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Via Electronic Submission

Ms. Susan B. Moskosky, MS, WHNP-BC
Acting Director
Office of Population Affairs
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Re: Notice of Proposed Rulemaking
Compliance With Title X Requirements by Project Recipients in Selecting Subrecipients
81 Fed. Reg. 61,639 (Sept. 7, 2016)

Dear Office of Population Affairs:

On behalf of Eagle Forum Education & Legal Defense Fund ("EFELDF"), this responds to the above-captioned notice of proposed rulemaking ("NPRM") in which the Department of Health & Human Services ("HHS") proposed to amend 42 C.F.R. §59.3 by adding subsection (b) to provide that "No recipient making subawards for the provision of services as part of its Title X project may prohibit an entity from participating for reasons unrelated to its ability to provide services effectively."

BACKGROUND

Title X of the Public Health Services Act provides federal subsidies for family-planning services to low income individuals. Family Planning Services & Population Research Act of 1970, Pub. L. 91-572, 84 Stat. 1504 (1970). As with all Spending-Clause legislation, participation is voluntary, but participating entities agree to comply with Title X's requirements.

HHS can terminate or curtail Title X funding – which is Title X's exclusive "enforcement" remedy – only after attempting to resolve any adverse issues informally and providing an opportunity for a hearing. 42 C.F.R. §§50.404(a)(1), (4), 406(a), (f); 45 C.F.R. §74.90(a); *cf.* 42 C.F.R. §59.10 (incorporating *inter alia* 42 C.F.R. Part 50, Subpart D and 45 C.F.R. Part 74). Final agency decisions are appealable to the "Department Grant Appeals Board" under 45 C.F.R. pt. 16, *see* 42 C.F.R. §59.10, and the final decision there is reviewable in district court. *See, e.g., Bowen v. Massachusetts,* 487 U.S. 879, 909-10 (1988).

I. HHS SHOULD CLARIFY THE BASES FOR THE NPRM, WHICH IS BASED SOLELY ON ABORTION-RELATED ISSUES.

II. HHS SHOULD ACKNOWLEDGE THE ABORTION-RELATED BASIS FOR THE NPRM.

Pursuant to 42 U.S.C. §300a-6, "[n]one of the funds appropriated under [Title X] shall be used in programs where abortion is a method of family planning." The NPRM acknowledges this obvious restriction explicitly, 81 Fed. Reg. at 61,640, but then seeks to hide the subject from the rest of the NPRM. Rather than refer to the abortion context at issue here, the NPRM uses stilted neutral language, but focuses throughout only on the 13 states that have attempted to restrict Title X funding provided to abortion-providing groups like Planned Parenthood.

Although proposed 42 C.F.R. §59.3(b) is worded neutrally to apply to any "reasons unrelated to [a sub-recipient's] ability to provide services effectively," the NPRM focuses only on instances of state regulations that impaired the ability of abortion providers and their affiliates to participate in state Title X programs. *Compare* 81 Fed. Reg. at 61,640 ("13 states have placed restrictions on or eliminated subawards with specific types of providers based on reasons unrelated to their ability to provide required services in an effective manner"), 61,641 ("states have prohibited specific types of providers from being eligible to receive Title X subawards"), and 61,644 ("13 states have taken actions to restrict participation by certain types of providers as subrecipients in the Title X program based on factors unrelated to the providers' ability to provide the services required under Title X effectively") *with* Laura Bassett, *Obama Moves To Protect Planned Parenthood Funding, Permanently: His new rule would block states from defunding the family planning provider for political reasons*, THE HUFFINGTON POST (Sept. 9, 2016) (Ex. 1); The Editorial Board, *A Way to Protect Planned Parenthood Services*, N.Y. TIMES (Sept. 9, 2016) (Ex. 2); Roxana Hegeman, *'A gift for Planned Parenthood': Feds push back on states restricting family planning grants*, ASSOCIATED PRESS (Sept. 26, 2016) (Ex. 3); and Claire Landsbaum, *Obama Introduces New Rule to Prevent States From Defunding Abortion Providers*, N.Y. MAG. (Sept. 12, 2016) (Ex. 4). Notwithstanding the coy use of neutral language – *e.g.*, "specific types of providers" and "certain types of providers" – the NPRM plainly concerns abortion-related issues and thus abortion politics. This raises several key threshold issues to address before EFELDF's other comments.

A. If HHS is responding to any issues other than abortion issues, the NPRM should identify those issues.

On information and belief, formed after reasonable inquiry, which likely could be proved with an opportunity for discovery, FED. R. CIV. P. 11(b)(3); *Rotella v. Wood*, 528 U.S. 549, 560-61 (2000), HHS has developed its NPRM to ensure that abortion-providing groups have access to Title X funding as subrecipients. While the conservative, pro-life, and states-rights commentators

who have written about the NPRM have pointed out this obvious connection, EFELDF relies on the attached reports from the "mainstream" and liberal media to establish that obvious connection. HHS should be forthcoming and acknowledge that its NPRM is connected to (*i.e.*, highly and even exclusively correlated with) abortion politics.

Comment: HHS should acknowledge that – notwithstanding its neutral language – this NPRM concerns abortion-related issues.

Comment: If HHS is responding to any issues other than abortion-related issues, the NPRM or a supplemental notice should identify those issues.

B. HHS should identify what is – and what is not – an abortion for purposes of Title X.

Because it prohibits abortion funding, 42 U.S.C. §300a-6, Title X begs the question of when an abortion (or a pregnancy) takes place. As explained in the following subsections, both medical science and religion suggest a fertilization-based definition, not an implantation-based definition. Compliance with 42 U.S.C. §300a-6 is integrally related to the question posed by the NPRM's proposed §59.3(b).

Comment: HHS should clarify that the NPRM's proposed §59.3(b) includes compliance with every statutory aspect of Title X – including 42 U.S.C. §300a-6 – when §59.3(b) inquires into the "ability to provide services effectively" under Title X.

1. Pregnancy – and thus abortion – begins at fertilization.

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

The standard definitions have pregnancy starting at the union of an ovum and spermatozoon, with that union described as both fertilization and conception. *See, e.g.,* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (25th ed. 1974) (pregnancy means "condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon"); DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (31st ed. 2007) (same); MOSBY'S MEDICAL DICTIONARY (7th ed. 2006) (pregnancy means "gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth," and conception means "beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote… the act or process of fertilization"). Other medical dictionaries have flirted with an implantation-based definition and returned to the fertilization-based definition. *Compare* STEDMAN'S MEDICAL DICTIONARY (21st ed. 1966) (conception means "act of conceiving, or becoming pregnant; the fecundation of the ovum") *with* STEDMAN'S

MEDICAL DICTIONARY (22nd ed. 1972) (conception means "Successful implantation of the blastocyst in the uterine lining"); *see also* STEDMAN'S MEDICAL DICTIONARY (24th ed. 1982) (conception means "act of conceiving, or becoming pregnant; the fertilization of the oocyte (ovum) by a spermatozoon"); STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006) (conception means "Fertilization of oocyte by a sperm"). At least one medical dictionary appears to have switched from fertilization to an implantation-based definition. *Compare* TABER'S CYCLOPEDIC MEDICAL DICTIONARY (18th ed. 1997) (conception means "union of the male sperm and the ovum of the female; fertilization") *with* TABER'S CYCLOPEDIC MEDICAL DICTIONARY (19th ed. 2001) (conception means "onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall"). As HHS is aware, no new scientific discoveries explain the changes in definition. Zygotes are as alive today as their predecessors were in the 1970s. While some definitional semantics supports an implantation-based definition, those changes reflect political manipulations,[1] not scientific developments, and do not represent the weight of authority or common understanding. *See* Christopher M. Gacek, J.D., Ph.D., *Conceiving "Pregnancy:" U.S. Medical Dictionaries and their Definitions of "Conception" and "Pregnancy"* (Family Research Council Apr. 2009) (Ex. 6).

