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Clearing Rhetorical Minefields

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Introduction

Progress towards understanding the importance of freedom of conscience for health care workers is not infrequently hindered by rhetorical minefields, conveniently illustrated by the titles of two publications: "Infant Homicides Through Contraception," a booklet written by pharmacist Bogomir Kuhar,[1] and "Contraception Can Save Lives in Humanitarian Emergencies"from the United Nations Population Fund.[2]

What follows is an attempt to clarify some of the points of dispute and identify key issues. It introduces the term "embryocide" and specifies the meaning of "abortifacient" and "contraceptive" based upon what is common to parties who hold contrary views about abortion and contraception.

Abortifacients

Until 1965 it was agreed that pregnancy began at conception, and that conception was the union of sperm and egg: fertilization. Pregnancy could be prevented by a contraceptive: a device or drug that prevented conception - the union of sperm and egg. Condoms, diaphragms and cervical caps acted as contraceptives by imposing a physical barrier to prevent fertilization. Birth control pills that suppress ovulation act as contraceptives because fertilization cannot occur in the absence of an egg.

However, in 1965 the American College of Obstetricians and Gynecologists introduced new definitions of both conception and pregnancy. "Conception" was redefined by the ACOG to mean implantation of the early embryo in the lining of the uterus and identified implantation as the beginning of pregnancy.[3] So, from that point, while the ACOG has continued to assert that "pregnancy begins at conception," its meaning is, in fact, that pregnancy begins at implantation. Rather than a "moment," it began to be argued, conception should be seen as a "process," beginning with fertilization and ending, several days later, with implantation, when, according to ACOG usage, pregnancy begins.[4]

This change in terminology has not been universally accepted. In fact, over 60% of 1800 American obstetrician-gynaecologists surveyed in 2011 hold that pregnancy begins with fertilization.[5] However, there is no dispute that the early embryo will implant in the lining of the uterus six to twelve days after fertilization,[6] and that disrupting a pregnancy after this point is an abortion. The Project restricts the use of the term "abortifacient" to products that may have this effect.

Health care workers who object to abortion for reasons of conscience will also object to the use of abortifacients, drugs like RU486, marketed under names like mifepristone and mifeprex, and used in conjunction with misoprostol. These products are meant to induce ‘medical abortions.’ If they fail to achieve this outcome, the patient is expected to have a surgical abortion because of the risk of fetal deformity.

While mifepristone is officially intended to be used within 50 days of implantation,[7] the literature indicates that it is being used for medical abortions up to 23 weeks gestation.[8] Again, product information states that a patient must visit the physician’s office three times during the treatment, which seems to presume that the successive doses of mifepristone and misoprostol will be administered by the same physician.[9] In fact, the use of abortifacient drugs in a two-part treatment sequence frequently involves a wider range of health care professionals, such as pharmacists, nurses and other non-physician health care workers.

Women given mifepristone by a physician (or nurse or other health care worker) may be sent home with misoprostol, which they self-administer two days later. After bleeding starts they may present at a hospital with an incomplete abortion, expecting the attending physician to complete the abortion begun by someone else.

If the fetus is dead, to assist the patient raises no ethical problem for conscientious objectors, though evacuating the uterus may be distressing. A much more serious situation arises when the fetus is still alive, especially if the gestational age is nearer 23 weeks than 50 days. This is a classic example of rising expectation colliding with reality, and it has been a problem for some time in South Africa. A survey conducted of Western Cape physicians found that almost half of them would not continue the abortion at this point:

> This is of course often in direct conflict with what the woman wishes and can precipitate heated exchanges leaving both the woman and doctor on call frustrated and emotional. Given that the reason for the terminations is often socio-economic (a reason for which most doctors would not do TOP’s), these women present problems of conscience for many doctors.[10]

Contraceptives

A definition of contraceptive as “that which prevents pregnancy” caused no problems while pregnancy was acknowledged to begin at conception, and conception was understood to mean fertilization. We have seen that the American College of Obstetricians and Gynecologists introduced new definitions of conception and pregnancy in 1965, so that conception, in the new usage, was extended to include the entire period beginning with fertilization and ending with implantation six to twelve days later.

If one thus expands the definition of conception, one also expands the definition of contraceptive, from a product that prevents the union of sperm and egg (fertilization) to a product that prevents either fertilization *or* implantation. Changing definitions in this way does not affect the underlying biological realities, but it can significantly complicate discussion of the ethical issues involved (see below: *Embryocides*).

