EMERGENCY CONTRACEPTION MANDATES IN CONNECTICUT: A CASE HISTORY*

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INTRODUCTION

In 2007 the Connecticut General Assembly overwhelming adopted "An Act Concerning Compassionate Care for Victims of Sexual Assault".[1] The bill mandates that every state licensed health care facility treating a female victim of sexual assault offer its patient emergency contraception (EC) in the form of prescription drugs.[2] These drugs are usually referred to as "morning after" pills. Because of long running debates over possible abortifaciant effects of those drugs, Connecticut's Catholic bishops strongly

* This manuscript was prepared for and was delivered in abridged form at the Twenty-Second Workshop for Bishops (2009), National Catholic Bioethics Center, in Dallas Texas. Subsequent developments in the relevant scientific literature has altered some foundational understandings of the mechanism of action of certain emergency contraceptives. Accordingly, the presentation provided here should be read in light of this authors subsequent work, including *Religious Liberty and Moral Courage: The Right to Fight (available at* http://www.holyapostles.edu/wp-content/uploads/Religious-Liberty-and-Moral-Courage-The-Right-to-Fight-7-21-16-2.pdf*)*. The abridged presentation of this paper is available in video format from the National Catholic Bioethics Center under the title *Impact of Legislative Mandates on the Catholic Health Care Ministry* at: www.ncbcenter.org/Page.aspx?pid=191&nccsm=21& nccscid=4& nccsct=Videos& nccspID=981.

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[1] Conn. Gen. Stat. sec. 19a-112e.

[2] The drug most commonly debated has been "Plan B", a trade name for the synthetic progesterone levonorgestrel Manufactured by Barr Pharmaceuticals Inc. This article will limit discussion of EC to Plan B.

resisted the legislation. For almost two years they waged a lonely struggle against the legislation in the face of a coordinated campaign of public vilification[3] of their persons and malicious distortion of Catholic teaching on human sexuality, contraception, and abortion. Shortly before its effective date of October 1, 2007, with new medical research questioning the possibility of any abortifaciant effect, they announced their policy of "reluctant compliance" with the legislation.[4] To say that their statement was controversial would be Kafkaesque. The response from across political, religious, medical and editorial circles was thunderous.[5] Careful bioethicists and moralists were

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[3] See "Shameful Treatment of Rape Victims", an op-ed piece appearing in the Hartford Courant on March 6, 2006, available at www.connsacs.org/aboutus/documents/HartfordCourantOp-Ed.pdf. See also the comments of Francis Kissling of Catholics for a Free Choice who commented in the Hartford Courant on February 22, 2006: "They will give it to women only if they don't need it. The opposition is not based on numbers or need, but it is an ideological crusade to ensure a woman does not have the option." See, www.catholicsforchoice.org/news/inthenews/20060222hartfordcourant_accesstocontraceptiveurged.asp

[4] The full text of the Bishops' statement is available on the web site of the Connecticut Catholic Conference www.ctcatholic.org. The statement acknowledges a lively debate within the Catholic health care community and the absence of definitive magisterial teaching on the question or clear scientific basis by which Plan B's supposed abortive effect can be proven ("since the teaching authority of the church has not definitively resolved this matter and since there is serious doubt about how Plan B pills work").

[5] The Waterbury Republican editorial of October 1, 2007 titled "The bishops cave" was caustic, labeling the bishops position "a terrible precedent, one that will encourage secularists in state government to continue bullying institutions and individuals who hold religious views lawmakers consider inconvenient." The Journal Inquirer's managing editor, a prominent defender of religious liberty, thundered in his September 29 commentary that "the bishops had lost their nerve", accused them of abandoning the 39 legislators who voted to protect religious liberty and suggested that the big issue now "was whether Connecticut would even *allow* religiously based medicine." See also, www.feninisting.com/archives/007814.html; www.myleftnutmeg.com/showDiary.do?diaryId=8129; http://www.americanpapist.com/2007/09/statement-connecticut-bishops-on-plan-b.html; http://www.lifesitenews.com/ldn/2007/sep/07092807.html; http://www.firstthings.com/onthesquare/?p=866; http://connecticutcatholic.blogspot.com/2007/09/local-reaction-to-plan-b-sucker-punch.html;

more nuanced.[6] Opponents welcomed their decision while questioning their long running resistance to the bill.[7] Former supporters lamented what they unjustly labeled "hair splitting".[8] Almost every reaction was tinged by partisan spirit. One Catholic theologian intemperately asserted that EC may never be provided to a rape victim even if it had no possible abortive action.[9]

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http://www.splendoroftruth.com/curtjester/archives/008379.php; http://www.cathmed.org/pressreleases/PlanB_and_CCC3.pdf

[6] For example, the National Catholic Bioethics Center issued a rational and balanced statement on October 3, 2007 available at www.ncbcenter.org/07-10-03-Connecticut.asp

[7] http://www.connsacs.org/CompassionateCareforRapeVictims.htm. State Sen. Jonathon Harris, a principal supporter of the bill, questioned both the long running opposition and the apparent change of position. State Representative Lawrence Cafero, a defender of the Church's position over the previous two legislative sessions, complained that "a 180-degree turnabout two days before the legislation becomes law, without any adequate explanation, is incomprehensible. It shows apparent disregard and disrespect for the political process and those of us who worked in their behalf." Rep. Cafero's reaction and that of others available at http://connecticutcatholic.blogspot.com/2007/09/local-reaction-to-plan-b-sucker-punch.html

[8] Rev. Thomas J. Euteneuer, *Plan A: Keep "Plan B" Out of Catholic Hospitals* at www.hli.org/sl_2007-10-05.html. The President of Human Life International, an outstanding and valued pro-life witness, unfortunately misstated several issues in an intemperate critique of the Connecticut Bishops. One priest accused the bishops' statement of being nothing more than "an exercise in obfuscation". See Fr. Peter Fehlner's highly provocative statement at http://airmaria.com/2007/10/09/father-peter-damian-fehlner-std-ways-in-on-plan-b-in-connecticut/ Fr. Fehlner's postings on Air Maria.com, a media ministry of the Franciscan Friars of the Immaculata in Griswold, Connecticut, were influential with a segment of Connecticut's orthodox Catholics. See http://airmaria.com/2007/10/20/father-peter-damian-fehlner-std-weighs-in-on-plan-b-in-connecticut-continued/ and http://airmaria.com/2007/10/24/fr-peter-vs-plan-b-the-battle-continues/.

[9] Fr. Peter Fehlner insisted that EC was intrinsically evil in all circumstance, rape included. See *World Renowned Theologian Renders Possible Decisive Blow in Debate of Plan B in Catholic Hospitals*, available at www.lifesitenews.com/ldn/2007/oct/07102305.html. His position demonstrates a fundamental misunderstanding of the Church's teaching on the evil of contraception and reduces it to mere biology. In fact, the issue is the severing of the link between the unitive and procreative significance of conjugal love,

This paper[10] presents a case a case history of that legislation. However, before undertaking that examination, it will be worthwhile to recall another history, one going back much further and greatly influencing the local climate in which the Connecticut "Plan B" battle was waged.

THE CONNECTICUT ENVIRONMENT

Political and Social Realities

In a few short years Connecticut has become a favored venue for a radical cultural and bioethical revolution. While the antecedents have been broad based in western society for a generation, relativism has captured Connecticut public policy as it has in few other places. Proponents of same sex marriage have triumphed in our small state by judicial fiat.[11] Same sex civil unions swept though the general assembly two years ago.[12] Mandatory contraception coverage in employee health insurance has been compelled by legislative mandate.[13] State agencies maintain close alliance with and actively fund

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something totally absent in rape. In truth, "[t]he efforts of a woman to prevent the sperm of her assailant from fertilizing her ovum is not a contraceptive act. To say that it is legitimate for her to seek to prevent conception in this way is not an exception to the universal prohibition of contraception. Contraception occurs only when one who chooses to have sexual intercourse seeks to prevent the act from having its fruitful outcome." Lawler, Boyle & May, *Catholic Sexual Ethics*, Our Sunday Visitor, p. 205 (1996). For further discussion see text accompanying footnotes 31 *infra* and text accompanying footnote 170 *infra*.

[10] Additional discussion of the legislation by this author includes: *Understanding Plan B*, The Catholic Transcript, April 27, 2007 ; *Plan B and the Rout of Religious Liberty*, Ethics & Medics, NCBC, December, 2007; *An 'A' Plan for Plan B*, National Catholic Reporter, November 11-17, 2007.

[11] Kerrigan v. Commissioner of Public Health, 289 Conn. 135 (2008). Available online at http://www.jud.ct.gov/external/supapp/Cases/AROcr/CR289/289CR152.pdf.

[12] Connecticut General Statutes §46b-38aa, et. seq.

[13] Connecticut General Statute §38a-503e.

radical bisexual, transgender, gay and lesbian organizations aggressively shepherding new legal definitions of family and gender.[14] A state stem cell commission has been created to distribute vast resources to researchers with special preference given to those targeting human embryos for stem cell harvesting and death.[15] The same legislation

[14] See e.g. the Department of Children and Families (DCF) Safe Harbor Project at http://www.ct.gov/dcf/cwp/view.asp?a=3270&Q=400418. DCF maintains a close relationship with True Colors, Inc. whose web site offers rich examples of how radical has become mainstream in Connecticut: http://ourtruecolors.org/. DCF's Safe Harbor resources has, in the past, carried extensive articles on the supposed "correct" interpretation of Sacred Scripture, including claims that St. David and King Saul's son Jonathon carried on a homosexual relationship as did Ruth and Naomi. Currently it maintains a link to "For the Bible Tells Me So – A Study Guide and Advocacy Training Curriculum" http://www.ct.gov/shp/lib/shp/pdf/for_the_bible_tells_me_so_curriculum.pdf which subtly hints in the same direction but more offensively injects the State into sectarian interpretation of Scared Scripture. Its current resources page links to many religious organizations and churches it describes as "LGBT" friendly and affirming, including St. Patrick and St. Anthony Church in Hartford, and through links captioned "Catholic" and "Roman Catholic" to the dissident group DignityUSA (http://www.dignityusa.org/) and the British dissident group Quest (http://questgaycatholic.org.uk/home.asp#). A link captioned "Inclusive Orthodoxy" directs the reader to a site created by an Episcopal seminarian although the pages seems intended to give the look and feel of the apostolic eastern orthodox faith (http://www.inclusiveorthodoxy.org/) while another captioned "Axios (Eastern Eskimo Orthodox)" links to a site titled "Axios - Eastern and Orthodox Gay and Lesbian Christians" (http://www.eskimo.com/~nickz/axios.html) which very much represents itself as traditional Eastern Orthodoxy and posts various liturgical texts titled "Orthodox Rite of Brotherhood" and "Same Sex Union", which it claims are "gay marriage" services in the Orthodox faith, a claim not supported by canonical Orthodox sources. More to the point, its link on the DCF website, despite an ineffective disclaimer, appears to endorse its content and demonstrates an unacceptable intrusion by the state into sectarian affairs. Similarly, the DCF site promotes the True Colors Conference (http://www.ct.gov/shp/site/default.asp) held annually in Connecticut which typically includes workshops on "correct" interpretation of Sacred Scripture in accordance with homosexual revisionist reading. (see http://www.ct.gov/shp/lib/shp/pdf/tc_16_conference_guide_workshop_descriptions.pdf) In combination with the links to Biblical interpretation, the sites selection of material and its endorsement and sponsorship of the True Colors Conference may violate the establishment clause if the First Amendment as currently interpreted by the United States Supreme Court. Noticeably absent for the list of links under "Catholic" or "Orthodox" are links to The Vatican, the Archdiocese of Hartford, or any of the multiple Orthodox Church jurisdictions present in Connecticut.