HHS's "SCHIP" rulemaking on the allowable definition of "child" provides precedent for this approach. In defining "child" to allow states to go back to conception, HHS "disagree[d] with [the] contention that there is only one appropriate interpretation of the statutory term at issue, and [HHS] believe[d] the range of comments supports [its] view that States should have the option to include unborn children as eligible targeted low income children." 67 Fed. Reg. 61,956, 61,960 (2002). Moreover, when a commenter suggested that the SCHIP regulations define "conception" to mean "fertilization" because "there are other potentially confusing definitions being used," HHS responded that it did "not generally believe there is any confusion about the term 'conception'" but that "[t]o the extent that there is… [HHS] believe[s] States should have flexibility to adopt any reasonable definition of that term." 67 Fed. Reg. at 61,963-64. At a minimum, Title X awardees deserve that same flexibility.

A fertilization-based definition also is consistent with the religious beliefs and moral convictions that explain Title X's excluding abortion funding in the first place. For example, although Southern Baptists and Catholics do not command the obedience of other faiths, their position on this subject suffices to demonstrate the reasonableness of a fertilization-based definition for religious purposes: "The Bible affirms that the unborn baby is a person bearing the image of God from the moment of conception." Southern Baptist Convention, Resolution on Thirty Years of *Roe V. Wade* (June 2003) (citing Psalm 139:13–16 and *Luke* 1:44) (Ex. 7); *see also*

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[1] *See, e.g.,* Robert G. Marshall & Charles A. Donovan, *Blessed Are the Barren: the Social Policy of Planned Parenthood,* 291-302 (1991) (Ex. 5).

Southern Baptist Convention, Resolution on Human Embryonic and Stem Cell Research (June 1999) ("Bible teaches that… protectable human life begins at fertilization") (Ex. 8).

> In this context, it is not possible to anaesthetize consciences, for example, concerning the effects of particles whose purpose is to prevent an embryo's implantation or to shorten a person's life…. In the moral domain, your Federation is invited to address the issue of conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia.

Pope Benedict XVI, *Address of His Holiness Benedict XVI to Members of the International Congress of Catholic Pharmacists* (Oct. 29, 2007) (Ex. 9); *see also* Pontifical Academy for Life, *Statement on the So-Called 'Morning-After Pill'* (Oct. 31, 2000) ("the proven 'anti-implantation' action of the *morning-after pill* is really nothing other than a chemically induced abortion [and] from the ethical standpoint the same absolute unlawfulness of abortifacient procedures also applies to distributing, prescribing and taking the *morning-after pill*") (emphasis in original) (Ex. 10). Religious and moral opposition to abortion provides the driving force behind Title X's exclusion of abortion funding and thus should guide HHS in regulating under Title X.[2]

Comment: HHS should adopt the prevailing fertilization-based definition of pregnancy and abortion for purposes of Title X funding.

2. Implantation-based definitions are inapposite.

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

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[2] Although the religious views supported here fall squarely within mainstream religious faiths and morality, religious conformity is not necessary to trigger the type of conscience-right protections provided by 42 U.S.C. §300a-6. *See, e.g., Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah,* 508 U.S. 520, 524 (1993) (finding unlawful restriction of a faith with animal sacrifice as a principal form of devotion).

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

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

U.S. Dep't of Health, Education & Welfare, Public Health Service Leaflet No. 1066, 27 (1963); *accord* 45 C.F.R. §457.10 (for SCHIP, "*Child* means an individual under the age of 19 including the period from conception to birth"); *see also* 67 Fed. Reg. at 61,963-64 (finding it unnecessary to define "conception" as "fertilization" in SCHIP because HHS did "not generally believe there is any confusion about the term 'conception'"). Having itself acknowledged in some contexts that pregnancy begins with fertilization, HHS cannot credibly deny the right of Title X awardees to reach that same conclusion.

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

> It was suggested that pregnancy should be defined (i) conceptually to begin at the time of fertilization of the ovum, and (ii) operationally by actual test unless the women has been surgically rendered incapable of pregnancy.
>
> While the Department has no argument with the conceptual definition as proposed above, it sees no way of basing regulations on the concept. Rather in order to provide an administerable policy, the definition must be based on existing medical technology which permits confirmation of pregnancy.

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

on the final rule, HHS's predecessor acknowledged that another of its pregnancy-related definitions served "interests of both consistency and clarity, although it may vary at times from legal, medical, or common usage." 40 Fed. Reg. 33,526 (1975). A decision to set an arguable floor (based on 1970s technology) for administrative expedience obviously cannot translate to the conscience context that underlies 42 U.S.C. §300a-6, where the question is whether individuals or institutions want to avoid participating in activities against *their* religious beliefs or moral convictions. Indeed, the enacting Congress expressly indicated that these definitions would not trump conscience-protecting legislation. S. REP. NO. 93-381 (1973), *reprinted in* 1974 U.S.C.C.A.N. 3634, 3655 ("It is the intent of the Committee that guidelines and regulations established by… the Secretary of HEW under the provisions of the Act do not supersede or violate the moral or ethical code adopted by the governing officials of an institution in conformity with the religious beliefs or moral convictions of the institution's sponsoring group").

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

Even if the term "conception" is redefined in human beings to mean "the point of implantation," defying all other known biological use of the term in other living creatures, that redefinition cannot change the reality that biological life begins at fertilization. Since the mechanism by which mammals reproduce has been known for at least the last 150 years, any biologist in the world can tell you that a mammal's life begins when the sperm from the father unites with the egg from the mother. This process is called fertilization, and when the DNA from a human father and a human mother combine, the egg is called a "fertilized egg" or "zygote." When the zygote splits into two cells, it is called a "two celled embryo." When it splits into four cells, it is called a "four celled embryo," etc. The definition of "embryo" is "the youngest form of a being." If this being is nourished and protected, it will proceed uninterrupted through the

developmental stages of embryo, fetus, newborn, toddler, child, adolescent, adult, and aged adult: one continuous existence. This being never develops into a pig, a frog, or a tree, but only into a human. This being is therefore, by definition, a living human being.

In summary, none of the bases for an implantation-based definition support the claim that the pro-abortion groups' preferred definition has any application in defining the religious beliefs or moral convictions of individuals and institutions who do not share the pro-abortion groups' views. The right to conscience would be a poor thing if limited to the right to believe what someone else tells us. Title X awardees have rights protected by 42 U.S.C. §300a-6, which the NPRM seeks to impair.

