paper (p. 339) Mol, et al, who conducted a meta-analysis on numerous papers between the years 1978-1994 observe that: "Condom use shows no increased risk. OCs show a slightly increased risk, in contrast to IUCD use and tubal sterilization, which shows a strongly increased risk."

This suggestion from the authors about the lack of need of the blastocyst for a well-prepared endometrium came as somewhat of a

surprise. From the first year of their studies and throughout their training, medical students learn about the normal ovarian cycle and of its impact on the endometrium. Under the influence of estrogen derived from the developing follicle, the endometrium undergoes remarkable growth during the first half of the month (proliferative phase). Under the influence of the leuteinizing hormone, the follicle that has grown the most bursts, releasing the egg (ovulation). The cells lining the wall of the now-empty follicle (corpus luteum) now begin to produce another hormone, progesterone, which prepares the uterus for pregnancy. The endometrium becomes much more lush, rich in blood supply and nutrients, ready to receive a tiny girl or boy. This is the type endometrium desired by IVF practitioners to accomplish embryo transfer from the petri dish to the womb, the most difficult technological step to accomplish in that variety of artificial reproduction.

The next question raised by the authors is, "Is there actual clinical evidence of early miscarriage in pill users?" They note that the typical clinical picture of spontaneous abortion (heavy bleeding, severe cramping, passage of tissue) is rarely, if ever, seen by practicing physicians caring for patients on the pill. They seem to overlook the facts that the abortions caused by the BCP occur when the baby is 5 to 14-16 days old and that the lining of the uterus is "less vascular, less glandular, thinner" than normal as they described it. From the clinical perspective, one would anticipate a non-event, just as in over 60% of ectopic pregnancies. From the moral perspective, however, it is quite another story. What we are witnessing here is a tragic loss of God's children, totally innocent and made in His image. It is well to also remember that, from the moral perspective, the numbers don't matter. If one child is lost, the tragedy isn't lessened. Following this, the authors asked, "What is the conception rate for women on hormone contraception?" They answer correctly that it is impossible to say. However, earlier in their paper they noted, quite accurately, that the medical literature documents an incidence of 3-5 pregnancies per 100 women per year for pill users. Dr. Don Gambrell, Jr., a renowned gynecological endocrinologist addressed this issue during the educational segment of this same meeting. He noted a 14% incidence of ovulation in women taking the 50 microgram BCP. This rate varies from pill to pill and patient to patient. Simple logic informs one that every fertilization occurring in women on the pill doesn't result in a term "pill pregnancy" or a surgically induced abortion. But this is the precise thesis of those stating that the BCP is not abortifacient. Simple logic and deductive reasoning would suggest that many more than the clinically diagnosed pregnancies that occur are aborted because of the acyclic, unfavorable-for-implantation endometrium. If IVF practitioners relied on an endometrium that is "less

vascular, less glandular, thinner" than that ideal for implantation, their success rate would approach zero today rather than the tens of thousands of babies born of that technology. More on this subject when viewing the mathematics of the issue.

The signatories were distressed by the statement that "millions and millions" of preborn sisters and brothers have been and will be lost to these hormonal agents which obviously can be abortifacient. Let's look at the math. Women on BCPs have 28-day cycles and thus have 13 cycles per year ($365/28 = 13.3$). According to *Facts in Brief* from the Alan Guttmacher Institute (faxed 3/13/98), 10,410,000 U.S. women are current pill users, 26.9% of all methods. This is second only to sterilization used by 27.7% of contraceptors. This would appear to be another sign of their anti-life nature. Dr. Don Gambrell has informed us that there is a 14% breakthrough ovulation rate in females taking the 50 microgram pills ($10,410,000 \times 0.14 = 1,457,400$ ovulations each cycle). $1,457,000 \times 13$ cycles per year = 18,946,200 possible exposures to pregnancy each year. The accepted rate for "pill pregnancies" is 3-5 per 100 women years. Noting the fact that there is a 60+% rate of spontaneous tubal abortions with an unfavorable implantation site in ectopic pregnancies, it is reasonable for us to calculate a rate of conceptions lost to early physician (BCP) induced abortion of intrauterine pregnancies in pill users as twice that of term "pill pregnancies", given once again, an endometrium that is "less vascular, less glandular, thinner" than normal. Thus the possible abortion rate induced by BCPs is $18,946,200 \times 0.06 = 1,136,772$ or $18,946,200 \times 0.1 = 1,894,620$ per year. We are convinced that the reasoning with regard to the math on this issue is sound.