[15] Connecticut General Statute §§19a-32e – 32g. The instructions for applying for state grants from the stem cell commission clearly provide that "priority will be given to human embryonic stem cell research that is not currently eligible for federal funding." http://www.ct.gov/dph/lib/dph/2009_RFP_Final.pdf.

creating and funding the stem cell commission cynically winked at banning human cloning while encouraging human gamete nuclear transfer but accomplished that end only by mandating the destruction of cloned embryos once they demonstrate certain developmental markers.[16] Similar so called "clone-and-kill" bills, have received wide support from Connecticut's federal congressional delegation, which joined unanimously in aggressive attempts to reverse President Bush's well known restriction on federal funding of destructive human ESC research. While thirty nine states have some form of parental consent or notification law dealing with the tragic crisis of minors seeking abortions, advocates for similar legislation in Connecticut cannot win a place on a legislative committee agenda for discussion, much less a vote on the house and senate floor. With one exception, every member of the state's congressional delegation voted against the federal ban on partial birth abortion, including all three Catholics.[17] Support remains strong for federal funding of international organizations promoting and advocating abortion, as well as for abortion in military medical facilities. Opposition

[16] Connecticut General Statute §19a-32d. The legislation defines "cloning of human beings" to mean "inducing or permitting a replicate of a living human being's complete set of genetic material to develop after gastrulation commences." 19a-32d (2). Gastrulation, in turn is defined as "the process immediately following the blastula state when the hollow ball of cells representing the early embryo undergoes a complex and coordinated series of movements that results in the formation of the three primary germ layers, the ectoderm, mesoderm and endoderm." Accordingly, the legislation recognizes – indeed encourages – the technique of nuclear transfer for the purpose of creating human embryos. That process is, in fact, cloning. By defining "cloning of human beings" as a unique legislative expression limited to a developmental stage occurring around day 14, the bill's proponents claimed that it banned cloning when in fact it mandated the execution of human beings and banned any possible embryo rescue.

[17] Connecticut has seven congressional representatives: four house members and two senators. Since the vote on partial birth abortion it has elected another Catholic to the House of Representatives. All four Catholics in the current Connecticut congressional delegation support abortion rights and embryonic stem cell research.

remains strong to basic humanitarian and family protective initiatives such as the Unborn Child Pain Awareness Act and the Child Interstate Notification Act.

The Connecticut Protocol

It was in that atmosphere of radical abortion advocacy and distorted autonomy that proposals for mandated EC in rape trauma treatment were proposed. The critical issue for Catholic health care facilities has always been determining whether a proposed intervention will have a destructive post fertilization effect. As is well known, the Ethical and Religious Directives for Catholic Health Care Facilities (ERDs) provide that medications may be provided to rape victims at Catholic facilities to suppress ovulation and prevent fertilization.[18] The Directives specifically prohibit actions that prevent implantation of a fertilized oven in the endometrial lining. Any action of that nature, identified as interceptive by *Dignitas Personae*,[19] would be abortive. This simply means that life already conceived must not be harmed.

Catholic health care providers and ethicists have struggled to determine how best to assure that rape victims receive appropriate annovulant therapy without harming

[18] ERD 36 provides in pertinent part that a female rape victim "should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum." A footnote to Directive 36 recommends that rape victims be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures.

[19] *Dignitas Personae*, Congregation for the Doctrine of the Faith, no. 23 (2008).

potentially nascent life at its earliest pre implantation stages. This struggle arises from the long held view that annovulant medications also possess an interceptive mechanism. That belief has been founded on a number of professional medical journal articles, product information supplied by pharmaceutical manufacturers and statements from the Federal Drug Administration (FDA) on the means by which EC functions. As a result, three views have emerged within the Catholic health care world. The pregnancy test approach maintains that the quantum of data obtained by pregnancy testing is sufficient to provide EC if testing is negative.[20] Others have suggested additional testing in view of the potential for an interceptive effect if suppression of ovulation is unlikely. In that view it would be better to withhold EC if blood serum or urine testing indicates that a woman has entered her ovulatory phase signaled by surge in Luteinizing Hormone (LH) since administration would no longer suppress ovulation it was thought that the risk of interceptive action increased. A third view holds that EC should never be provided in view of potential interceptive action. The ongoing discussion on this topic as it relates to pregnancy and ovulation phase testing is well described in Helen Alvare's presentation at the twenty-first Workshop for Bishops in 2007 entitled *The Prevention of Pregnancy after Sexual Assault*[21]. The elements of a typical ovulation phase testing protocol were

[20] The Committee on Doctrine and Pastoral Practices of the USCBB examined EC issues in 2004 and concluded that rape treatment protocols relying on pregnancy testing only prior to Plan B administration do not violate Directive 36 of the ERDs. See Ashley, DeBlois and O'Rourke, *Health Care Ethics, A Catholic Theological Analysis* at p. 86 (2007).

[21] H. M. Alvare, *The Prevention of Pregnancy After Sexual Assault* at pp. 146-149, in Urged On By Christ, Catholic Health Care in Tension with Contemporary Culture, The Twenty-first NCBC Workshop for Bishops (E.J. Furton, Editor)(2007). See also John B. Shea, M.D., *The 'Morning-After' Pill*, Social Justice Review available at http://socialjusticereview.org/articles/morning_after.php

addressed at the 2005 Workshop for Bishops[22]. It is enough note here that an LH test protocol employing blood serum testing is frequently referred to as a "Peoria protocol" because the prototype was developed at St. Francis Medical Center in Peoria, Illinois.[23] Where such testing is carried out by means of a urine dip strip test it is typically referred to as a "modified Peoria protocol".

Some have recently suggested that the efficacy of one form of EC known as Plan B, containing the progestin[24] levonorgestrel (LNG), may be fully explained by pre-fertilization events.[25] But when the debate in Connecticut over mandatory EC in rape treatment protocols began the majority view, even among proponents of EC, was that Plan B possessed a potential interceptive action preventing implantation.[26]

CLEARING OBSTACLES AND THE GROOMING OF PUBLIC OPINION

Before addressing the possible alternative mechanisms by which EC operates, as well as the dynamics that played out in Hartford in 2006 and 2007 and various ongoing

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[22] Rev. Albert S. Moraczewski, *Rape Protocols and Emergency Contraception* at p 155 in Live the Truth, The Moral Legacy of John Paul II in Catholic Health Care, The Twentieth NCBC Workshop for Bishops (Edward J. Furton, Editor)(2006).

[23] See G.J. McShane, et. al. *Pregnancy Prevention after Sexual Assault* in Catholic Health Care Ethics: A Manual for Ethics Committees, Chapter 11 (P.J. Cataldo and A.S. Moraczewski, O.P., Editors)(2001).

[24] Progestin is synthetic progesterone derived from the naturally occurring hormone. See also footnote 168, *infra*.

[25] Frank Davidoff and James Trussell, *Plan B and the Politics of Doubt*, 296 JAMA 1775 (October 11, 2006).

[26] The National Abortion Rights Action League (NARAL), the Center for Reproductive Rights, The Kaiser Foundation and Princeton University's Emergency Contraception web site all contained statements that EC does or might prevent implantation of an fertilized egg. See this author's commentary *Understanding Plan B* in The Catholic Transcript (Archdiocese of Hartford), April, 2007 available online at http://www.catholictranscript.org/index2.php?option=com_content&do_pdf=1&id=268.

controversies, certain terms bear clarification due to the havoc worked on language by the abortion lobby.

Abortion advocates, pharmaceutical manufacturers and allied organizations have engaged in decades long pogrom designed to groom public opinion to accept abortion and contraception as one interdependent civil liberty. That effort produced substantial fruit in Justice Sandra Day O'Connor's plurality opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey:*

> [I]n some critical respects the abortion decision is of the same character as the decision to use contraception… .
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> …
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> [F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail."[27]

Professor Janet Smith has cogently pointed out that the claim of interdependency between abortion and contraception as a unified civil liberty is grounded in the reality that both treat babies "as an unwelcome intrusion into a sexual relationship, as a burden."[28] Similarly, John Paul II pointed out in *Evangelium Vitae* that the pro-abortion culture is strongest where the Church's teaching on contraception is rejected and noted the link between the two:

[27] 505 U.S. 833, 852 and 856 (1992).

[28] Janet Smith, *The Connection Between Contraception and Abortion*, www.goodmorals.org/smith4.htm

> "[D]ispite their differences in nature and moral gravity, contraception and abortion are often closely connected, as fruit of the same tree. ... The close connection which exists, in mentality, between the practice of contraception and that of abortion is becoming increasingly obvious. It is being demonstrated in an alarming way by the development of chemical products, intrauterine devices and vaccines which, distributed with the same ease as contraceptives, really act as abortifacients in the very early stages of the development of the life of the new human being."[29]

Nonetheless, it is clear to anyone surveying the national cultural landscape that the vast majority of people continue to radically differentiate abortion and contraception not only in their ends but in their motivational origins. While the former is often lamented or tolerated as someone else's business, at least in early stages of pregnancy, the later is affectionately embraced and widely practiced by most married couples. Its absence from non-marital intercourse is generally considered irresponsible.

As a result of the lingering hesitancy of American culture to embrace abortion, its advocates have resorted to verbal ploy, redefining words so as to label abortive practices, molecules and devices merely "contraceptive". This strategy has been recognized and commented on elsewhere.[30] The principal terms at play in the debates over EC are "conception", "pregnancy" and "abortion".[31] In proponent's lexicon "pregnancy" arises

[29] Evangelium vitae no. 13.

