

## Emergency Contraception: What's Happening?

State legislatures continue to take up the issue of requiring all the hospitals in their state to provide emergency contraception (EC) to women who have been sexually assaulted. California, Massachusetts, New York, New Jersey, New Mexico, Minnesota and Washington have already passed such legislation. Most recently (May 30, 2007), the Connecticut and Oregon legislatures also passed such a bill. Florida, Pennsylvania and Wisconsin legislatures are considering similar legislation.

State Catholic conferences have differed in their approaches to this type of legislation. In some states, such as Connecticut and Pennsylvania, the bishops have strongly opposed the legislation, believing emergency contraception (Plan B) to be abortifacient and the requirement of its use to be a violation of religious freedom. Several state Catholic conferences have pursued conscience clause protection, but to no avail. In other states, the bishops have either not opposed the legislation or have taken a more conciliatory approach. The Wisconsin Catholic Conference, for example, has remained neutral on the matter, and the New York Catholic Conference worked with their legislature several years ago to develop legislation that they could live with.

As noted above, the two issues for Catholic conferences and for Catholic health care are 1) whether the medications are abortifacient and 2) the inclusion of conscience clauses so that Catholic hospitals are able to deliver health care in a manner that is consistent with their religious convictions. Conscience clause provisions would seem

to be important whether or not these particular medications are abortifacient.

But are the medications abortifacient? After doing a review in 2004 of most of the literature on the mechanism of action of EC, CHA staff came to the conclusion that “at this time, scientific studies on the mechanism(s) of action of EC are not conclusive. While there is substantial evidence of the anovulant effect of EC, there is no definitive evidence of its other possible mechanisms of action, including possible abortifacient effects (i.e., making the endometrium inhospitable to implantation).”\*

CHA recently concluded an update of its literature review with a particular focus on the mechanism of action of levonorgestrel (Plan B). Of the nine articles describing “original research,” only one strongly suggested a possible abortifacient effect, but the researchers who wrote that article employed a “simulation model” rather than physical examination of endometrial tissue. The other research studies were either inconclusive about post-ovulatory effects or found none or none sufficient to prevent implantation. One 2007 study concludes this way: “A larger study is needed to prove our hypothesis that LNG [levonorgestrel] ECP has a major contraceptive effect when taken prior to but not after ovulation and that it does not interfere with postfertilization events” (Novikova, N., et al., “Effectiveness of levonorgestrel emergency contraception given before or after ovulation—a pilot study,” *Contraception* 75 (2007): 117).

\* Excerpted from CHA's preface to the summary of the literature. CHA members can view the summaries of the literature on the mechanism of action of Plan B by visiting [www.chausa.org/planb](http://www.chausa.org/planb).

Two studies with animals (one with rats in 2003 and the other with Cebus monkeys in 2004) found no interference with implantation. Hence, while it seems to be the case that EC medications have several mechanisms of action, there is no definitive evidence, and, in many research studies, no evidence at all, of any effect on the endometrium such as to render the endometrium inhospitable to implantation of a fertilized egg.

Despite the continued scientific uncertainty about the mechanism of action of EC, there seems to be a move in the direction of not permitting the administration of EC in Catholic hospitals if the woman is at or around the time of ovulation, when conception could possibly occur, and of claiming, without any qualification, that EC is abortifacient.

## Dying in America, Post Schiavo

Over the past 30 or so years, a “fragile consensus” has been forged in the United States regarding end-of-life decision making. This has been due to multiple factors, including court cases, the developing field of bioethics, the literature on the subject, conferences and lectures, people's experiences, the growth of hospice and palliative care, and much more. The consensus consisted in agreements on three principle issues. The first is a belief that there are limits to the use of medical technology at the end of life and that the limits can be discerned through an assessment of the benefits and burdens of the treatment upon the patient. The second is general (though surely not universal) agreement that there is a difference between killing (euthanasia and assisted-suicide) and allowing to die (forgoing or

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withholding life-sustaining treatment). And the third is the conviction that patients (or their surrogates) have the moral and legal right to make treatment decisions in light of their own values, resources, lifestyle, etc.

This fragile consensus may well be eroding, especially post Schiavo. Why is this the case? On one hand, there are those who wish to see the legalization of physician assisted suicide (PAS) and/or euthanasia. While only Oregon permits PAS, several states have considered legislation that would permit it, California being the most recent. It is probably only a matter of time before more states follow Oregon's lead. Legalization of PAS and/or euthanasia absolutizes autonomy and banishes the distinction between killing and allowing to die. It also makes an assessment of benefits and burdens unnecessary.

On the other hand, there is increasing evidence from a number of sources of a "tightening" around end-of-life decisions. Of course, there is the Schiavo case and all that was said and written about that. Then there is the papal allocution of March 2004 and the

controversy that followed. Since these two significant events, there have been several bishops who have made public statements about end-of-life care, several state Catholic conferences that have either issued pastorals on the topic or revised advance directive forms, state legislatures that are revisiting advance directive legislation or, in the case of Texas, revisiting their "futile treatment" legislation, and several groups proposing legislation with regard to withdrawing nutrition and hydration from patients without expressed wishes.

There seem to be recurring themes in some, but certainly not all, of these developments, namely:

- Considering artificial nutrition and hydration to be basic care and generally morally required for all dying patients, not just patients in a permanent vegetative state.

- Restricting the withdrawal of life-sustaining treatment to the time when the patient is imminently and irreversibly dying.

- Narrowing the understanding of benefit to the treatment achieving its physiological or biological purpose.

- Not permitting the withdrawal of artificial nutrition and hydration from patients who cannot speak for themselves and who do not have expressed wishes regarding such withdrawal.

- Considering the refusal of artificial nutrition and hydration in an advance directive to be morally unacceptable.

- Reframing advance directives so that they are no longer an attempt to limit treatment, but are, rather, requests for life-sustaining treatment, except in a narrow range of circumstances.

If these directions take hold, it is quite likely that the fragile consensus will collapse, for they begin to erode the traditional understanding and practice of ordinary/extraordinary means and when it is morally permissible to forgo or withdraw treatment. They could even have the effect of diminishing patient autonomy. Some would say that in response to efforts to legalize PAS and euthanasia, these developments move in the direction of vitalism. In any case, they could well have a significant impact on the way that Catholic health care currently cares for the dying in its midst.