Comment: Even if it declines to adopt a fertilization-based definition, HHS should clarify that neither 45 CFR §46.202(f) nor any other federal or medical definition nor science justifies the use of an implantation-based definition of "abortion" for 42 U.S.C. §300a-6.

III. HHS SHOULD CLARIFY ITS PERCEIVED AUTHORITY FOR THE NPRM.

The NPRM posits that courts would defer to an HHS regulation, 81 Fed. Reg. at 61,641, but that is not universally true, no matter how broad the authority that Congress delegates to an agency. First, courts are the first and final arbiters on constitutional issues: the "power to interpret the Constitution … remains in the Judiciary." *City of Boerne v. Flores,* 521 U.S. 507, 524 (1997). But even on statutory issues, courts remain the first arbiter if the statute's application is unambiguous under traditional tools of statutory construction. *Chevron U.S.A., Inc. v. N.R.D.C.,* 467 U.S. 837, 842-43 (1984). Under those tools of construction, EFELDF respectfully submits that HHS lacks the authority to impose its NPRM on the States under this Spending Clause statute.

Title X is a cooperative-federalism statute enacted under the Spending Clause, *New York v. Richardson*, 473 F.2d 923, 926 (2d Cir. 1973), which further limits HHS's leeway to coerce any recipient and especially *State* recipients. Under such statutes, federal funds are made available on a matching basis – here, 90% federal – and states have the option of participating under such lawful terms as the funding agency or Congress shall impose. *Id.* Courts analogize Spending-Clause programs like Title X to contracts struck between the government and recipients, with the public as third-party beneficiaries. *Barnes v. Gorman*, 536 U.S. 181, 186 (2002). To regulate recipients based on their accepting federal funds, however, Congress must express Spending-Clause conditions unambiguously. *Gorman*, 536 U.S. at 186. Indeed, "[t]he legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of th[at] 'contract.'" *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). The Supreme Court recently clarified that this contract-law analogy is not an open-ended invitation to interpret Spending-Clause agreements *broadly*, but rather – consistent with the clear-notice rule – applies "only as a potential *limitation* on liability." *Sossamon v. Texas*,

563 U.S. 277, 290 (2011) (emphasis added). This clear-notice rule requires HHS to make explicit the actions that HHS is taking and the legal impact of those HHS actions on recipients.

Further, federal courts and agencies should "never assume[] lightly that Congress has derogated state regulation, but instead [should] address[] claims of pre-emption with the starting presumption that Congress does not intend to supplant state law." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 654 (1995). Accordingly, in preemption analysis, all fields – and especially ones traditionally occupied by state and local government – require courts and agencies to apply a presumption against preemption. *Wyeth v. Levine,* 555 U.S. 555, 565 (2009); *Santa Fe Elevator,* 331 U.S. at 230. When this presumption applies, courts do not assume preemption "unless that was the clear and manifest purpose of Congress." *Santa Fe Elevator,* 331 U.S. at 230; *Wyeth,* 555 U.S. at 565. Significantly, even if Congress had preempted *some* state action, the presumption against preemption applies to determining the *scope* of preemption. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Thus, "[w]hen the text of an express pre-emption clause is susceptible of more than one plausible reading, courts ordinarily accept the reading that disfavors pre-emption." *Altria Group, Inc. v. Good,* 555 U.S. 70, 77 (2008) (*quoting Bates v. Dow Agrosciences LLC,* 544 U.S. 431, 449 (2005)). Agencies must do the same.

A. Title X did not delegate authority for HHS to answer questions of deep economic and political significance under *Chevron*.

Under *King v. Burwell*, 135 S.Ct. 2480, 2489 (2015) – which cites *Util. Air Regulatory Group v. EPA*, 134 S.Ct. 2427, 2444 (2014) ("*UARG*") – courts must "determine the correct reading" of statutes that raise "question[s] of deep economic and political significance" without regard to administrative deference. *King*, 135 S.Ct. at 2489 (interior quotations omitted). *King* involved a new statute where Congress failed to speak expressly of an expansive agency power, 135 S.Ct. at 2489, whereas *UARG* involved an old statute in which the agency purported to find vast new authority lurking. 134 S.Ct. at 2444. From a separation-of-powers perspective, each form of *sub silentio* agency self-aggrandizement is shocking in its own way, but here HHS follows the *UARG* model.[3]

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[3] It should go without saying that not all regulations are lawful: "the government notes, and plaintiff doesn't contest, that in the event of conflict the regulation must yield to a valid statute." *Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales,* 468 F.3d 826, 828 (D.C. Cir. 2006). Moreover, HHS's Title X delegation is neither unlimited, *Planned Parenthood Fed'n, Inc. v. Heckler*, 712 F.2d 650, 655 (1983) ("however sweeping this delegation of authority, it is not unlimited"), nor even as broad as the Clean Air Act authority that proved insufficient in *UARG*. *Compare* 42 U.S.C. §300a-4(a) *with* 42 U.S.C. §7601(a)(1).

Novel arguments might plausibly have their place under novel statutes, but it is implausible to invent in Title X a cudgel to coerce and commandeer states into accepting HHS's abortion politics, contrary to tools of statutory construction identified in this Section:

> When an agency claims to discover in a long-extant statute an unheralded power to regulate a significant portion of the American economy, we typically greet its announcement with a measure of skepticism. We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast economic and political significance.

UARG, 134 S.Ct. at 2444 (interior quotations omitted). Indeed, while *UARG* concerned stationary-source emissions under the Clean Air Act, its cited authority concerned the far-more-trivial economic and political field of tobacco products. *Compare id. with FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000) ("*B&WT*"). While the abortion issues here do not rise to the economic level of all stationary sources (*e.g.*, factories, refineries, etc.) nationwide, the abortion issues here are easily more politically significant than smoking and even stationary sources.

Comment: In light of *King*, *UARG*, and *B&WT*, HHS should recognize that it lacks the authority to issue binding regulations on States that concern the highly charged political issue of abortion, especially under this cooperative-federalism statute under the Spending Clause.

B. HHS should recognize that the presumption against preemption applies not only to HHS's authority but also the effect of its proposed rule.

"Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens." *Medtronic*, 518 U.S. at 475; *see also U.S. v. Morrison*, 529 U.S. 598, 618-19 (2000) (Congress *lacks* a general police power under the Constitution). Given both that the states were heavily involved in all relevant aspects of health care and that Congress did not provide clear and manifest evidence of its intent to preempt state laws under the States' police power, any fair arbiter would construe Title X narrowly in order to avoid impinging on States' rights. Where courts or agencies *can* adopt narrow interpretations to avoid preemption, *Altria Group,* 555 U.S. at 77, those courts or agencies *should* do so.

In administrative-law terms, "*Chevron* step one" requires courts to employ "traditional tools of statutory construction" to determine congressional intent, on which courts are "the final authority." *Chevron*, 467 U.S. at 843 n.9. Only if the attempt to interpret the statute is inconclusive does a federal court go to "*Chevron* step two," where a court would defer to a plausible agency interpretation of an ambiguous statute. *Id.* at 844. Where (as here) the presumption against preemption applies, *Chevron* deference would be inappropriate.