[30] Rev. Albert S. Moraczewski, *Rape Protocols and Emergency Contraception*, footnote 41 infra, pp 161-162.

[31] Other terms have been similarly restructured for public consumption in debates related to abortion, embryonic stem cell research, same-sex marriage and sexual orientation. They include "person", "gender", "cloning" and "contraception". In the case of EC it is not infrequent to hear Catholics speak of Church acceptance of "contraception" following rape as though it were an exception to its teaching of the intrinsic evil of contraception. It would be better to focus attention on the absence of a truly unitive act in the case of rape. Without freedom in the physical relation there is no true "conjugal" act with a joined

only after implantation in the endometrium. Likewise, "conception" is admitted only after implantation, but not at fertilization. Consequently, since "abortion" is limited to disruption of a pregnancy, it can only refer to post implantation actions: what *Dignitas Personae* refers to as "contragestative".[32] By this rationale, preventing the implantation of a fertilized ovum is not abortive but merely contraceptive. Some medical associations have accepted these new definitions. Others have not.[33] The strategy has been to isolate

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procreative and unitive significance. Simply put, rape is not free and it is therefore neither unitive nor conjugal. Subsequent annovulant therapy is not an exception to the Church's teaching on contraception, but an act specified by an entirely different object. See footnote 9 *supra* and text accompanying footnote 165 *infra*.

[32] *Dignitas Personae*, no. 23.

[33] The Merck Manuals Online Medical Library states: "Pregnancy begins when an egg is fertilized by a sperm." See http://www.merck.com/mmhe/sec22/ch257/ch257a.html. One of the leading studies in human reproduction in the last decade is *Conception to ongoing pregnancy: the 'black box' of early pregnancy loss* by Macklon, Geraedts and Fauser in Human Reproduction Update, Vol 8, No.4 pp. 333-343 (2002). The authors make the following statements: "Pregnancies may be lost at any time between fertilization and implantation, or up to term." (Ibid at p. 333); "published studies point to a rate of pregnancy loss prior to implantation of 30%" (Ibid at p. 335); "It has become clear that from the moment of fertilization, there is a continuous reduction or 'selection' of conception products showing chromosome abnormalities. Starting from ˜38% at conception and ending at 0.6% at birth…selection against aneuploid embryos probably starts at the morula/blastocyst transition…" Ibid at p. 339). Each of these statements presumes that pre-implantation status constitutes "pregnancy" or "conception". See also *The Merck Manual*, Seventeenth Edition p. 2014 (1999) which reads "Conception (fertilization) occurs about 14 days before a menstrual period, just after ovulation." Medline's popular online medical dictionary adopts the Merriam-Webster dictionary definition of conception: "the process of becoming pregnant involving fertilization or implantation or both." See http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=conception. Dorland's Medical Dictionary defines conception as "an imprecise term denoting the formation of a viable zygote." http://www.mercksource.com/pp/us/cns/cns_hl_dorlands_split.jsp?pg=/ppdocs/us/common/dorlands/dorland/two/000023409.htm. It is even more precise in defining pregnancy as follows: "**pregnancy** (preg´nən-se) the condition of having a developing embryo or fetus in the body, after union of an oocyte and spermatozoon. … The period during which a female is pregnant, in humans being about 266 days from the time of fertilization of the oocyte until birth (or 288 days from the last normal menstrual period to birth." See online at http://www.mercksource.com/pp/us/cns/cns_hl_dorlands_split.jsp?pg=/ppdocs/us/common/dorlands/dorland/seven/000086088.htm.

the Church and divide those opposed to abortion by playing to widespread support for contraception, even within pro-life circles, without confronting the deep societal rift over abortion. In fact, these definitions were operative if unexpressed in much of the testimony presented by advocates of mandatory EC during the legislative debates in 2006. A subtle shift developed in 2007 as some proponents argued that recent studies demonstrated that Plan B does not have an interceptive effect. While the research underlying that claim is undoubtedly significant, it is inconclusive.[34] Nonetheless, proponents continued to maintain that even if post fertilization interceptive effects were operative, they would not constitute anything more than contraception.

EVENTS PRECEEDING 2006: THE RISING TIDE

The history of the Connecticut statute began years before legislation was first proposed in 2006. Proponents of EC have long joined their campaign to the sympathy naturally felt for rape victims. A wide net of ideologically associated organizations maintained aggressive campaigns promoting the use and easy availability of EC, other contraceptives, access to abortion services and comprehensive sexual education of youth. Typically they are united in their advocacy on behalf of same sex marriage as well as transgender, lesbian, gay and bisexual identity politics. Planned Parenthood, National Abortion Rights Action League or NARAL, the American Civil Liberties Union, The Guttmacher Institute, The Kaiser Foundation, Catholics for a Free Choice, the Population

[34] For further discussion of the underlying scientific research see footnotes 92-118 and accompanying text, *infra*.

Council, Population Services International, United Nations related entities[35], National Organization for Women, and their many state affiliates are but a small representative handful of this enormous movement. They are well funded and well organized. They maintain sophisticated planning operations that select the best venues for various initiatives and they put boots on the ground when legislative committees hold hearings.[36] The International Consortium for Emergency Contraception and the American Society for Emergency Contraception link many of these organizations through electronic media, regional, national and international conferences, and maintain detailed on-line newsletters monitoring EC developments worldwide.[37] The Massachusetts based Abortion Access Project helps guide a nationwide effort to mandate EC in rape treatment protocols as well as mandated insurance coverage for contraceptives and abortion.[38] Together and individually, these organizations have a powerful influence on public opinion, professional health care societies, the establishment of standards of care and development

[35] The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction has been widely known for many years by the abbreviation, HRP. Established by the World Health Organization (WHO) in 1972, HRP brings together policy makers, scientists, health care providers, clinicians, consumers and community representatives to identify priorities in sexual and reproductive health. Emergency contraception has become one of its priorities. HRP is the only body within the United Nations system with a global mandate to lead research in human reproduction and is sponsored by the United Nations Development Programme, the United Nations Population Fund, World Health Organization and the World Bank.

[36] See *Abortion Activists' Plan B*, National Catholic Register, November 4-10, 2007 Issue, available at www.ncregister.com/site/article/7130

[37] www.cecinfo.org; www.emergencycontraception.org/asec/.

[38] See the Massachusetts Catholic Conference Legislative Testimony on similar legislation in our neighboring state in 2003. Available at http://www.macathconf.org/03-EC%20Mandate%20Testimony%20Judiciary%206-11.pdf.

of legislative initiatives and government funding programs. They offer intern positions, public policy advocacy workshops, political action programs, and educational and advocacy opportunities. They are particularly active on college campuses and in urban settings.

In December 2003 the National Sexual Violence Resource Center (NSVRC), a project of the Pennsylvania Coalition Against Rape, together with the Education Fund of Family Planning Advocates of New York State and the ACLU of Pennsylvania, published *Preventing Pregnancy from Sexual Assault*.[39] This 137 page manual is a blueprint for enacting mandatory EC rape treatment laws in individual states. It also provides strategic plans for extending EC in rape treatment through administrative action, litigation and voluntary change. It provides specific instructions on coalition building, legislative lobbying, selection of sponsors (such as Catholic legislators from large families), planning media coverage, building public support and anticipating opposition from Catholic conferences. It provides key statutory language to assure universal coverage and a special section dedicated to defeating requests from Catholic hospitals for exemptions from the law. It also provides instructions on conducting surveys of state hospitals in order to establish spotting EC availability in cases of sexual assault. It is intended as a companion for the ACLU's *E.C. in the E.R.: A Manual for Improving Services for Women Who Have Been Sexually Assaulted*, published in July, 2003. The ACLU manual provides even greater specificity on conducting state hospital surveys and

[39] Available at http://www.nsvrc.org/_cms/fileUpload/ECtoolkit-1.pdf.

also contains specific provision on how to anticipate and overcome objections from Catholic hospitals.

The Connecticut tentacles of this movement activated a vast array of organizations supporting its goals during the Connecticut EC debates.[40] Additional organizations, such as local sexual assault crisis centers and out of state "reproductive rights" advocacy groups, sent representatives to testify at the legislative hearings. Following closely the strategies set forth in the NSVRC and ACLU manuals, umbrella organizations established a well structured communication, public relations and lobbying campaign. The Connecticut Sexual Assault Crisis Service (CONNSACS)[41] conducted a

[40] The American Academy of Pediatrics, Connecticut Chapter, American Association of University Women, American Civil Liberties Union - Connecticut, American College of Obstetricians and Gynecologists, Connecticut Coalition Against Domestic Violence, Connecticut Conference of United Church of Christ, Connecticut Coalition for Patient Safety, Connecticut Chapter of the National Organization for Women, Connecticut Sexual Assault Crisis Service, Republican Majority for Choice (Connecticut), Connecticut Women's Consortium, Connecticut Women & Disability Network, Connecticut Women's Educational & Legal Fund, Connecticut Women's Health Campaign, Eastern Connecticut State University Women's Center Hadassah, Health Care for All, Hispanic Health Council, Latino & Puerto Rican Affairs Commission, League of Woman Voters of Connecticut, NARAL Pro-Choice Connecticut, National Council of Jewish Women, Northeast Regional Council YWCA, Planned Parenthood of Connecticut, People of Faith Connecticut, Religious Coalition for Reproductive Choice, Rosie Fund of Connecticut, Ruth Boyea Women's Center of Central Connecticut State University, Southern Connecticut State University Women's Center, State Employee Bargaining Agent Coalition, Trinity College Women's Center, University of Connecticut Medical Students for Choice, University of Connecticut Women's Center, University of Hartford Connections Health Education and Women's Center, Wesleyan University Davison Center/WesWel, Yale Nursing Students for Choice and the Young Women's Leadership Program.

[41] CONNSACS represents that it "works to end sexual violence through victim assistance, community education, and public policy advocacy" and that it's "mission is to end sexual violence and ensure high quality, comprehensive, and culturally competent sexual assault victim services." See http://www.connsacs.org/aboutus/index.htm. However, it is also a member of NARAL Pro-Choice Connecticut's "Coalition for Choice", an association made up exclusively of the following abortion rights advocacy organizations: Planned Parenthood of Connecticut, National Council of Jewish Women, Connecticut Women's Education and Legal Fund, American Association of University Women, Connecticut Conference of the United Church of Christ, Republicans for Choice, Connecticut Civil Liberties Union and Connecticut National Organization for Women. See http://www.pro-

telephone survey modeled on the manuals and reported that 20% of Connecticut's emergency rooms did not routinely provide a full regimen EC to victims of sexual assault. Although the 20% figure does not appear to differentiate circumstance such as pre-existing pregnancy, post-menopausal victim, other than vaginal assault, prior surgical sterilization that would contraindicate EC, it became a mantra in Hartford. Equally troubling was the reluctance of proponents to release details of their survey, leading some to question its accuracy.