For the purposes of addressing the freedom of conscience issues that have arisen in this context, the

Project bases its position on what is not in dispute. The union of sperm and egg forms a zygote, a unicellular human embryo.[11] Preserving the customary and embryologically correct terminology, we refer to this event as fertilization or conception, and confine the use of the term "contraception" to mean the prevention of fertilization.

Some practitioners may decline to prescribe or dispense contraceptives to people who are unmarried, on the grounds that to do so would implicate them as parties to wrongful conduct. Others, adhering to Catholic doctrine, or who happen to have similar beliefs, will facilitate contraception only in cases of rape.[12] Articulating the reasons for conscientious objection to contraception faces some significant obstacles.

First: contraception is not, in the popular mind, associated with causing the death of a human embryo or fetus, and so is not seen as raising any significant moral issue. Second: contraception is widely practised all over the world, and people have become accustomed to thinking of it not only as morally acceptable, but praiseworthy. In fact, young people are drilled with the notion that the failure to use contraceptives is stupid and irresponsible, so that mothers of large families in Canada, for example, are frequently subjected by complete strangers to snide comments and condescending or disgusted looks. Third: the role of health care workers in contraception is often indirect. They provide contraceptive counselling and the drugs or devices, but the actual use of the products is usually in the hands of the patient. Finally, if one assumes that the attitudes of the general population are mirrored in the health care community, one must assume that many health care workers are practising contraception.

Without doubt, then, conscientious objectors to contraception form a minority within the health care professions, and it is probably true that it is a much smaller minority than minorities opposed to abortion. This does not, however, create a new situation. Conscientious objectors will always be in a minority position, and to deny them freedom on that basis would emasculate the very concept of freedom of conscience.

Embryocides

Some products may *either* prevent fertilization (thus preventing an embryo from coming into existence), or prevent implantation (which causes the death of an existing embryo). One cannot be morally certain, in advance, which of these mechanisms of action will be in play at any given time, even if one is more probable than the other.[13] Those who have adopted the 1965 ACOG terminology usually refer to these products as contraceptives.

Nonetheless, to prevent an embryo from coming into existence is one thing; to cause the death of an *existing* embryo by preventing implantation quite another. It is more akin to abortion, in that it causes the death of an embryo or fetus. The use of the term 'abortifacient' in this context can be supported,[14] and the term continues to be used in this sense by many who object to causing the death of an embryo. However, the description of these products as abortifacients is highly controversial because of widespread use of the 1965 ACOG definitions of conception, pregnancy and contraception.

This controversy makes it extremely difficult to discuss the exercise of freedom of conscience in health care in relation to products that may cause the death of an embryo. The Project originally described these as *potentially* abortifacient, an expression that was meant to capture the uncertainty that existed with respect to the method of action, as well as the morally significant possibility of doing greater harm by causing death. However, even this approach was unsatisfactory.

Once more attempting to resolve the problem of terminology by reference to what is not in dispute, the Project adopted the term *potential embryocide* to describe products that, like the IUD, may cause the death of an embryo *before* implantation.[15] However, it was later noted that drugs or devices are marketed as contraceptives - not *potential* contraceptives - even though it is acknowledged that there may be some doubt about the mechanism of action.

For the sake of simplicity and consistency, then, the Project describes products that may cause the death of an embryo before implantation as *embryocides*, though it is frequently desirable to acknowledge that a product may act either as a contraceptive or embryocide. This maintains a clear distinction between such products and abortifacients (which, it is universally admitted, act *after* implantation), while keeping attention on one of the issues that is of concern to conscientious objectors: the possibility of causing the death of a human embryo.

Post-coital interceptives

"Emergency contraception"is the preferred marketing term for drugs and devices (the IUD) used as post-coital interceptives, but the term is contentious. Many object to the notion that the possibility of pregnancy is a medical emergency. Moreover, proponents of these drugs and devices and those who object to them, citing various professionally acceptable sources - and sometimes the same sources - agree that they may sometimes have an embryocidal effect, the probability of this in a given case being a matter of conjecture.[16] 'Morning after pill' is less contentious, as well as popular. However, it is misleading, since there is more than one such drug, and they may be effective up to 120 hours after intercourse.[17]

Since "post-coital interceptive" is unwieldly in popular communication and "emergency contraception" a loaded and contentious term, the Project continues to use "morning-after pill" as a generic term for birth control drugs used after intercourse.