In a dissent joined by Chief Justice Roberts and Justice Scalia, and not disputed in pertinent part by the majority, Justice Stevens called into question the entire enterprise of administrative preemption vis-à-vis the presumption against preemption:

> Even if the OCC did intend its regulation to pre-empt the state laws at issue here, it would still not merit *Chevron* deference. No case from this Court has ever applied such a deferential standard to an agency decision that could so easily disrupt the federal-state balance.

Watters v. Wachovia Bank, N.A., 550 U.S. 1, 41 (2007) (Stevens, J., dissenting). Significantly, *Watters* arose under banking law that is more preemptive than federal law generally. *Id.* at 12 (majority). The Courts of Appeals have adopted a similar approach against finding preemption under these circumstances. *See Nat'l Ass'n of State Utility Consumer Advocates v. F.C.C.,* 457 F.3d 1238, 1252-53 (11th Cir. 2006) ("[a]lthough the presumption against preemption cannot trump our review … under *Chevron,* this presumption guides our understanding of the statutory language that preserves the power of the States to regulate"); *Fellner v. Tri-Union Seafoods, L.L.C.,* 539 F.3d 237, 247-51 (3d Cir. 2008); *Massachusetts Ass'n of Health Maintenance Organizations v. Ruthardt,* 194 F.3d 176, 182-83 (1st Cir. 1999); *see also Albany Eng'g Corp. v. F.E.R.C.,* 548 F.3d 1071, 1074-75 (D.C. Cir. 2008); *Massachusetts v. U.S. Dept. of Transp.,* 93 F.3d 890, 895 (D.C. Cir. 1996). Clearly federal agencies – which draw their delegated power from Congress – cannot have a freer hand here than Congress itself.

Comment: HHS should re-propose its NPRM, giving full consideration to the preemptive effect and the preemptive scope of the proposed rule and justifying its intention, if any, to preempt state law under the presumption against preemption.

C. HHS should recognize that – as Spending Clause legislation – Title X poses additional limits on HHS's authority to compel state compliance with HHS rules.

With Spending Clause statutes like Title X, the Supreme Court has recognized agencies' authority to adopt regulations that control agency proceedings – such as funding-termination – but do not create enforceable private rights: "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval,* 532 U.S. 275, 291 (2001); *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 292 (1998) ("Agencies generally have authority to promulgate and enforce requirements that effectuate the statute's … mandate, even if those requirements do not purport to represent a definition of [prohibited conduct] under the statute") (citations omitted). To provide recipients with sufficient notice of the conduct required – and the exposure triggered – by participating in Title X, HHS should make the implications of its rules clear.

At various points, the NPRM discusses using the new rule in fund-termination proceedings (81 Fed. Reg. at 61,643) and discusses preemption generally in the context of Executive Order 13,132 (*id.* at 61,646), but does not come out and state that the NPRM – if adopted – would *preempt* state law. Instead, the NPRM would "implicate some state laws" (*id.*) and "implicate state law or policy" (*id.* at 61,645), whatever that means. If HHS intends that recipients would face any repercussions beyond potential fund-termination proceedings, HHS's rulemaking should make that clear.[4]

As HHS acknowledges, HHS awards Title X funding under a competitive process, 81 Fed. Reg. at 61,640, and HHS could choose to deny contracts to States that do not adopt policies and laws that mirror HHS's lawful funding criteria. Where differences emerge after a Title X award, HHS could move to terminate funds under the remedies that Congress enacted into Title X. Indeed, assuming *arguendo* that HHS has authority for its NPRM, HHS still could apply the presumption against preemption to the *scope* of Title X's preemption, *Medtronic*, 518 U.S. at 485, by limiting the application of the proposed rule to fund-termination proceedings, without any impact on third-party or private behavior or rights.

Comment: Under the Spending Clause, HHS's proposed rule does not put parties on notice of any legal impacts from HHS's proposal except the possibility of a funding-termination proceeding.

Comment: The presumption against preemption limits the scope of the proposed rule to use in HHS funding-termination proceedings, with no spillover into third-party or private rights or causes of action.

Comment: Restricting State participation with abortion-providing entities and affiliates based on an opposition to abortion is not "discrimination" or discriminatory under federal law.

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[4] The NPRM refers to eliminating "discrimination" against "certain providers," *id.*, and "in making subawards." *Id.* at 61,646. The aspersion of discrimination is inappropriate unless the act of choosing – without violating any law – counts as "discrimination." Disparate treatment of a potentially pregnant person because of sex-neutral criteria (*e.g.*, opposition to abortion) is not discrimination *because of that person's sex. Bray v. Alexandria Women's Health Clinic,* 506 U.S. 263, 271-72 (1993). "While it is true … that only women can become pregnant, it does not follow that every … classification concerning pregnancy is a sex-based classification." *Id.* (interior quotations omitted); *Harris v. McRae,* 448 U.S. 297, 322 (1980).

IV. HHS SHOULD CLARIFY NOT ONLY §59.3'S ENFORCEABILITY BUT ALSO THE PROCESS FOR ENFORCING OR AVOIDING ENFORCEMENT OF §59.3.

When Congress – and *a fortiori* a mere agency like HHS – amends an existing Spending Clause statute like Title X, on pains of recipients' losing a significant portion of participation in that program, the amendment "pass[es] the point at which "pressure turns into compulsion[,]" *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (citation omitted), and must be declared invalid. This statutory (or here regulatory) coercion commandeers the independently sovereign States into mere arms of the federal government, contrary to our constitutional system of divided sovereignty. *Id.*; *New York v. U.S.*, 505 U.S. 144, 162 (1992). Such brinksmanship gives States the Hobson's choice between: (1) accepting the newly transformed – and objectionable – program; and (2) opting out of the program and losing federal healthcare assistance for their neediest citizens.

Even if Congress – or *a fortiori* HHS – had successfully amended Title X to provide that what §59.3(b) purports to provide, recipients could decline to accept the amended Title X regime because federal courts "scrutinize Spending Clause legislation to ensure that Congress is not using financial inducements to exert a power akin to undue influence." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2602 (2012) ("*NFIB*") (interior quotation omitted). Here, HHS is trying to coerce States to adopt new requirements, based on the threat of terminating Title X funding. As *NFIB* explained, the federal government cannot add new requirements to existing Spending-Clause regimes on threat of losing all federal funding:

> The legitimacy of Congress's exercise of the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system.

NFIB, 132 S.Ct. at 2602 (interior quotation omitted). Under *NFIB,* the new HHS overlay onto Title X is impermissible as "economic dragooning that leaves the States with no real option but to acquiesce in the [statutory or, here, regulatory] expansion." 132 S.Ct. at 2605.

Indeed, HHS's attempt here in Title X is an even greater expansion than the expansion rejected in *NFIB* as an impermissible "shift in kind, not merely degree." *NFIB*, 132 S.Ct. at 2605. There, Congress expanded a statute "designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children" to one designed "to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *NFIB*, 132 S.Ct. at 2605-06. Here, HHS attempts to negate the States' primacy in health care and *States'* First Amendment rights. *Rust v. Sullivan*, 500 U.S. 173, 178 (1991); *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 540-41 (2001). While *NFIB* holds that Congress itself could not impose those new conditions *by statute*, EFELDF

respectfully submits that mere federal agencies cannot do so by regulation. The *NFIB* limitation on commandeering states has two implications here.