Shortly before CONNSACS conducted its telephone survey, the proceeding of the 2005 Workshop for Bishops included presentation by Fr.Albert Moraczewski on "Rape Protocols and Emergency Contraception".[42] His presentation was a balanced discussion of the two most common approaches followed by Catholic health care facilities that provide EC as part of rape treatment – pregnancy test vs. ovulatory phase test. Following that Workshop a review of the rape treatment policies at Connecticut's four Catholic hospitals began. At that time one of the hospitals provided EC if a pregnancy test was negative.[43] The others had no policies authorizing EC in rape cases. However, anecdotal evidence suggests that EC may have been surreptitiously provided to rape victims by

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choicect.org/coalition/members.shtml. CONNSACS membership in NARAL's coalition suggests that it holds an ideological commitment to abortion advocacy.

[42] Published in Live the Truth, The Moral Legacy of John Paul II in Catholic Health Care, Proceedings of the Twentieth Workshop for Bishops, p. 155 (Edward J. Furton, Editor) National Catholic Bioethics Center (2006).

[43] St. Vincent's Medical Center, Emergency Department, Reported Sexual Abuse Policy, Section VI.4. provided "Per the Ethical and Religious Directives for Catholic Healthcare Services, pregnancy prophylaxis is only permitted for instances of sexual assault. Serum pregnancy test, Beta HCG qualitative must be negative to offer pregnancy prophylaxis. Ovral (norgestrel + ethinyl estradiol), 2 tablets orally initially and 2 tablets 12 h later. Consider anti-emetic."

hospital staff.[44] In approximately January, 2006 it was decided that all four facilities would follow uniform practice employing a "modified Peoria Protocol" with urine testing for LH surge, which, if positive, precluded administration of EC.[45]

Certain members of the Connecticut General Assembly, along with many allied advocacy groups, claimed the new protocol jeopardized women's health and failed to meet the recognized medical standard of care for rape trauma treatment. Legislative sponsors introduced An Act Concerning Emergency Health Care for Sexual Assault Victims, Senate Bill 445. The bill required licensed health care facilities treating victims of sexual assault to advise patients about EC, offer it to them and provide it to those who want it.

THE 2006 LEGISLATIVE HEARING

The Public Health Committee of the General Assembly conducted a hearing on the proposed legislation on March 6, 2006. Appearing in favor of the bill were an

[44] During the 2006 legislative hearings an obstetrician from a secular hospital in Connecticut testified that there was an well known unspoken practice in emergency rooms at some hospitals with policies prohibiting EC whereby physicians and physicians assistants provided EC to rape victims by way of a "workaround" that jeopardized their employment. See Public health Committee Transcript, 03/06/2006 at p. 212. A state representative similarly testified that in the past, Connecticut Catholic hospitals had routinely allowed doctors to evade Church teaching related to contraception when it involved EC and rape victims. That testimony is explored further in text accompanying footnote 56-57 *infra*. This author's interview with Emergency Room personnel at one Connecticut Catholic hospital was noteworthy for the comment that while the facility did not have a policy regarding EC in rape cases prior to 2006 "I'm not saying it didn't happen."

[45] Note that the hospital policies were actually adopted at the various facilities at later dates. St. Vincent Medical Center's (Bridgeport) Female Sexual Assault Treatment Protocol was approved as an Emergency Department protocol on May 6, 2006. Similarly, St. Francis Medical Center's (Hartford) Emergency Contraception policy was approved as a Department of Pharmacy policy on June 26, 2006. The time variant may be explained by adaptation of the common protocol to individual hospital circumstances, a process that took a number of months.

impressive collection of pro choice advocacy groups, politicians, doctors, nurses, sexual assault victims and counselors, lawyers, politicians and citizens. A careful review of their testimony discloses certain common features. Advocates presented a case for victim compassion, stressing the emotional and physical burdens that rape victims endure. They typically asserted that Plan B never induces an abortion, although none explained that their definition of abortion to applied only to contragestative actions. Some provided first hand and anecdotal accounts of rape victim experience. Legal experts provided carefully nuanced analysis of existing constitutional case law designed to persuade legislators that the proposed bill did not intrude on religious liberty and did not require or warrant any institutional conscience clause exemption. At least one out of state advocacy group delivered important testimony about similar legislation in New York, a fact that proved critical before the Plan B bill debate wrapped up in late 2007. Other testimony sought to shame opponents of the bill as witnesses expressed their shock at the Church's opposition. An element common to the testimony of several representatives of abortion advocacy organizations was the acceptance of EC without LH testing by various state Catholic conferences and health care organizations. A more detailed review is worthwhile so that the methods and force of the proponents' legislative advocacy may be fully appreciated.

The Executive Director of the State Permanent Commission of the Status of Women presented compelling testimony on the number of rapes occurring annually in the United States and the time sensitive nature of efficacious EC treatment. She insisted that EC never causes an abortion because it cannot dislodge an implanted embryo. In fact, she argued, it reduces the number of abortions by preventing unwanted pregnancy. She

also argued that it protects the religious liberty of the rape victim. She repeatedly stressed the CONNSACS survey data that 20% of Connecticut's hospitals did not routinely offer EC treatment to rape victims.[46]

Her testimony was followed by the State Attorney General who strongly supported the legislation as a victim's rights measure. He stressed the injustice of requiring rape victims to shuttle between hospitals when prompt administration of EC is vital for efficacy. He noted adoption of similar laws in other jurisdictions and defended the constitutionality of the law while at the same time suggesting that room could be made for individual conscientious objector exemption, although not for a facility.[47]

State representative Denise Merrill was a particularly forceful advocate. As a witness before the committee she declared herself shocked that the bill was opposed by anyone given the horror of rape and the need for prompt treatment. She related her flawed understanding that a recent shift had occurred in Catholic hospitals in Connecticut concerning the provision of EC to rape victims such that Catholic hospitals were now opposed to providing EC in their emergency rooms.[48] She suggested that passage of mandatory EC laws in other states was behind that shift. Her claim was that Connecticut's Catholic hospitals had long followed a "nervous policy" concerning EC treatment of rape victims by allowing doctors to find ways around Catholic teaching on contraception. She described it as "don't ask, don't tell" by which EC had been routinely

[46] Public Health *Committee Hearing Transcript, 03/06/2006 page 22-33.*

[47] *Ibid, pp 36-39*

[48] *Ibid at p. 66. She* was simply mistaken in her understanding. Catholic hospitals only opposed Plan B if a LH urine test was positive.

offered to rape victims.[49] Repeatedly stressing that Catholic hospitals receive substantial state funds she expressed her displeasure with the "awkward situation" of nonprofit hospitals with religious affiliations having "their own set of moral and religious objections to certain things". [50]

The Program Director of a sexual assault victims' service agency in Waterbury, Connecticut testified that it had recently come to her attention that victims were being denied EC at specific hospitals and were discouraged by the notion of having to travel to another hospital or agency to obtain EC. She related the facts of a specific case in which she accompanied a victim to an emergency room. Her account included the following: "Knowing the policy of this particular hospital, I knew I would have to refer the client elsewhere to receive emergency contraception", advice that left the traumatized victim "very discouraged". She testified that the "hospital staff treated the victim with compassion and respect that evening. I knew that it was not a personal decision of the staff not to provide emergency contraception, but rather a policy that they are required to follow." Follow up questioning concerning the identity of the facility clarified the issue: "Catholic hospitals is the issue."[51] She also asserted that Catholic hospitals do not refer victims to other providers and do not discuss the possibility of pregnancy with victims.[52]

[49] Ibid p. 67.

[50] Ibid p. 70.

[51] Ibid p. 192.

[52] Ibid at p. 197.

A staff attorney from Family Planning Advocates of New York also testified. The thrust of this testimony proved critical to many votes in the general assembly in 2007. The witness pointed out that New York passed a similar law two and one half years earlier. Initially the bill was opposed by the New York State Catholic Conference, but that position changed. She represented that the Chief Executive Officer of her agency and "the Executive Director of the New York State Catholic Conference went to the legislators jointly to show their joint support for this act."[53] She also related the findings of a survey conducted by her agency in New York that showed 75% of Catholic hospitals provide EC to any rape victim on request. The significance, she asserted, was that the results "demonstrated that there is no absolute prohibition of providing EC at Catholic sponsored hospitals."[54]

A practicing OB-GYN repeated what had been presented by others: EC treatment in rape cases is a standard of care established by several medical entities including the American Medical Association and the American College of Obstetricians and Gynecologists; it is time sensitive requiring administration within 72 hours of assault; and victims are traumatized such that they are emotionally and sometimes physically unable to obtain EC if it is denied at the emergency room. She claimed that a positive LH test makes EC all the more imperative since impending ovulation means that the woman is

[53] Ibid at p. 198.

[54] Ibid. Note use of the term "Catholic sponsored hospital". Many abortion advocates are careful to avoid the term "Catholic hospital". They prefer phrases such as "Catholic affiliated hospitals" or "Catholic Sponsored hospitals" in order to emphasize their view that hospitals are not religious entities entitled to considerations associated with the free exercise clause of the First Amendment.

most vulnerable to becoming pregnant. "To inform the victim that because she is especially likely to get pregnant from her assailant and then to say, sorry we can't give you this, is just to [sic] cruel to comprehend."[55] Disturbingly, she confirmed earlier testimony that there was an unauthorized and unspoken practice in some emergency rooms whereby physicians and physician's assistants provided EC to rape victims where their hospital policy dictated otherwise.[56] Accordingly, this witness advocated adoption of the bill as a form of "job protection" for hospital staff who were knowingly violating facility protocol by providing EC.[57]

The stunning testimony of a rape victim riveted the committee as L.F. recounted her kidnapping and rape by a gang of four armed men. She was provided with EC at an emergency room and took the full dose. She provided a firsthand account of the trauma endured by rape victims and told the committee that if she were required to find a pharmacy to obtain EC it would have cruelly prolonged her agony. Stressing that rape is

[55] Ibid at p. 212. It must be noted that once LH surge is detected it is unlikely that ovulation can be suppressed. Durand, et. al., *On the mechanisms of action of short-term levonorgestrel administration in emergency contraception*, Contraception, 2001. 64(4): p. 227-34. Accordingly, EC administration after LH surge will not prevent pregnancy by annovulant action. For Plan B to be effective at that stage of a woman's cycle a secondary mechanism must actualize to prevent fertilization or implantation. That may include release of ova resistant to fertilization. See Verpoest, et. al., *Relationship between midcycle luteinizing hormone surge quality and oocyte function*, Fertility and Sterility, 73:1 (January 2000): 75-77. Some research suggests that it is improbable that LNG would produce an interceptive effect when administered *after* ovulation given the finding of successful implantation following post ovulatory LNG use reported by Novikova, et. al., *Effectiveness of levonorgestrel emergency contraception given before or after ovulation: a pilot study*, Contraception, 2007. 75(2): p. 112-18. See discussion in footnotes 97-99 and 106 and accompanying text, *infra*.