Birth control pills

There is a growing awareness that some birth control pills may also have an embryocidal effect.[18] This is causing more health care workers to question their involvement in prescribing or dispensing them, and there is increasing acknowledgement that the principle of informed consent requires that the potentially embryocidal nature of a product be brought to a patient's attention.[19]

Questions about the potentially embryocidal effect of the morning after pill or birth control pills must begin with an evaluation of scientific claims. The evidence on this point is somewhat unstable, and those for whom such evidence is important must keep abreast of current research on the subject.[20] However, disagreement, when it arises, is not usually about scientific findings, but about the correct moral or ethical response to them. Typically, the central issue is whether or not the probability of causing the death of an embryo is morally significant. Such questions cannot be resolved by appeals to science because they are not scientific questions.

Discourse between disciplines

Even when there is no dispute about a mechanism of action, scientists and moralists may use key terms in different ways because of a legitimate difference in usage their respective disciplines. This point is often overlooked and can contribute to serious misunderstandings.

Dr. Hanna Klaus, an obstetrician/gynecologist, warned a group of Catholic physicians that discussion of the possibility of an abortifacient [i.e., embryocidal] effect of ordinary birth control pills must be undertaken with special attention to terminology. She noted that ovulation occurred in one third of the cycles of women in a Swedish study of triphasic oral contraceptives, but added that the effect of even a low dose of progestin (10 micrograms) would make cervical mucus impenetrable to sperm. Thus she believed that there is a "remote possibility" that an oral contraceptive can act as an abortifacient [embryocide], but cautioned that it is incorrect to say the pill is an abortifacient [embryocide] *medically*," though "you can say that *morally* because if there is even a remote possibility, you have an obligation not to try it"(emphasis added). She illustrated this point with a familiar example:

> . . . two hunters go out, separate, there's a movement in the bush . . . one doesn't know if . . . the movement is due to a buck or to his fellow hunter. Is he allowed to try to fire? The answer would be "no". Is it likely the other hunter is there? Well, I don't know. But can you take a chance?[21]

Speaking to a mixed audience of laymen and physicians, she made the same point:

> I've heard a number of people state flatly that the pill is an abortifacient [embryocide]. *That has to be heard within the context of moral theology.* If something has even a remote possibility of acting as an abortifacient [embryocide], you may call it that. But if you say that to a doctor they think you're crazy. Or hysterical. That you're overdue. And I think that the doctors in the room will agree with me . . . [i]f you want to maintain credibility you have to have not only qualitative but quantitative thinking and vocabulary. If you explain that if there is even a 1% possibility that this may cause an abortion, this is your intention, then say so. But don't be surprised if the medical group comes back and says, "Well, but 99% of the time it doesn't, and any time we get a p-value of p.05 we think we've got certainty, which means 95 times out of a 100."
>
> . . . I hold no brief for abortion, but we've got to keep our language straight. (Emphasis added)[22]

Summing up

To minimize controversies that complicate discussion of freedom of conscience in health care, the Protection of Conscience Project uses terminology based upon what is not disputed even by those who hold radically different moral positions.

- There is no dispute that the union of sperm and egg forms a zygote, a unicellular human embryo.
    - We refer to this event as fertilization or conception, and confine the use of the term

"contraception" to mean the prevention of fertilization.

- It is agreed by all parties that the early embryo will implant in the lining of the uterus six to twelve days after fertilization, and that preventing implantation will cause the death of the embryo.
  - The Project uses the term *embryocide* to describe products that may cause the death of an embryo *before* implantation.
- It is common ground that causing the death of an embryo or fetus by disrupting a pregnancy *after* implantation is an abortion.
  - We restrict the use of the term "abortifacient" to products that may have this effect.

A product may have more than one mechanism of action, and that it may not be clear which is operative in a given case.