Comment: Under *NFIB*, HHS does not have the authority to compel States to comply with additional Title X conditions at the risk of losing all Title X funding.

Comment: HHS should propose a process for States to decline HHS's proposed expansion of Title X's conditions for federal funding.

CONCLUSION

In summary, HHS should not issue the proposed rule at all, but – if it elects to publish a rule – HHS should clarify the rule's preemptive scope, the definition of abortion that underlies the rule, the contexts in which the rule can be enforced, and the procedures for opting out of the rule.

Yours sincerely,

/s/ Lawrence J. Joseph

Lawrence J. Joseph

Counsel for Eagle Forum Education & Legal Defense Fund

Enclosures

EXHIBIT 1

POLITICS

Obama Moves To Protect Planned Parenthood Funding, Permanently

His new rule would block states from defunding the family planning provider for political reasons.

09/09/2016 05:36 pm ET | **Updated** Sep 12, 2016

Laura Bassett
Senior Politics Reporter, The Huffington Post

WASHINGTON — The Obama administration has proposed a new rule that would prevent states from defunding Planned Parenthood or any other family planning provider for political reasons.

The new rule, which the Department of Health and Human Services proposed last week, says that states cannot withhold Title X federal family planning money from certain recipients for any reason other than the provider's "ability to deliver services to program beneficiaries in an effective manner." That means states can no longer vote to defund Planned Parenthood because some of its clinics offer abortion services.

"This will make a real difference in so many people's lives," said Cecile Richards, president of Planned Parenthood. "Thanks to the Obama administration, women will still be able to access the birth control they need to plan their families, and the cancer screenings they need to stay healthy."

The Title X program provides basic preventive health care and family planning services for 4 million low-income Americans. About 85 percent of patients who use Title X have incomes below $23,500. Planned Parenthood serves about a third of those patients, using the $70 million a year it receives in Title X grants to subsidize contraceptives and cancer and sexually transmitted infection screenings for people who can't afford them. Title X does not allow any money to be used to pay for abortions for any reason.

Still, politicians in 11 states have voted to block public funds from Planned

debunked undercover videos produced by anti-abortion activists that purport to show Planned Parenthood selling fetal body parts.

Rep. Diane Black (R-Tenn.), a member of the House select committee that's investigating the video's claims, called the Obama administration's new rule to protect Planned Parenthood a "stunt."

"We must use the full force of Congress and the grassroots strength of the national pro-life movement to defeat this absurd rule and prevent the Obama Administration from acting unilaterally to carry out political favors and prop up a scandal-ridden abortion provider," she said in a statement.

The political problem for Republicans right now in their endeavor to demonize and defund Planned Parenthood is that family planning providers are on the front lines in the fight against Zika, the rapidly spreading virus that causes severe birth defects. The Centers for Disease Control said the "primary strategy" to reduce Zika-related pregnancy complications should be to help women avoid or delay pregnancy through family planning and birth control, and Planned Parenthood is already distributing Zika prevention kits and education in neighborhoods where the virus is spreading. But some of the most high-risk states for the mosquito-borne and sexually transmitted virus — Florida, Louisiana and Texas — have voted to block funds to Planned Parenthood. About 84 pregnant women in Florida are currently infected with Zika, officials have said.

If the new Title X rule becomes permanent after a 30-day public comment period, which is likely, those states will be forced to back down from the fight against the nation's largest family planning provider.

"This rule makes it clear that politicians cannot ignore the law as they pursue their agenda to stop women from getting the care they need," Richards said.

More: Obama Planned Parenthood Zika Defund Planned Parenthood Title X

Suggest a correction

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EXHIBIT 2

The New York Times | http://nyti.ms/2csiho3

The Opinion Pages | EDITORIAL

A Way to Protect Planned Parenthood Services

By THE EDITORIAL BOARD SEPT. 9, 2016

Opponents of Planned Parenthood in recent years have cut funding to the organization that goes through the Title X Family Planning Program, which provides federal money for services like contraception, testing for sexually transmitted infections and cancer screenings. (Like all federal programs, it is largely barred from paying for abortions.) State and local governments distribute that money to health care providers, and at least 14 states took actions to cut the share they direct to Planned Parenthood.

This month, the Department of Health and Human Services proposed a rule that could stop states from doing this. The rule would make clear that state governments must apportion Title X funds based on a provider's ability to perform family planning services effectively — not on other factors like whether a provider also offers abortions.

State efforts to strip Planned Parenthood of Title X funds have hurt low-income residents, who are likely to depend on Planned Parenthood clinics for free or low-cost health services. In New Hampshire, for instance, the state's Executive Council voted in 2011 not to renew Planned Parenthood's contract under Title X, leaving parts of the state with no federally funded family planning services until the

Department of Health and Human Services stepped in with an emergency grant three months later. Fortunately, the council voted in June to restore funding.

In 2011, Texas cut its state family planning budget and changed the way it allocated Title X funds to significantly reduce grants to Planned Parenthood and other "abortion-affiliated providers." More than 75 clinics, a third operated by Planned Parenthood, closed as a result.

Title X also provides funding to reduce maternal mortality, which remains stubbornly high across the country. In Texas, the maternal mortality ratio — maternal deaths per 100,000 live births — doubled between 2000 and 2014.

Some state lawmakers have argued that community health centers can easily provide the same family planning services that Planned Parenthood offers. But a study published this year found that providers focused on reproductive health care, like Planned Parenthood, offered a wider range of family planning services and higher quality care than centers without an emphasis on reproductive health.

Planned Parenthood also serves an enormous number of patients; though it operates only 10 percent of all health centers that receive Title X funds, it treats about a third of all patients receiving federally funded family planning services nationwide.

The proposed Health and Human Services rule will be open for public comment for 30 days, after which the department will decide whether to issue a final version. If the rule takes effect, it will benefit people all over the country who need reliable reproductive health care.