[56] Ibid. It seems a fair read to suggest that this was a reference to Catholic hospitals.

[57] Ibid. This testimony appears to have been directed at Catholic facilities.

not the victim's choice, she proposed that subjecting the victim to a hospital's religious beliefs was unfair, especially in view of the time sensitive nature of EC.[58]

The Executive Director of the American Civil Liberties Union of Connecticut testified that the bill was constitutionally sound and reviewed recent state appellate and Supreme Court decisions on the related issues of state mandates for contraceptive coverage in employee provided health insurance.[59] He argued that religiously related institutions, such as Catholic Charities and Catholic hospitals, are not themselves religious entities and had no constitutional basis to claim exemption from either a contraceptive health insurance mandate or an EC rape treatment mandate. His discussion of the case law was sophisticated and he assured the legislators that no recognized religious liberty interest was implicated in the proposed legislation. He strongly urged that no religious exemption be introduced by which Catholic hospitals would be excluded from the bill's coverage. He did not comment on the applicability or substance of Connecticut's Religious Liberty Act, a surprising development given the extra constitutional protections it provides.[60]

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[58] Ibid at pp. 213-216.

[59] Ibid at p. 221-224. The related cases, Catholic Charities of the Diocese of Albany v. Serio, 7 N.Y. 3d 510 (2006) and Catholic Charities of Sacramento v. Superior Court, 32 Cal. 4th 527 (2004) are discussed in Marie T. Hilliard's *Contraceptive Mandates and the Avoidance of Culpable Negligence*, Urged on By Christ, supra at 127.

[60] Connecticut General Statute 52-571b. For further discussion of the Act and its applicability to state mandates see this authors article *Plan B and the Rout of Religious Liberty*, footnote 10 *supra* and footnotes 171-172 and accompanying text, *infra*.

An advocate from the Center for Women and Families in Bridgeport, Connecticut[61], the Executive Director of the Connecticut Sexual Assault Crisis Services[62] and several citizen witnesses also testified in support of the bill. Of particular importance was the testimony of the Executive Director of CONNSACS who forcefully objected to the testimony of the State's Victim Advocate[63] who had unexpectedly appeared to oppose the bill.[64] She represented that his testimony against the bill in no way reflected the opinions of the state's sexual assault crisis community.

The Executive Director of NARAL Pro-Choice Connecticut presented the bill as a common sense pregnancy prevention measure. She argued that Plan B does not cause an abortion but would help reduce the need for abortion and highlighted similar legislation in other states.

Additional testimony was offered by the community relations coordinator for the Connecticut Sexual Assault Crisis Service who read a statement from the Clinical Director of the Sexual Assault Crisis and Education Center in Stamford, Connecticut. The statement related meetings recently concluded with two women who were pregnant

[61] Public Health Committee Hearing Transcript, 03/06/2006 page 228.

[62] Ibid at p. 233-236

[63] The State Victim Advocate is appointed by the Governor to, *inter alia*, "undertake legislative advocacy" supportive of the interests of crime victims. Conn. Gen. Stat. sec. 46a-13c(8).

[64] The State Victim Advocate's testimony and the related controversy are discussed *infra* at text accompanying footnotes 80-87.

from rape. As a result they faced the anguished decision of whether to abort, a decision, she claimed, that could be avoided if timely EC were provided in emergency rooms.[65]

A certified sexual assault crisis counselor related the sexual assaults of teenagers and the shocked, tearful, embarrassed, numbed and disbelieving reaction many of them had to their experience. Some had never been to an emergency room or had an internal gynecological exam. Some were unaware of issues such as sexually transmitted diseases, HIV or pregnancy. In her experience none of them asked any questions of the sexual assault counselor. Some just wanted to go home after examinations and questions that can last from five to eight hours or more. The impression left with the committee and everyone listening was one of desperate suffering and alienation, a reality, she suggested, that may be ameliorated to some degree by provision of EC.[66]

A former State trooper and practicing forensic nurse testified about her experience in law enforcement and in forensic training of health care professionals. She stressed the time sensitive nature of EC, the emotional trauma to the victims - some of whom have been blindfolded, gagged, stabbed, shot and even left for dead - and the lack of uniformity in providing EC in Connecticut's hospitals.[67]

[65] Public Health Committee Hearing Transcript, 03/06/2006 at p 224-225.

[66] Ibid at p. 226-227.

[67] Ibid at p. 230-232.

A graduate student at UCONN's School of Social Work repeated much of the previous testimony.[68]

Such was the case presented for the bill. Opposition came from one state senator witness, the State Victim Advocate, a representative of the Connecticut Catholic Hospital Council, a small number of pro-life citizen activists (two from Connecticut Right to Life) and a smaller number of citizens who identified themselves as pro life Roman Catholics. Some of the citizen witnesses presented claims against Planned Parenthood, asserted links between birth control, abortion and breast cancer, and otherwise provided ineffective, disjointed and rambling testimony. Others defended the compassionate treatment of rape victims at Catholic hospitals and defended the Church's teaching on the sanctity of life. Their sparse testimony was not a factor in subsequent developments.

Senator DeLuca made a passionate defense of religious liberty and pointed out that every Catholic hospital in the State was within a few minutes of a secular hospital and that no urgent need justifying mandated EC in a Catholic facility when alternative facilities were readily accessible.[69]

The Catholic Hospital Council representative and General Counsel of St. Francis Hospital in Hartford provided background testimony on religious liberty with reference to both constitutional and statutory sources. He outlined the new protocol being introduced

[68] Ibid at p. 220-221.

[69] Ibid at p. 58-62. His comments echoed those of Connecticut's United States Senator Joseph Lieberman who supported the right of Catholic hospitals to refuse EC to rape victims for "principled reasons". Although he did not testify at the hearing, Senator Lieberman clearly recognized the ready availability of EC at nearby secular hospitals: "In Connecticut, it shouldn't take more than a short ride to get to another hospital." www.nhregister.com/articles/2006/03/13/import/16292372.txt.

at all four Connecticut Catholic hospitals; explained the reason for the LH test and its relation to Catholic teaching on the beginning of human life; explained its relation to the ERDs; and assured the committee that Catholic hospitals would assist in the transfer of any rape victim to another hospital if LH testing precluded administration of EC. He made a dispassionate and professional presentation of the then current understanding of Plan B's primary and secondary modes of action, including interfering with implantation of a fertilized ovum in the uterine wall.[70] He further explained the role of pregnancy testing in both Catholic and non Catholic hospitals. Although he mistakenly, if hesitantly, expressed the view that EC may have a contragestative effect on an already implanted embryo[71], he correctly pointed out that no hospital provides EC if a pregnancy test is positive. He also provided a candid explanation to inquiring committee members as to why changes had occurred in Connecticut's Catholic hospitals in this delicate area. He commented that prior to Archbishop Mansell's arrival in Hartford there was no uniformity in the practices of the four Connecticut Catholic hospitals.[72] Reasonably enough, both Archbishop Mansell and Bishop Lori wanted to develop a common policy in the State and they undertook a thoughtful process of deliberation and study that lasted nearly a year.[73] That process concluded about two months before the hearing[74] when the decision on a standardized protocol was finalized utilizing LH surge testing in

[70] Public Health Committee Hearing Transcript, 03/06/2006 at p. 201-203.

[71] Ibid at p. 205.

[72] Ibid at p. 203.

[73] Ibid.

[74] Ibid at p. 207.

appropriate cases by means of a noninvasive urine analysis.[75] He testified that the previous method of hormone level testing of rape victims required blood serum analysis for progesterone.[76] The new protocol[77] significantly simplified the means by which Catholic facilities could determine if ovulation was imminent. He proposed that the new test did not require a blood sample, yielded immediate results and was more accurate.[78] It also means that while the manner of testing changed, the purpose did not. When questioned about the potential financial cost to a rape victim of inter-hospital transfer, he represented that any expense associated with the transfer not covered by insurance would be covered by the Catholic hospital.[79]

Unquestionably, the surprise of the day was the testimony of the State's Victim Advocate, who many had assumed would support a rape victim's immediate access to EC in any and all hospital settings. The Victim Advocate opened his testimony by representing to the committee that he was a Roman Catholic deacon but that his "sole intention in testifying before you today is to protect the credibility and the integrity of the victims' rights and victims' services in Connecticut and to uphold the good will that this Body, the Connecticut State Legislature, has heretofore afforded crime victim causes in

[75] Ibid.

[76] Ibid. Such a method would constitute an element of a "Peoria Protocol".

[77] The new protocol may be referred to as a "Modified Peoria Protocol" utilizing urine testing in lieu of blood serum analysis. That modification of the Peoria Protocol was developed by Ascension Health together with the National Catholic Bioethics Center for hospitals in the Diocese of Austin, Texas.

[78] Ibid.

[79] Ibid at p. 208.

our state."[80] He asserted that there had been no denial of services to rape victims since EC is available from other facilities and, if testing is negative, even from Catholic facilities. He represented that in his "six-plus years [as] the State Victim Advocate [he] had not one call from a rape victim complaining about the issue".[81] As a result he perceived that crime victims were being used to advance another agenda, one related to victims' services, and that such manipulation would ultimately weaken "real" victim needs and the credibility of advocacy on their behalf before the legislature. He also brought forward the religious liberty issue suggesting that a balance should be struck between victims needs and the tradition of respect for the diversity of religious beliefs.[82] A heated exchange followed with the committee chair who strongly challenged the advocate's appearance in opposition to the bill. In response, the advocate claimed that victims' organizations were using rape victims to "pull your heartstrings"[83] and asserted that more legislators needed to "see through the smoke" and resist what he perceived to be victim exploitation. A critical point was reached when he argued that the law was constitutionally flawed because it infringed on religious liberty without a compelling state interest. However, since its 1990 decision in *Employment Division v. Smith*[84] the

[80] Ibid at p. 90.