Dr. Murphy Goodwin was asked to review this reasoning and math. He wrote (personal communication, 4/23/98): "It is possible that there are more than a million such losses per year but a reasonable calculation could also put the loss rate at one tenth of that number." He added: "1) I believe that it is most likely that the total number excess fetal losses (abortions) due to the combined pill is in the range of several hundred thousand, substantially less than the number of elective abortions annually and 2) the fact that this is not the intended effect of the pill in most cases and the effect in any one circumstance is unknowable makes the ethical issues much more complex than those surrounding elective abortion. The educational and political challenge of elective abortion is much more straightforward and is a necessary prerequisite of undertaking the more complex moral issue of the abortifacient effect of the pill." These sound thoughts deserve the prayerful reflection of all right-to-lifers. Using a normal fecundity rate of 20% and other scientifically sound variables, Dr. Goodwin arrived at pill-induced abortions totals between 104,100 per year

and 1,561,500 per year. Curiously his high number is approximately half-way between our two calculations. His low number is not insignificant. We must also remember that with RU-486 and methotrexate waiting in the wings or available today, chemical and hormonal killing of the preborn may one day make surgical abortion look pale in the shade. We should also recall that 10-15% represent conservative estimates of spontaneous early abortions in normally cycling females desirous of pregnancy and favored with a delicately balanced reproductive cycle designed by God. To state or feel that BCP-consuming females experience a 0% rate of physician-induced abortion (from the pill) is wishful thinking of the highest order.

Mother Teresa (Lord, rest her) addressed the National Prayer Breakfast in 1994. At one point she stated: "But I feel the greatest destroyer of peace today is abortion, because Jesus said, 'If you receive a little child, you receive Me.' So every abortion is the denial of receiving Jesus, the neglect of receiving Jesus."

Peggy Noonan reported in *Crisis*, Feb. 1998, pp. 12-17, the following:

Well, silence. Cool deep silence in the cool round cavern for just about 1.3 seconds. And then applause started on the right hand side of the room, and spread, and deepened, and now the room was swept with people applauding. And they would not stop for what I believe was five or six minutes. As they clapped they began to stand, in another wave from right of the room to the center and the left.

Now adds Noonan:

Now, Mother Teresa is not perhaps schooled in the ways of world capitals and perhaps did not know that having said her piece and won the moment she was supposed to go back to the airier, less dramatic assertions on which we all agree.

Instead, she said this: "[Abortion] is really a war against the child, and I hate the killing of the innocent child, murder by the mother herself. And if we accept that the mother can kill even her own child, how can we tell other people not to kill one another? How do we persuade a woman not to have an abortion? As always, we must persuade her with love... The father of that child, however, must also give until it hurts. By abortion, the mother does not learn how to live, but kills even her own child to solve her problem. And by abortion, the father is taught that he does not have to take any responsibility at all for the child he has brought into the world. So that father is likely to put other women into the same trouble. So abortion just leads to more abortion.

"Any country that accepts abortion is not teaching its people to love one another but to use any violence to get what they want. This is why the greatest destroyer of love and peace is abortion." (more applause) Mother Teresa continued. "I know that couples have to plan their family, and for that there is natural family planning. The way to plan the family is natural family planning, not contraception. In destroying the power of giving life or loving through contraception, a husband or wife is doing something to self. This turns the attention to self, and so it destroys the gift of love in him and her. In loving, the husband and wife turn the attention to each other, as happens in natural family planning, and not to self, as happens in contraception. Once that loving is destroyed by contraception, abortion follows very easily. That is why I never give a child to a family that has used contraception, because if the mother has destroyed the power of loving, how will she love my child?"

Now preparing to conclude, the undersigned wish to express their gratitude to Chris Kahlenborn, M.D., a young internist from Kettering, OH. Dr. Kahlenborn is currently on sabbatical and writing a book entitled *Understanding the Link Between Abortion, Breast Cancer and the Pill*. One of his references clearly indicates that even the pro-abortionists recognize that the Pill is abortifacient. The *New York Times* of Thursday, April 27, 1989 carried a transcript of the oral arguments in the Supreme Court case of *Webster v. Reproductive Health Services*. On pB13 the following dialogue between Frank Susman, lawyer for the Missouri abortion clinics and Justice Scalia appears:

Mr. Susman ...For better or worse, there no longer exists any bright line between the fundamental right that was established in *Griswold* and the fundamental right of abortion that was established in *Roe*. These two rights, because of advances in medicine and science, now overlap. They coalesce and merge and they are not distinct.