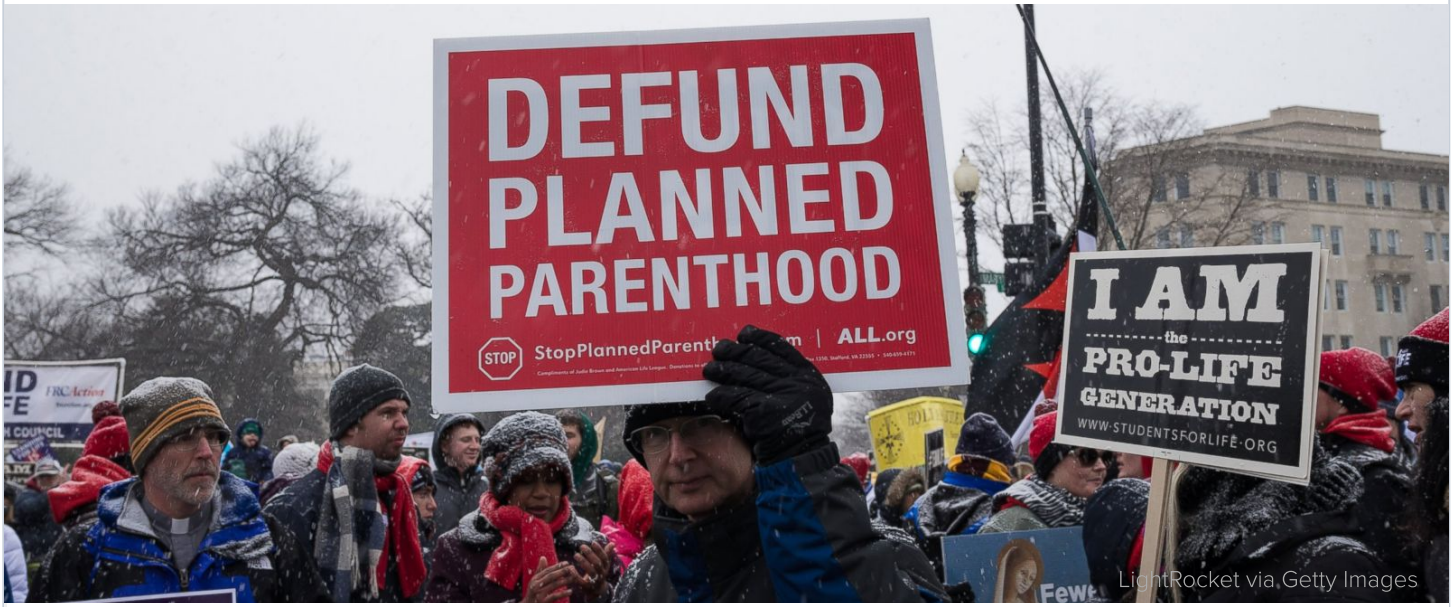
Follow The New York Times Opinion section on Facebook and Twitter (@NYTopinion), and sign up for the Opinion Today newsletter.

A version of this editorial appears in print on September 10, 2016, on page A18 of the New York edition with the headline: A Way to Protect Planned Parenthood Services.

EXHIBIT 3

Feds Push Back on 13 States Targeting Planned Parenthood Funds

By ROXANA HEGEMAN, ASSOCIATED PRESS ·
WICHITA, Kan. — Sep 24, 2016, 10:36 AM ET



Pro-Life marchers participate in the "March for Life" in Washington, Jan. 22, 2016.

The Obama administration has proposed barring states and other recipients of federal family planning grants from placing their own eligibility restrictions on where the money can go, which would undermine the efforts of 13 Republican-led states to prevent such money from going to Planned Parenthood.

The Department of Health and Human Services is accepting public comments about the proposed changes to the Title X grant program until Oct. 7. It contends that these state restrictions have hurt the quality and geographic availability of family planning services to the poor families that Title X is intended to reach. It also says the program is

cost-effective, noting that every grant dollar spent on family planning saves an average $7.09 in Medicaid-related costs.

The proposed rule change was welcomed by Planned Parenthood, which relies on Title X to provide reproductive health care services to 1.5 million patients across the country, making it the medical provider for about a third of the patients served by the grant program.

"This is critically important and I am grateful that the Obama administration is taking these efforts to make sure nobody stands in the way of the care that people need. These proposed regulations make it clear that politicians can't stop women from getting services," said Dr. Raegan McDonald-Mosley, chief medical officer for the Planned Parenthood Federation of America.

Title X is designed to provide contraception services, pregnancy tests, screening and treatment for sexually transmitted diseases and cancer screenings at little or no cost to low-income patients. It doesn't pay for abortions, except in cases of rape, incest or when the mother's life is endangered. Title X grants account for 10 percent of the public funding clinics receive for family planning services, with Medicaid picking up 75 percent, according to the Guttmacher Institute, a research group that supports abortion rights.

Federal law prohibits blocking a qualified provider from getting Medicaid, and no court so far has upheld a single attempt by a state to block Medicaid funding to Planned Parenthood, said Kinsey Hasstedt, a Guttmacher Institute policy expert. But because Title X is a grant program, some states have been more successful in restricting the

In 2011, Kansas established a tiered system for dispersing its Title X funding that favors county health departments and other providers that offer more comprehensive medical services, rather than those that specialize in reproductive health, such as Planned Parenthood.

The tiered system, which took effect in 2014 after an appeals court upheld its legality, made it harder for families to access medical services, particularly in the rural western part of the state, where Planned Parenthood closed a clinic in Hays and an unaffiliated family planning clinic shut down in Dodge City. The number of Kansans who received Title X services fell from 38,461 in 2011 to 24,047 in 2015 — a decrease of more than 37 percent, according to HHS.

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Other Republican-led states have passed similar restrictions, including Arkansas, Arizona, Florida, Indiana, New Hampshire, North Carolina, Ohio, Oklahoma, Tennessee, Texas, Utah and Wisconsin.

If states don't scrap their restrictions, they stand to lose all their Title X funding. For 2015, that ranged from $785,000 in New Hampshire to $13.67 million in Texas, according to figures compiled by the National Family Planning & Reproduction Health Foundation. HHS said the Texas State Department of Health did not receive a 2016 Title X grant, while Kansas received $2.52 million that year.

Abortion opponents, who have tried various ways of trying to defund Planned Parenthood because it provides abortions at some of its clinics, are outraged by the proposed Title X rule change.

"This is intended to undermine the state authority in Kansas — to undo [redacted] — and is intended to be a gift for Planned Parenthood," said Kathy Ostrowski, legislative director for the anti-abortion group Kansans for Life.

84 Comments

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http://www.southbendtribune.com/news/local/a-gift-for-planned-parenthood/article_ff009851-7ab5-5e3c-a79c-7c7993bf80e3.html

'A gift for Planned Parenthood'

Feds push back on states restricting family planning grants

By Roxana Hegeman Associated Press Sep 26, 2016

WICHITA, Kan. — The Obama administration has proposed barring states and other recipients of federal family planning grants from placing their own eligibility restrictions on where the money can go, which would undermine the efforts of Indiana and 12 other Republican-led states to prevent such money from going to Planned Parenthood.

The Department of Health and Human Services is accepting public comments about the proposed changes to the Title X grant program until Oct. 7. It contends that these state restrictions have hurt the quality and geographic availability of family planning services to the poor families that Title X is intended to reach. It also says the program is cost-effective, noting that every grant dollar spent on family planning saves an average $7.09 in Medicaid-related costs.

The proposed rule change was welcomed by Planned Parenthood, which relies on Title X to provide reproductive health care services to 1.5 million patients across the country, making it the medical provider for about a third of the patients served by the grant program.

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In 2011, Kansas established a tiered system for dispersing its Title X funding that favors county health departments and other providers that offer more comprehensive medical services, rather than those that specialize in reproductive health, such as Planned Parenthood.

The tiered system, which took effect in 2014 after an appeals court upheld its legality, made it harder for families to access medical services, particularly in the rural western part of the state, where Planned Parenthood closed a clinic in Hays and an unaffiliated family planning clinic shut down in Dodge City. The number of Kansans who received Title X services fell from 38,461 in 2011 to 24,047 in 2015 — a decrease of more than 37 percent, according to HHS.

Other Republican-led states have passed similar restrictions, including Arkansas, Arizona, Florida, Indiana, New Hampshire, North Carolina, Ohio, Oklahoma, Tennessee, Texas, Utah and Wisconsin.

If states don’t scrap their restrictions, they stand to lose all their Title X funding. For 2015, that ranged from $785,000 in New Hampshire to $13.67 million in Texas, according to figures compiled by the National Family Planning & Reproduction Health Foundation. HHS said the Texas State Department of Health did not receive a 2016 Title X grant, while Kansas received $2.52 million that year.