[81] Ibid at p. 93.

[82] Ibid at p. 91 and 94.

[83] Ibid at p. 96.

[84] *Employment Division v. Smith*, 494 U.S. 872 (1990). Note, however, that following *Smith,* and in response to it, Connecticut adopted a Religious Liberties Act, Conn. Gen. Stat. sec. 52-571b which effectively restored the "compelling government interest – least restrictive means" test that prevailed before *Smith.* The representative of the Connecticut Catholic Hospital Council made pointed reference to

United States Supreme Court had held that neutral legislation of general applicability passed muster under constitutional analysis even where it resulted in an incidental burden on the free exercise of religion. In effect, it had discarded the "compelling government interest – least restrictive means" test articulated by the Victim Advocate in such cases. That fact was not lost on the committee chair (now Congressman Christopher Murphy) who quickly noted Justice Scalia majority opinion in *Smith*. The exchange between witness and chair, already pointed, sharpened: "I don't care whether you pass legislation here or not. There's no way that the Church is going to condone and provide that pill when they think it's inappropriate."[85] The committee chair challenged the Victim Advocate explain why private victim advocacy groups were overwhelmingly supportive of the legislation and, in fact, were providing testimony directly contrary to his regarding the experiences of rape victims. In response the Advocate reiterated his view that victims' services groups had ulterior motives and were "hiding behind victims' concerns and victims' rights".[86] In context, this could only have been a reference to the wide ranging abortion rights advocacy of many of the groups appearing to testify on the bill. He concluded with a startling position for a state victim advocate – however true it may have been – and one that opened him up to charges that he allowed his religious affiliation to undermine his official duty: "The problem that the rape advocacy groups

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the state act in both his 2006 and 2007 testimony. This issue is more fully discussed in *Plan B and the Rout of Religious Liberty*, Ethics & Medics, NCBC (December 2007).

[85] Public Health Committee Hearing Transcript, 03/06/2006 at p. 96.

[86] Ibid at p. 97.

have is it's not being provided in the Catholic hospital. That is the issue because the issue is an attack on the Catholic institutions. That's what I'm responding to."[87]

Reaction to the committee hearing was dramatic. Intense media attention was focused on the Victim Advocate's opposition to the bill and the claim that it represented an attack on the Catholic Church. Political supporters of the bill were furious, with some calling for the resignation or firing of the Victim Advocate. Lieutenant Governor Kevin Sullivan demanded the Governor request the Victim Advocate's immediate resignation: "I respect his strongly held personal, religious beliefs, but he has a sworn duty and constitutional obligation to leave his opinions outside his office. He could have testified as a private individual. He did not. Instead he abused his office and the public trust that put him there."[88] The Governor instructed her legal counsel to express her displeasure to the Advocate over his allegedly inappropriate intervention and was quoted as saying that he "now understands that he went far beyond the bounds of victim advocacy. [H]e knows he must not cross the line again between his personal beliefs and the interests of those for whom he advocates." [89]

2006 was an election year and state legislators, taken by surprise at the swiftly escalating controversy, were anxious to avoid claims of religious intolerance. In any event, informal legislative vote counts suggested that the Connecticut Catholic Conference had secured enough votes to defeat the bill in the Public Health Committee.

[87] Ibid at p. 98.

[88] Lt. Governor Sullivan's press release available at www.ct.gov/ltgovksullivan/cwp/view.asp?A=1717&Q=310716.

[89] *Victim Advocate Urged to Quit*, The Hartford Courant, March 8, 2006.

In view of those developments, the Bill was tabled by its committee supporters and opponents claimed a victory. In a final gasp that suggested retaliation, proponents of mandatory EC slipped a provision into a spending bill originating in the Appropriations Committee chaired by EC proponent and hearing witness Denise Merrill. The spending provision allocated millions of dollars in energy assistance to hospitals but limited such funds to "hospitals providing full pharmaceutical services to victims of rape."[90] To the credit of those legislators who spied the stealth attempt to punish Catholic hospitals, the move was seen for what it was and never got out of committee for a floor vote. Nonetheless, it was a portent of things to come. What was trumpeted as victory had, in fact, laid the ground work for a terrible defeat. Any disinterested observer assessing the 2006 legislative debate would have scored the proponents presentations as superb. Opposition was disjointed and thin. Without any testimony from medical or scientific experts, Catholic organizations such as the Knights of Columbus, Catholic bioethicists, Catholic women's organizations, or Church members in any substantial numbers, astute observers recognized that a Plan B tsunami would arrive in the 2007 legislative session. Reaction to the Victim Advocate's role effectively silenced him going forward and, justly or not, his intervention was suspected by some of having been coordinated with the Catholic Conference.

THE INTERIM BETWEEN LEGISLATIVE SESSIONS

[90] For additional details of this most unusual development see the following Associated Press story: http://www.boston.com/news/local/connecticut/articles/2006/03/31/budget_spending_plan_contains_emergency_contraception/.

Even before the 2006 legislative session ended proponents of mandatory EC begun aggressive lobbying. They were determined to present an overwhelming case in the 2007 session. Their efforts in the period between the 2006 and 2007 legislative sessions persuaded many that mandatory EC would steam roll through the General Assembly. In addition, two developments during that time, each with a markedly different impact on the debate, warrant attention.

First, the Federal Drug Administration (FDA) approved over the counter (OTC) sale of Plan B to anyone over the age of 18.[91] Since 2003 the FDA had twice rejected recommendations of its advisory committee to approve OTC sale of Plan B. The reversal in August, 2006 meant that the vast majority of rape victims could obtain EC without a prescription. While such approval was lamentable, its significance to the mandatory rape protocol wars was serendipitous. Proponents of mandatory EC had long argued that rape victims denied EC at emergency rooms faced intolerable burdens in locating a prescribing authority, sometimes in the middle of the night. OTC availability largely undermined that argument. Ambulance crews, paramedics, rape crisis counselors, pharmacies, private clinics, forensic investigators, public safety officers, public health offices or anyone else could easily stock Plan B and distribute it to adult women without restriction. Although OTC approval did not extend to minors, it unquestionably opened new opportunities for Catholic hospitals to identify alternative means by which any government interest in provision of EC to rape victims could be satisfied without imposing on Catholic conscience.

[91] http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html.

Second, in October, 2006 The Journal of the American Medical Association (JAMA) published *Plan B and the Politics of Doubt*[92] by Dr. Frank Davidoff and James Trussell, Director of Princeton University's Office of Population Research[93], two well known proponents of EC and former members of the FDA advisory committee on OTC sale. They took direct aim at the Pontifical Academy for Life's October 2000 *Statement on the So-Called Morning After Pill.*[94] In that statement the Academy asserted that "the proven 'anti-implantation' action of the morning after pill is really nothing other than a chemically induced abortion".[95] Davidoff and Trussell challenged that claim and in turn asserted that the authors of the Academy's Statement "offered no supporting evidence regarding Plan B's mechanism of action."[96] Citing various studies, clinical trials and one unpublished manuscript, since published[97] (hereinafter Novikova, et. al.) they concluded that little if any scientific evidence exists to support the view that Plan B interferes with implantation of a fertilized ovum. In addition to Plan B's anovulant mechanism they suggested pre-fertilization actions impede sperm migration, disrupt sperm capacitation and condition some ova to resist fertilization. Novikova, et. al. related the findings of a

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[92] F. Davidoff and J. Trussell, *Plan B and the Politics of Doubt*, 296 JAMA 1775, October 11, 2006.

[93] The Office of Population Research maintains the following web portal with extensive resources on population related topics including EC: http://opr.princeton.edu/.

[94] *Statement on the So-Called "Morning-After Pill"* available online at: http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pa_acdlife_doc_20001031_pillola-giorno-dopo_en.html.

[95] Ibid at n. 3 (2000).

[96] F. Davidoff and J. Trussell, footnote 92 *supra* at p. 1775.

[97] The manuscript has since been published. See N. Novikova, et. al., *Effectiveness of levonorgestrel emergency contraception given before or after ovulation – a pilot study*, Contraception 75:112 (2007).

pilot study investigating woman provided LNG before and after ovulation. Fifty one women had non contraceptive intercourse between Days -5 to 0 (with 0 being the day of ovulation).[98] Seventeen of the participants took Plan B on day 2 after ovulation. Forty three participants took Plan B before or around ovulation. If Plan B had the predicted interceptive effect, one would expect some reduction in the number of anticipated pregnancies absent Plan B use, perhaps even a total absence of pregnancy. In fact three pregnancies were confirmed among the woman who took Plan B *after* ovulation whereas none were reported in the group who took Plan B *before or around* ovulation.[99] While the small scale of the study makes it far from conclusive, its findings lend force to the argument that Plan B does not have an interceptive action when used *after* ovulation. Recognizing that no method currently exists to definitively resolve the question of Plan B's interceptive potential Davidoff and Trussell conclude:

> In the absence of absolute proof about Plan B's mechanisms of action, the right to make personal decisions about whether its use is morally acceptable must be respected and for that reason women should continue to be informed, as they are now in the Plan B labeling, that its use may affect postfertilization events.[100]

[98] No data was reported and no reliable analysis is possible regarding the fertility of the study participants' partners. The age range of the women was 15 to 43 years.

[99] Pregnancy was determined by follow-up telephone calls to participants. Reported pregnancies were then confirmed by ultrasound. However, reports of no pregnancy were accepted as accurate without follow up examination. It is not possible, based on the study's methodology, to determine if absence of pregnancy from the group who used Plan B before or around ovulation resulted from suppression of ovulation or interception action following breakthrough ovulation and fertilization.

[100] Davidoff and Trussell, footnote 92 *supra* at p. 1777.

The authors further recommend that women be advised that any interceptive effect by Plan B is "speculative" and that its ability to prevent pregnancy can be fully accounted for by actions that do not interfere with post fertilization events.[101]

The finding of Novikova, et. al. have been reviewed in exchanges between Catholic ethicists and doctors in the National Catholic Bioethics Quarterly (NCBQ). Those exchanges took opposing views as to the appropriate weight to be accorded the underlying study. Fr. Nicanor Pier Giorgio Austriaco asserted that, "given the limitations of scientific certitude", the study taken in tandem with another recently published report of an *in vitro* experiment on human embryo attachment to endometrial tissue, [102] (hereinafter referred to as Lalitkumar, et. al.) suggest that "when administered once" Plan B is not an abortifacient. [103] A response by Marie Hilliard[104] challenged various aspects of the underlying studies and the force of Fr. Austriaco's conclusions. An additional response by Patrick Yeung, M.D., Erica Laethem and Fr. Joseph Tham[105], also a medical doctor, points to significant methodological, substantive, statistical and reporting

[101] Ibid.