Justice Scalia Excuse me, you find it hard to draw a line between those two but easy to draw a line between (the) first, second and third trimester.

Mr. Susman I do not find it difficult -

Justice Scalia I don't see why a court that can draw that line can't separate abortion from birth control quite readily.

Mr. Susman If I may suggest the reasons in response to your question, Justice Scalia. The most common forms of what we most generally in common parlance call contraception today, IUD's, low-dose birth control pills, which are the safest type of

birth control pills available, act as abortifacients. They are correctly labeled as both.

Under this statute, which defines fertilization as the point of beginning, those forms of contraception are also abortifacients. Science and medicine refer(s) to them as both. We are not still dealing with the common barrier methods of Griswold. We are no longer just talking about condoms and diaphragms.

Things have changed. The bright line, if there ever was one, has now been extinguished. That's why I suggest to this Court that we need to deal with one right, the right to procreate. We are no longer talking about two rights.

The undersigned believe that the facts as detailed in this document indicate the abortifacient nature of hormonal contraception. This is supported by the scientific work of the Alan Guttmacher Institute which can, in no way, be confused with a right-to-life organization. We also want to make it clear that we have no desire to cause confusion and division among pro-life forces. However, we do want to make it clear that we do desire that all women using the Pill are truthfully and fully informed about all its modes of action.

Marie A. Anderson, M.D., FACOG
Tepeyac Family Center
Fairfax, VA 22033

Paddy Jim Baggot, M.D.
Geneticist, Perinatologist
Pope Paul VI Institute, Omaha, NE

Thomas L. Bodensteiner, M.D.,
FACOG
Beatrice, NE

John J. Brennan, M.D., FACOG
Associate Clinical Professor of
Obstetrics and Gynecology
Medical College of Wisconsin

John T. Bruchalski, M.D.
Diplomate,
American Board of
Obstetrics and Gynecology
Medical Director,
Tepeyac Family Center, Fairfax, VA

William F. Colliton, Jr., M.D.
Clinical Professor of Obstetrics and
Gynecology
George Washington University
Medical Center

Lorna L. Cvetkovich, M.D., FACOG
Wichita, Kansas

Charles H. Dahm, M.D., FACOG
St. Louis, MO

Michael B. Dixon, M.D., FACOG,
Dip. ABFP
St. Louis, MO

Hans E. Geisler, M.D., FACOG,
FACS
Director of Division of Gynecologic
Oncology
St. Vincent Hospital and Health
Centers
Clinical Professor of Obstetrics and

Gynecology
Indiana University Medical Center

Kim Anthony Hardey, M.D.
Diplomate
American Board of Obstetrics and
Gynecology
Lafayette, LA 70503

David R. Harnisch, Sr., M.D.,
F.A.A.F.P., J.F.A.C.O.G.
Beavercreek, OH

John F. Heffron, M.D., FACOG
Assistant Professor, Department of
Obstetrics and Gynecology
Creighton University School of
Medicine

Steve Hickner, M.D., FACOG
Assistant Professor, Department of
Obstetrics and Gynecology
Michigan State School of Medicine

Thomas W. Hilgers, M.D.
Senior Medical Consultant, Pope
Paul VI Institute
Associate Clinical Professor of
Obstetrics and Gynecology
Creighton University School of
Medicine

William J. Hogan, M.D., FACOG
Rockville, MD

Helen T. Jackson, M.D., FACOG
Brookline, MA

James Linn, M.D.
Associate Clinical Professor,
Obstetrics and Gynecology
Medical College of Wisconsin

John C. Linn, M.D., FACOG
Milwaukee, WI

Julie Mickelson, M.D., Jr. FACOG
Board Member, AAPLOG

Bernard N. Nathanson, M.D.,
FACOG
Perinatologist, New York, NY

James O'Connor, M.D.
Diplomate, ABOG
Manager, Ernst and Young Health
Care Consulting

Konald A. Prem, M.D., FACOG
Professor Emeritus, Department of
Obstetrics and Gynecology
University of Minnesota Medical
School

Gary W. Smith, M.D., FACOG
Medical Director, Women's Health
at Robin Wood

Mark Stegman, M.D., FACOG
St. Louis, MO

Arthur J. Stehly, M.D., FACOG
Escondido, CA