Abortion opponents, who have tried various ways of trying to defund Planned Parenthood because it provides abortions at some of its clinics, are outraged by the proposed Title X rule change.

"This is intended to undermine the state authority in Kansas — to undo tiering — and is intended to be a gift for Planned Parenthood," said Kathy Ostrowski, legislative director for the anti-abortion group Kansans for Life.

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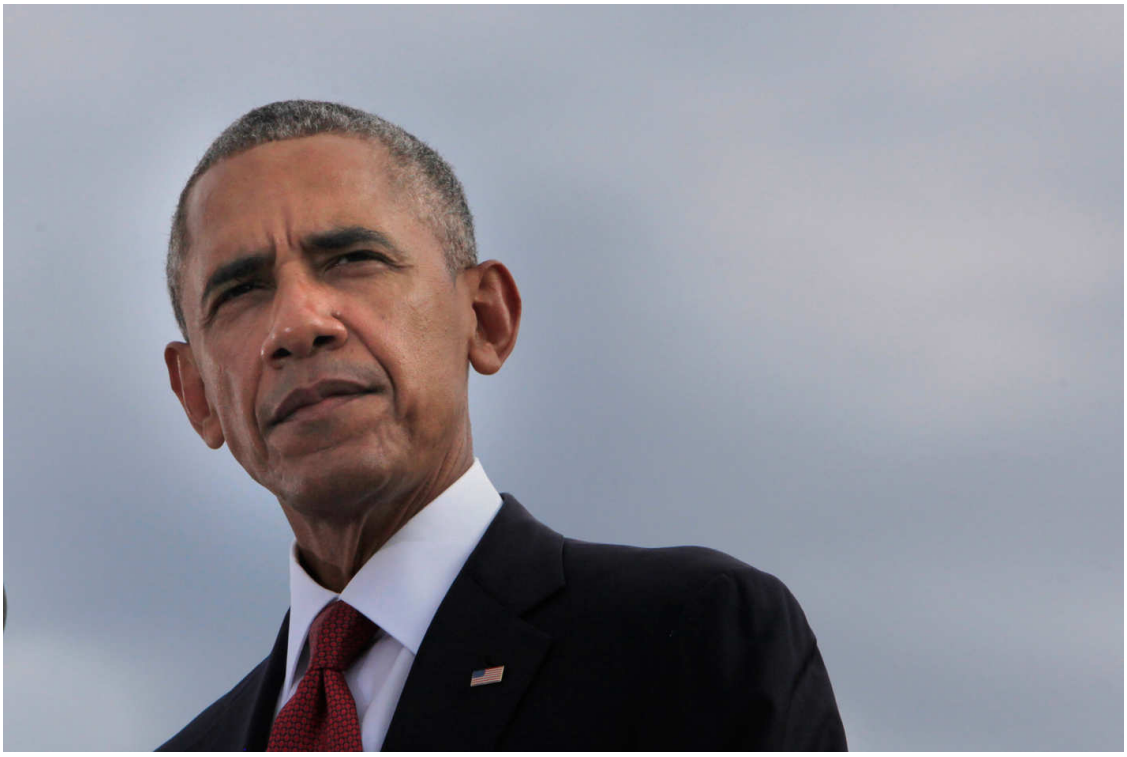
EXHIBIT 4

The Cut

September 12, 2016 10:34 a.m.

Obama Introduces New Rule to Prevent States From Defunding Abortion Providers

By **Claire Landsbaum**



President Obama is making moves in his final term. Photo: Dennis Brack-Pool/Getty Images

President Obama is making moves on women's and LGBTQ issues in his final months in office. At the beginning of the summer, he issued sweeping guidelines to combat transgender discrimination in public schools, and now he's moved to protect funding for Planned Parenthood, which he has long supported.

Last week, the Obama administration introduced a new rule that would prevent states from withholding Title X federal family-planning money for reasons other than a provider's "ability to deliver services to program beneficiaries in an effective manner." In other words, it mandates state governments can't deny providers funding just because they offer abortion services.

The Title X program provides approximately 4 million low-income Americans with basic health and family-planning services, such as cancer screenings, birth control, and STI screenings. The program doesn't allow any funds to be used for abortions or abortion research. But that hasn't stopped Republican lawmakers from conflating the two; most recently, 11 states voted to block all federal funding from family-planning clinics after a series of fraudulent videos surfaced suggesting Planned Parenthood sold fetal tissue from abortions.

Unsurprisingly, the rule has its opponents — Tennessee representative Diane Black, who's on a committee to investigate the Planned Parenthood video's claims, released a statement calling the rule a "stunt." "We must use the full force of Congress and the grassroots strength of the national pro-life movement to defeat this absurd rule and prevent the Obama Administration from … prop[ping] up a scandal-ridden abortion provider," she wrote.

Planned Parenthood president Cecile Richards, meanwhile, praised the rule. "Women in nearly half the states in this country have faced political attacks on cancer screenings, birth control, and other basic care," she said in a

statement. “This rule makes it clear that politicians cannot ignore the law as they pursue their agenda to stop women from getting the care they need.”

Before the rule is put into effect, it will undergo a 30-day comment period. Based on public input, the Department of Health and Human Services will decide whether to issue a final version.

CONNECT:

EXHIBIT 5

BLESSED ARE THE BARREN

The Social Policy of Planned Parenthood

By
Robert G. Marshall
and
Charles A. Donovan

IGNATIUS PRESS SAN FRANCISCO

Chapter Twelve

Old Lies and New Labels: When Contraception Is Abortion

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

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

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

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

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

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

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

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

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

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

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

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

[3] Bent G. Boving, "Implantation Mechanisms", in *Mechanisms Concerned with Conception*, ed. C. G. Hartman (New York: Pargamon Press, 1963), 386.

[4] Ibid., 321.

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

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

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

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

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

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

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

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

[8] Ibid., 212.

[9] Ibid., 213.

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

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

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

> Early pregnancy factor and other factor(s) produced by the preimplantation embryo may play a role in suppressing maternal cellular immune response, thereby preventing maternal rejection of the embryo.
>
> However, other than the early pregnancy factor (EPF), present in the sera of pregnant women shortly after fertilization (24 hours), there is no other factor produced in significant amounts at time of implantation. Therefore this factor plays a possible role in the prevention of maternal rejection of the oligocellular embryo.[12]

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

No One Knows When Human Life Begins

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

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

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

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

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

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

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

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

> Dr. Marchetti and I are rarely together. . . . He believes that an abortion is murder, and under these conditions he does not feel that it can ever be justified.
>
> My feeling is that the fetus, particularly during its early intra-uterine existence, is simply a group of specialized cells that do not differ materially from other cells. I do not think they are made in God's image. I think they are made in man's image. . . . If one can justify shooting a burglar who enters your home . . . one can certainly justify the elimination of some cells, which from my point of view, have simply not yet become a human being, but simply have the potentialities of life. Philosophically we are too far apart to try to compromise; it is impossible.[16]

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

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

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

The "ignorance is bliss" posture has received widespread endorsement

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

[15] Ibid., 48–49.