[102] P.G.L. Lalitkumar, et. al, *Mifepristone, but not levonorgestrel, inhibits human blastocyst attachment to an in vitro endometrial three-dimensional cell culture model*, Human Reproduction 22.11 (November 1, 2007): 3031-3037.

[103] Rev. Nicanor Pier Giorgio Austriaco, O.P., *Is Plan B an Abortifacient? A Critical Look at the Scientific Evidence, 7 NCBQ 703, 707 (2007).*

[104] Colloquy: *Plan B's Abortifacient Effect* by Marie T. Hilliard and Fr. Austriaco's reply in Vol. 8, No.1 NCBQ (Spring 2008)

[105] Colloquy: *Is Plan B Abortifacient? Further Responses* by Patrick Yeung, MD, Erica Laethem and Fr. Joseph Tham, L.C., M.D., Ph. D. along with Fr. Austriaco's reply in Vol. 8 No.2 NCBQ, pp. 217-221 (Summer 2008).

inadequacies in the Novikova and Lalitkumar articles.[106] They concluded that "more definitive evidence would be needed before a conclusion could be made against abortifacient effects for emergency contraception." While Fr. Austriaco acknowledged that the cited studies do not definitively answer the question, he aggressively maintained that they "cast serious doubt on the claim that Plan B is an abortifaciant"[107] such that that existing scientific evidence is insufficient to withhold EC treatment of rape victims with Plan B.

A second round of exchanges between Fr. Austriaco and Dr. Yeung and his colleagues further clarified their disagreements. Yeung, et. al. maintain that there is "convincing evidence for a post fertilization effect" and "that a conclusion - even a strong suggestion - against an abortifaciant mechanism of action is scientifically unsustainable and misleading."[108] Austriaco, with equal vigor, disputes their claims and stands by his earlier conclusion that "it is unlikely that Plan B is an abortifaciant."[109]

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[106] With respect to Novikova, et al. see footnotes 97-99 and accompanying text. In addition, the manner in which data was grouped and reported fails to adequately identify the striking relationship between expected and actual pregnancies when Plan B was used during the pre-ovulatory fertile window, a critical time frame for endometrial development and break through ovulation. See Yeung, et. al. footnote 116 *infra* and accompanying text. With respect Lalitkumar, et. al. and the *in vitro* endometrial attachment study, Yeung et. al note that "the in vitro endometrial samples were all mid-cycle samples cultured for five days before the comparisons were done. As a result … it is not able to refute the hypothesis that LNG has a post-fertilization effect on the development of the endometrium through abnormal luteinization." Yeung et. al, footnote 105, supra at p. 218. This is similar to one of Hilliard's criticisms and is acknowledged by Fr. Austriaco, although he maintains other studies provide adequate evidence that endometrial development is not significantly altered by Plan B administration.

[107] Austriaco, footnote 103 *supra* at 707.

[108] Yeung, et. al., *More on Plan B*, Vol. 8, No. 3 NCBQ, pp. 418-421 (Autumn, 2008)

[109] Austriaco, *More on Plan B*, Vol. 8, No. 3 NCBQ, pp.421-425 (Autumn, 2008). Note, however, that Fr. Austriaco did not repeat his original claim that his conclusion is established as "scientific certitude".

Lalitkumar, et. al concluded that the rate of embryo attachment to tissue exposed to LNG and that which was not was "not significantly different".[110] In the NCBQ Fr. Austriaco described this finding in slightly different language: the rate of attachment in one group was "similar to the proportion" and "comparable to the other group. Yeung et. al. described it as showing "no discrepancy of in vitro implantation rates".[111] The actual raw numbers revealed that six of fourteen embryos attached to tissue exposed to LNG (43%) while ten of seventeen (59%) attached to tissue that had not been exposed to LNG. The difference in attachment rates was 16%. One may question why an attachment rate to LNG exposed tissue that is 16% less than that associated with tissue not exposed to LNG is considered "comparable". The answer is found in the underlying study that applied Fisher's exact test, a statistical significance test used in the analysis of categorical data where sample sizes are small. A statistical analysis showing that an observed difference is not significant may reflect a true absence of significance or it may be the result of random chance unless the sample size is large enough to have the "power" to detect real difference. In this case, given the size of the study and the rate of attachment to non exposed tissue, the only way Fisher's exact test yields a statistically significant difference in attachment rates is if none of the fourteen embryos attached to the LNG exposed tissue. This highlights one limitation of the study as a basis to conclude that Plan B is not an interceptive.[112]

[110] P.G.L. Lalitkumar, et. al, footnote 102 *supra*.

[111] Yueng, et. al. footnote 105 *supra* at 218

[112] It should also be noted that Hilliard, Yeung and Austriaco agree that the study size is too small to reach definitive conclusions. They also agree that hormones affect embryos and endometrial tissue differently

The exchanges between Austriaco and Yeung, et. al. point to an ongoing debate within the scientific community – a debate likely to intensify. That assessment is confirmed by two recent developments.

First, a study[113] published by leading EC researchers in 2007 demonstrated that LNG administered in the same dose as Plan B "had no effect on the quality of cervical mucus or on the penetration of spermatozoa in the uterine cavity."[114] Accordingly, the authors concluded that their "initial hypothesis that LNG could interfere with sperm function and penetration and could contribute to the mechanism of action in EC was not confirmed in our *in vivo* and *in vitro* studies."[115] That finding substantially undermines a thirty year dogma of EC advocates that LNG impedes sperm migration, a pre-fertilization mechanism that Davidoff and Trussell had claimed in *Plan B and the Politics of Doubt*. On the other hand, the study found no significant effect on the expression of glycodelin-A, a major progesterone regulated glycoprotein considered one of the most potent markers of endometrial receptivity. However, that finding has suspect relevancy to the question of pre-ovulatory phase Plan B effect on endometrial development because, although LNG was administered prior to ovulation, endometrial sampling was done, at

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in vitro than they do *in vivo,* thereby limiting the ability to draw definitive conclusions. Yeung, et. al. further note that the endometrial tissue samples were all mid-luteal phase samples cultured for five days before comparisons were done and therefore do not provide any information of the effect of Plan B on the development of the endometrium during follicular phase or the possible consequence thereof on implantation.

[113] JA do Nascimento, et al, *In vivo assessment of the human sperm acrosome reaction and the expression of glycodelin-A in human endometrium after levonogestrel-emergency contraceptive pill administration*, Human Reproduction 2007; 22:2190-5.

[114] Ibid.

[115] Ibid.

most, two to three days after ovulation. Glycodelin-A is not expressed in the endometrium until six days after ovulation.[116] In any event, the study's authors plainly state: "the mechanism of action of LNG as an EC is still poorly understood."[117]

Second, Dr. Yeung, who an Obstetrician/Gynecologist specializing in minimally invasive gynecologic surgery and endometrial care, and colleagues including Fr. Joseph Tham, also a medical doctor and Professor at the School of Bioethics, Regina Apostolorum, currently have a manuscript in the process of publication that proposes a physiological model in which LNG administered 2 to 5 days *before* ovulation indirectly results in impaired endometrial development and interceptive consequence following breakthrough ovulation. Their analysis appears consistent with well designed studies that provide indirect scientific evidence of post fertilization effects of pre-ovulatory LNG; demonstrates that existing studies do not rule out their model; and estimates the frequency of interceptive action as 3% to 13% when LNG is administered in the pre-ovulatory fertile window, a figure much higher than previous earlier calculations had suggested.[118] It is my understanding that the manuscript will be part of the next edition of the NCBC *Manual for Ethics Committees*.

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[116] Yeung, et. al., *A scientific analysis of the evidence regarding postfertilization effects of levonorgestrel*, p. 7-8, unpublished manuscript at time of this writing but planned as part of the forthcoming revision of *Catholic Health Care Ethics: A Manual for Ethics Committees*, NCBC.

[117] do Nascimento, et. al, footnote 113, supra.

[118] See footnote 116, *supra*.

By the time the 2007 legislative session opened in Hartford the battle lines were clearly drawn. Op-ed articles, media interviews and university and community activism were expertly coordinated by the bill's proponents. The 2006 bill was re-introduced with a new title that captured the emotional nature of the debate: *An Act Concerning Compassionate Care for Victims of Sexual Assault*. A public hearing was conducted by the Human Services Committee on March 13, 2007.

Many of the witnesses who appeared at the 2006 legislative hearing returned. However, several significant differences were immediately apparent. First, the Victim Advocate did not testify. Second, Dr. Davidoff did testify and powerfully so. Several other witnesses came forward with personal accounts of sexual assault that could not help but evoke great sympathy. In addition to the impressive list of witnesses appearing in 2006, supporters added The Merger Watch Project, The Secretary of State, the State Comptroller, several state legislators, Miss Connecticut, representatives from religiously affiliated organizations, additional health care professionals including obstetricians and gynecologists, internists, physician's assistants, registered nurses, emergency medical practitioners, multiple social workers, additional legal experts and representatives of professional medical organizations and an out of state abortion advocacy group relating successful passage of similar bills in other states. Sympathetic committee members were ready with carefully developed lines of questioning drawing out critical points in the debate. The themes were similar to 2006 with the additional claim that Davidoff and Trussell's JAMA article established that no scientific evidence supported the claim that Plan B was an interceptive. A Quinnipiac University poll suggesting that 74% of Connecticut Catholics supported the bill was repeatedly touted by witnesses.

Opposition remained similar to 2006 although some additional citizen witnesses identifying themselves as Catholics appeared. Two rape victims, one of whom became pregnant as a result of the attack and subsequently gave birth to a daughter,[119] appeared to oppose the bill. Other testimony raised FDA approval of OTC Plan B and the consequent ease with which Plan B could be now provided by alternative means. The principal witness testifying in opposition was the General Counsel of St. Francis Hospital and Medical Center on behalf of the Connecticut Catholic Hospitals Council. Once again, no medical or scientific expert witness appeared in opposition. At various points the hearing was diverted to receive testimony on other bills pending before the same committee. A senior administrator of one of Connecticut's Catholic hospitals appeared to testify on a bill increasing Medicaid reimbursement but he had nothing to say about Plan B. Written testimony was submitted from a senior administrator of another Catholic hospital on Medicaid modernization, but it he did venture any position on mandatory EC. That striking anomaly was not lost on the committee members or the bill's supporters, virtually all of whom saw the Church as isolated and weakly supported by its own constituency.