Notes:

1. American Life League's Pro-life Store, (http://americanlifeleague.stores.yahoo.net/inhomthrougc.html) Accessed 2009-03-10

2. UNFPA, 20 May, 2008 (Shannon Egan) (http://www.unfpa.org/news/news.cfm?ID=1129) Accessed 2009-03-10

3. ACOG Terminology Bulletin, *Terms Used in Reference to the Fetus*, Chicago, American College of Obstetrics ad Gynecology, No. 1, September 1965

4. Gold, Rachel Benson, "The Implications of Defining When a Woman is Pregnant." *The Guttmacher Report on Public Policy*, May, 2005, Vol. 8, No. 2. (http://www.guttmacher.org/pubs/tgr/08/2/gr080207.html) Accessed 2009-03-10

5. Chung GS, Lawrence RE, Rasinski KA, et al. Obstetrician-gynecologists' beliefs about when pregnancy begins. Am J Obstet Gynecol 2011;206 (http://www.ajog.org/article/S0002-9378(11)02223-X/abstract) Accessed 2012-02-13

6. Wilcox AJ, Baird DD, Weinberg CR. Time of implantation of the conceptus and loss of pregnancy. N Engl J Med. 1999;340:1796] 9 (http://www.ncbi.nlm.nih.gov/pubmed/10362823?dopt=Abstract) Accessed 2012-02-23

7. Drugs.com, Mifepristone (Systemic). (http://www.drugs.com/xq/cfm/pageID_0/htm_50027/type_cons/bn_Mifepristone/micr_medex/qx/index.html) Accessed 2005-08-26

8. Ojidu Sangeeta, D, Sabhwarwal, J, Setting up a one-stop mifepristone misoprostol medical termination of pregnancy service for all gestations from 5 to 23 weeks: a review of 482 cases. Obstet Gynaecol. 2001; 21(4): 386-388. A search of the PubMed database disclosed other studies of medical abortion between 5-14 weeks, 9-14 weeks, 13-20 weeks and 13-22 weeks.

9. Drugs.com, Mifepristone (Systemic). (http://www.drugs.com/xq/cfm/pageID_0/htm_50027/type_cons/bn_Mifepristone/micr_medex/qx/index.html) Accessed 2005-08-26.

10. Ward, Harvey, *Are State Doctors in the Western Cape willing to implement the Choice of Termination of Pregnancy Act of 1996? An opinion survey conducted in the Western Cape in November 1997*, p. 12 (In fulfillment for the requirements of the FCOG (S.A.) part 2). (http://www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion15.html)

11. Keith L. Moore and T.V.N. Persaud, *The Developing Human* (Philadelphia: W.B. Saunders Company, 1998), p. 2

12. The Catholic Church holds that it is permissible to intervene in such cases to prevent fertilization (ie, to use a contraceptive to accomplish this) - but nothing must be done to endanger the life of an embryo if conception has occurred. *Catholic Health Association Supports Medically Appropriate, Morally Acceptable Care for Sexual Assault Victims*. News release, 21 March, 2002. (http://www.consciencelaws.org/Conscience-Archive/News-Releases/News-Releases-2002-01-to-03.html#CHA)

13. ". . .the primary contraceptive effect of all the non-barrier methods, including emergency use of contraceptive pills, is to prevent ovulation and/or fertilization. Additional contraceptive actions for all of these also may affect the process beyond fertilization but prior to pregnancy. For some methods these actions may be significant in contributing to their overall contraceptive efficacy." American College of Obstetricians and Gynecologists, Equity Toolkit (2012) (http://www.acog.org/About_ACOG/ACOG_Departments/State_Legislative_Activities/Equity_Toolkit) Accessed 2012-02-26. From ACOG *Statement on Contraceptive Methods* (July, 1998).

14. Keith L. Moore and T.V.N. Persaud, *The Developing Human* (Philadelphia: W.B. Saunders Company, 1998), p. 45, 58, 59, 532

15. "There are many varied mechanisms whereby IUDs exert their antifertility actions. Most of these mechanisms act simultaneously to achieve the desired effect. The following two sections present the principal contraceptive actions."