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

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

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

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

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

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

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

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

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

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

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

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

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

Enacting Antiabortion Laws Will Deny "Contraceptives" to Women

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

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

> apply to acts done with an intent to terminate pregnancy at any time, from the moment of conception. . . . The broad language of statutes and cases would suggest that to use pre-implantation means on a pregnant woman would be unlawful . . . under statutes where [proving] pregnancy is an element of the offence . . . manufacturers, distributors or sellers of the pre-implantation means might be prosecuted under ¼statutes prohibiting the manufacture, distribution or sale of abortifacients.[25]

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

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

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

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

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

> Since the function of the pre-implantation means of fertility control is to interrupt pregnancy, their use would no doubt violate abortion statutes which do not require proof of pregnancy as an element of the offence. . . .
>
> But with the problems of overpopulation facing us, as it is today, allowing society to legally expand methods of birth control to the instant of implantation does not seem unreasonable.[26]

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

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

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

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

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

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

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

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

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

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

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

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

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

[28] Shettles, Letter to Editor.

[29] No. 84–1379, Supreme Court, October 1984 term.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[40] Ibid.

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

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

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

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

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

EXHIBIT 6

Insight

CONCEIVING "PREGNANCY:"

U.S. MEDICAL DICTIONARIES AND THEIR DEFINITIONS OF "CONCEPTION" AND "PREGNANCY"

Christopher M. Gacek

"When *I* use a word," Humpty Dumpty said, in rather a scornful tone,
"it means just what I choose it to mean – neither more nor less."
"The question is," said Alice, "whether you *can* make words mean so many different things."
"The question is," said Humpty Dumpty, "which is to be master – that's all."

~ *Through the Looking Glass*
by Lewis Carroll

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

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

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I. Background

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

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

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

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

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

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

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

II. Medical Dictionaries as Purveyors of Scientific-Medical Consensus

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

The Four Major Medical Dictionaries

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

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

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

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

III. Definitions of "Conception" and "Pregnancy"

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

A.

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

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

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

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

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

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

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

B.

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

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

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

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

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

***Stedman's* on Pregnancy**.

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

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

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

† *See* Appendix B to track the described changes more easily. Also, after 1972, "baby" replaced "child."

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

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

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

***Stedman's*: Analysis**.

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

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

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

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

C.

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

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

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

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

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

D.

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

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

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

IV. Loose Ends: Ectopic "Pregnancy" and Embryology

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

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

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

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

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

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

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

Embryology

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

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

The 23 Carnegie Stages of human embryological development are well known and run from Day 1 to Day 60 of pregnancy.[16] Implantation occurs on Days 6-12.[17] Of course, uterine implantation is critical to embryological development, but implantation does not mark the beginning of the developmental process.

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

V. Conclusion

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

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

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

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

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

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NOTES

[1] Package Insert (label), Plan B® (Levonorgestrel), "Clinical Pharamcology" section, p. 1.

[2] For example, the "Clinical Pharmacology" section of the package insert for the ParaGard® T 380A Intrauterine Copper Contraceptive states: "The contraceptive effectiveness of ParaGard® is enhanced by copper continuously released into the uterine cavity. Possible mechanism(s) by which copper enhances contraceptive efficacy include interference with sperm transport or fertilization, and prevention of implantation."

[3] Planned Parenthood is the largest abortion provider in the United States.

[4] Robert G. Marshall and Charles A. Donovan, *Blessed Are the Barren: The Social Policy of Planned Parenthood* (San Francisco: Ignatius Press, 1991): ch. 12 (pp. 291-302) (the source containing the best discussion of the effort to change these definitions to eliminate objections to hormonal birth-control technologies as possibly being abortifacients).

[5] Marshall and Donovan, *Blessed Are the Barren*, p. 293.

[6] Rachel Benson Gold, "The Implications of Defining When a Woman Is Pregnant," *Guttmacher Report on Public Policy* 8 (May 2005): 7.

[7] This research strategy would probably not be available for those living elsewhere – with the possible exception of New York City.

[8] In 1971 ACOG changed its official policy regarding abortion, endorsing abortion upon patient request as acceptable medical practice.

[9] This edition defines implantation as: "The attachment of the fertilized ovum (blastocyst) to the endometrium, and its subsequent embedding in the compact layer, occurring six or seven days after fertilization of the ovum."

[10] Note that *Dorland's* later use of "viable zygote" may reflect this shift in *Stedman's* phrasing.

[11] "Gestation" and "fetation" appeared in every definition of "pregnancy" from 1912 to 2008. Either one or two of these three – gravidity, graviditas, or gravidism – has also been included in the definition.

[12] "Cyophoria" is a difficult term to find in any reference source. Using the Yahoo search engine I was able to find a webpage (<http://www.wordinfo.info/words/index/info/view_unit/606/?letter=C&spage=31>) that defined it as "[a]n awareness of pregnancy."

[13] LINK: < http://www.nlm.nih.gov/MEDLINEPLUS/ency/article/000895.htm >.

[14] Keith L. Moore and T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology* (8th ed., 2008): p. 15. There are additional, helpful definitions from embryology. An earlier edition of Moore and Persaud contains this definition of "zygote":

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

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

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

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

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

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

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

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

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

Appendix A: "Conception" Defined

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

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

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

Appendix B: "Pregnancy" Defined

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

Appendix B: "Pregnancy" Defined

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

Appendix B: "Pregnancy" Defined

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

EXHIBIT 7

ON THIRTY YEARS OF ROE v. WADE

June 2003

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

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

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

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

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

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

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

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

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

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

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

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

rights; and be it further

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

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

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

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

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

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

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

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

Phoenix

EXHIBIT 8

RESOLUTION ON HUMAN EMBRYONIC AND STEM CELL RESEARCH

June 1999

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Atlanta, Georgia

EXHIBIT 9

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

Consistory Hall
Monday, 29 October 2007

Mr President,
Dear Friends,

I am happy to welcome you, members of the International Congress of Catholic Pharmacists, on the occasion of your 25th Congress, whose theme is: "The new boundaries of the pharmaceutical act".
The current development of an arsenal of medicines and the resulting possibilities for treatment oblige pharmacists to reflect on the ever broader functions they are called to fulfil, particularly as intermediaries between doctor and patient; they have an educational role with patients to teach them the proper dosage of their medication and especially to acquaint them with the ethical implications of the use of certain drugs. In this context, it is not possible to anaesthetize consciences, for example, concerning the effects of particles whose purpose is to prevent an embryo's implantation or to shorten a person's life. The pharmacist must invite each person to advance humanity, so that every being may be protected from the moment of conception until natural death, and that medicines may fulfil properly their therapeutic role. No person, moreover, may be used thoughtlessly as an object for the purpose of therapeutic experimentation; therapeutic experimentation must take place in accordance with protocols that respect fundamental ethical norms. Every treatment or process of experimentation must be with a view to possible improvement of the person's physical condition and not merely seeking scientific advances. The pursuit of good for humanity cannot be to the detriment of people undergoing treatment. In the moral domain, your Federation is invited to address the issue of conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia.

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

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

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

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

EXHIBIT 10

PONTIFICAL ACADEMY FOR LIFE

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

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

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

* * *

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

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

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

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

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

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

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

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

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

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

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

Vatican City, 31 October 2000.