"Inflammatory reaction to foreign body. . . denatures endometrial enzymes, interferes with implantation of blastocysts and modifies endometrial metabolism of glycogen. Copper bearing IUDs. . . inflammatory response: qualitatively the same as with non-medicated IUDs. . . interferes with glycogen metabolism by endometrial cells; interferes with uptake of estrogen by endometrial cells; modifies content of DNA in endometrium. Progestin bearing IUDs: suppresses endometrium, impairs implantation of blastocysts."
Connell, EF, Tatum, HJ, *Women's Reproductive Health Care*. Shaw, E. (Ed.) London, Ont.: Creative Infomatics, 1992, p. 94-95

"Combination oral contraceptives act by suppression of gonadotrophins. Although the primary mechanism of this action is inhibition of ovulation, other alterations include changes in the cervical mucus (which increases the difficulty of sperm entry into the uterus) and the endometrium (which reduces the likelihood of implantation)." PDR Drug Information for Ortho Tri-Cyclen Lo Tablets. (http://www.drugs.com/pdr/ortho_tri_cyclen_lo_tablets.html) Accessed 2005-08-23. The same statement appears in PDR Drug Information for the Ortho Evra Transdermal System ("the Patch") (http://www.drugs.com/pdr/ortho_evra_transdermal_system.html) Accessed 2005-08-23.

16. "In summary, the primary contraceptive effect of all the non-barrier methods, including emergency use of contraceptive pills, is to prevent ovulation and/or fertilization. Additional contraceptive actions for all of these also may affect the process beyond fertilization but prior to pregnancy. For some methods these actions may be significant in contributing to their overall contraceptive efficacy." American College of Obstetricians and Gynecologists, Equity Toolkit (2012) (http://www.acog.org/About_ACOG/ACOG_Departments/State_Legislative_Activities/Equity_Toolkit) Accessed 2012-02-26. From ACOG *Statement on Contraceptive Methods* (July, 1998).

17. Trussel J. Raymond EG. *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* (http://ec.princeton.edu/questions/ec-review.pdf) Accessed 2012-02-23

18. "Oral contraceptives (the "Pill") containing estrogen and progestin are highly effective in preventing ovulation, which is considered their primary mechanism of action. In addition, Pill hormones also result in thick cervical mucus that interferes with sperm transport and may have an effect on fluids in the uterus and Fallopian tubes and on transport for sperm and egg in the Fallopian tube. These hormones may also affect sperm final maturation and readiness of the uterine lining for implantation." American College of Obstetricians and Gynecologists, Equity Toolkit (2012) (http://www.acog.org/About_ACOG/ACOG_Departments/State_Legislative_Activities/Equity_Toolkit) Accessed 2012-02-26. From ACOG *Statement on Contraceptive Methods* (July, 1998).

19. Spinnato, JA. Informed consent and the re-defining of conception: a decision ill-conceived? J. Matern Fetal Med. 1998 Nov-Dec; 7 (6): 264-8. The commentary in an ethics scenario posted by the American Medical Association offers the following advice: ". . .patients in general . . . may have no knowledge that Plan B® might in some instances act as an abortifacient. Then too, a physician should be consistent in his or her conscientious objection. To be ethically and morally consistent, a physician who objects to the use of post-coital steroids on the grounds that their effect in some cases may be to prevent implantation of the fertilized ovum should also object to the use of other forms of steroid contraception (eg, birth control pills) that affect the endometrium in ways that can prevent implantation." Watson A. Bowes, Jr., in *Clinical case: reproductive rights*. AMA (Medical Ethics) (http://www.ama-assn.org/ama/pub/category/12783.html) Accessed 2006-06-28.

20. Trussel, James, *Mechanism of Action of Emergency Contraceptive Pills*. Editorial, Contraception 74 (2006) 87-89 (http://ec.princeton.edu/references/Mechanism_of_action_Contraception2006.pdf) Accessed 2009-03-10. The problem is further complicated by the use of different drugs for post-coital interception. Contrast the findings in Novikova N, Weisberg E, Stanczyk FZ, Croxatto HB, Fraser IS, *Effectiveness of levonorgestrel emergency contraception given before or after ovulation--a pilot study*. Contraception. 2007 Feb;75(2):112-8. Epub 2006 Oct 27, with Gao X, Wu E, Chen G., *Mechanism of emergency contraception with gestrinone: a preliminary investigation.* Contraception. 2007 Sep;76(3):221-7. Epub 2007 Jul 26

21. Klaus, Hanna, "The Medical Case Against Contraception." *Address to the Catholic Physicians' Guild*, Vancouver, 1993. Audiotape by St. Joseph Communications Canada.

22. Klaus, Hanna, "An Obstetrician Looks at *Humanae Vitae*." Address to conference *On the Role of the Christian Family in the Transmission of Life,* Vancouver, 1993. Audiotape by St. Joseph Communications Canada.