Minutes before the hearings opened State Representative Denise Merrill, who was a vocal supporter of the bill and a witness at the 2006 Public Health Committee hearing, painfully recounted her personal ordeal with rape in a press conference in the legislative office building rotunda. Her story was moving to say the least. Her subsequent

[119] The witness's testimony was promptly acknowledged by mandatory EC proponents who commended her on her choice to carry her child to term. They argued that choice was precisely the value they sought to promote through the pending bill: giving victims the choice to engage pregnancy from rape or not.

testimony was equally powerful. In addition to her own story, she noted that new survey data from the first six months of 2006 indicated that 40% of rape victims were not offered or did not receive the full dose of EC at Connecticut hospital emergency rooms.

Dr. Davidoff's testimony largely repeated the finding of his JAMA article. He claimed that "Plan B turns out to be almost completely ineffective in preventing pregnancy when it's taken after fertilization has occurred"[120] and that recently published studies suggest that "there is relatively little, perhaps very little, efficacy of this drug in interfering with the implantation of a fertilized" ovum.[121] While recognizing a "theoretical possibility" he dismissed claims in the manufacturer's product labeling identifying that potential. He recounted his experience as a member of the FDA Advisory Committee of OTC marketing of Plan B:

> we heard the presentation by the President of Barr Labs at the FDA hearings and she was not able to cite any evidence that actually supported that. … It's a logical possibility. But as I read the actual evidence there is not only no evidence to support it, but some of it, as I've already described in more detail, to my mind is incompatible with that possibility.[122]

His testimony on the timing of Plan B administration and its relation to thickening of cervical mucus, sperm capacitization and secondary wave sperm migration suggested that any non anovulant action of Plan B may be explained by pre-fertilization events.[123] He did not mention, and may not have known, of the study acknowledged by Trussell in

[120] Human Service Committee Hearing Transcript, 03/13/2007 at p. 125.

[121] Ibid at p. 127.

[122] Ibid at p. 133.

[123] Ibid at p. 127-129, 134-136.

October 2008, which offers compelling evidence undermining his claim that Plan B impedes sperm mobility.[124] However, absent expert testimony to the contrary, his assertion went unchallenged. Finally, he attacked the reliability of urine LH testing, asserting that it renders high percentages of false results.[125] On each and every one of the substantive points in Dr. Davidoff's testimony, no competent contradictory scientific evidence was offered by opponents of the bill.[126] This led to a perception within the General Assembly that the Church simply misunderstood the science behind Plan B, a development that became dominant during the floor debates on the bill.

Testimony in opposition from the Connecticut Catholic Hospital Council deepened that perception. Repeated assertion that Plan B can act only as an abortifacient after a positive LH test was promptly discounted following the subsequent testimony of Dr. Davidoff. Inability to convincingly explain or challenge the claim that Catholic bishops in other jurisdictions accepted Plan B in rape protocols without LH testing was devastating. Perhaps that was inevitable given the split of opinion among Catholic

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[124] See footnotes 113-117 *supra* and accompanying text.

[125] Human Services Committee Hearing Transcript, 03/13/2007 at p. 129. But see Guermandi, et. al., *Reliability of Ovulation Tests in Infertile Women*, Obstetrics & Gynecology 97.1 (January 2001): 95 wherein urine LH tests were demonstrated to have a positive predictive value of 0.97%, an indication of a high degree of reliability.

[126] However, an interesting example of the scientific uncertainty evident in Plan B's mechanisms of action arose from the testimony of an obstetrician-gynecologist supporting mandatory EC. The doctor was the Medical Director of Women's Health Connecticut and Physicians for Women's Health. His oral testimony deferred to Dr. Davidoff's explanation of Plan B. However, his written testimony directly supported the claim that Plan B sometimes operates to prevent implantation of fertilized ova: "On the rare occasion that it does not prevent the egg from being released, emergency contraception simply makes it much more likely that it will not find a place to land." See Human Services Committee Joint Favorable Report summarizing testimony of Matthew Saidel, M.D. at www.cga.ct.gov/2007/jfr/s/2007SB-01343-R00HS-JFR.htm.

ethicists. The committee Chair sought an explanation about different approaches "allowed by the Catholic Church in New Jersey, New York and in Massachusetts."[127] Perhaps inelegantly, but with obvious sincerity and genuine desire to understand Catholic teaching, he asked: "Are they [Connecticut's bishops] just not as religious or would people here not think that they were being true to the faith. How do you explain the difference?" The explanation offered insight to particular applications of ERD 36 but also suggested a slide toward relativism:

> Joe Lieberman is an Orthodox Jew and he celebrates Rosh Hashanah for two days. I celebrate Rosh Hashanah for one day. Am I less religious?
>
> Is he right, am I wrong or is it the other way around? What we're talking about here are religious beliefs. Not all Jews believe the same.
>
> Not all Catholic s believe the same. The bishops within particular Diocese have the authority and the responsibility under Roman Catholic Code of Canon Law to apply moral precepts and concepts and moral beliefs in accordance with their beliefs.
>
> And that is why there are differences among Catholic Bishops on this issue as well as other issues throughout the country. …
>
> There certainly are some Bishops in certain states that take a different view just as there are some Bishops in certain Dioceses who will not even allow any emergency contraception in their hospitals under any circumstances.
>
> So we have a situation here where the Catholic Bishops of Connecticut have made their best judgment on the basis of advice they've received from Catholic ethicists who are well respected.
>
> They have made their judgment as to the appropriate manner in which Catholic hospitals under their jurisdiction apply the ethical and religious directives **and when we're talking about religious beliefs it's never a question of who is right and who is wrong.**[128]

[127] Ibid at p. 106.

[128] Ibid at p. 106-107 (emphasis added).

The witness was pressed on the same point by another member of the committee who observed: "You know, it does seem to go against the fact that this is in some way inhibiting, being offensive or being oppressive or attacking … the Catholic religion because you have 40 Catholic hospitals in New York State able to basically comply with the same policy directive that is being discussed here… [W]e have evidence throughout the Country that the Catholic faith is able to make this policy work."[129] The response again distinguished different applications of ERD 36, this time repeatedly suggesting relativism:

> There are certain Catholics [Bishops] that have seen fit to establish different standards but again **that doesn't mean that they are right and that they are wrong.**
>
> …
>
> There are some Bishops in this country that do not subscribe to our protocol but instead prohibit even emergency contraception when the woman hasn't ovulated yet. Farther, way off to the extreme.
>
> That isn't what has been adopted by the Catholic Bishops in Connecticut. **It's not that anyone is right, it's not that anyone is wrong.** It's a question of beliefs and interpretation of Catholic directives and catholic morals.[130]

While this testimony had the merit of demonstrating the moderate position taken by Connecticut Bishops, it also suggested that their judgment was based on entirely flexible grounds and did not implicate fundamental questions of morality: i.e. "when talking about religious beliefs it's never a question of who is right and who is wrong". As subsequent developments would show, the matter was one of prudential judgment

[129] Ibid. at p. 110.

[130] Ibid at p. 110-111 (emphasis added).

subject to amendment as scientific knowledge advanced. Nonetheless, when the public hearings were conducted, it was the firm position of the Connecticut Catholic Conference that Plan B could function only as an abortifaciant once LH surge was detected. Suggesting that no right or wrong position could exist with respect to that presupposition undermined the Conference's position and played into the opposition's repeated effort to cast the issue as peripheral to Catholic teaching.

By the time the hearing ended near 11:00 P.M. it was clear that advocates for mandatory EC were in a commanding position. The committee overwhelmingly approved the bill two days later and issued a Joint Favorable Report on March 20, 2007.

The ensuing weeks saw repeated efforts by representatives of the Catholic Conference to negotiate a resolution. As early as March 22, 2007 Archbishop Mansell suggested that a solution might be near involving third party providers, although he did not elaborate.[131] By April 24, 2007 efforts to reach a compromise collapsed when the Church refused to accept an on-site third party provider solution at Catholic hospitals. Given the then firm Conference view that Plan B was a proven abortifacient, any third party on-site provision would have raised serious questions of cooperation. Senator Jonathan Harris, who chaired the Human Services Committee hearing, issued a press release[132] expressing his disappointment and repeating what had become - and would remain - the insurmountable political obstacle to the Catholic conference's position: "I

[131] *Catholic Bishops Speak Out on Issues*, Catholic Transcript, April 2, 2007 available at www.catholictranscript.org/index.php?option=com_content&task=view&id=264&Itemid=999999.

[132] Press release available at www.senatedems.ct.gov/pr/harris-070424.html.

don't know why what's good enough for millions of Catholics in other states is so unacceptable in Connecticut." The Director of Policy for CONNSACS suggested that the Conference had actually proposed the on-site third party solution:

> It is extraordinarily disappointing that after weeks of negotiations that the Connecticut Catholic Conference is at this late date saying that they do not support the bill. We are confused as to why the very concept proposed by the Conference, with a commitment for a timely resolution, is now six weeks later being rejected.[133]

On April 25, 2007 the State Senate debated and passed the mandate, which included an optional on-site third party dispenser provision. Senator Harris represented that the concept of third party provision originated with the Catholic Conference on March 23, 2007.[134]

Three days later, on April 28, 2007, Bishop Lori responded to that claim and disclosed some of the history behind the attempt to negotiate a solution:

> Some advocates for this misguided legislation will also tell you that the Church in Connecticut reneged on its promise to deliver a so-called "Third Party Solution" for the yet-to-occur case of a victim to whom Plan B cannot be ethically administered.
>
> Please take another look. The Church did suggest a third-party procedure that would have respected the rights of all. It called for the State to make arrangements for sexual assault victims to obtain the Plan B medication at home or in another convenient place but not on the premises of the hospital where the medical and nursing staff would have to become

[133] Ibid.

[134] Senate Session Transcript for 04/25/2007 at p. 102.

> formally involved. The third-party procedure initially proposed by the Church was rejected by advocates of Plan B legislation.[135]

The Senate debate witnessed repeated references to the acceptance of Plan B without ovulation phase testing by Catholic hospitals in other states,[136] with several senators expressing sincere perplexity over that fact, including one of the most ardent pro-life members of the body[137] who eventually voted in favor of the mandate for precisely that reason. Willingness to use hospital personal and telephones to arrange, provide and then pay for immediate transportation of patients to secular hospitals was turned against the Church with advocates for mandated EC imposing their own test of cooperation:

> Well, if your [sic] going to do all that, how is that so far removed that that's okay, and yet, if we have a third party, contracted out by the church, to someone else, but it happens to take place in a corner of an emergency room in that facility, that's not okay.[138]

With virtually no support from senate colleagues, opponents expressed their reservations that religious liberty was being trampled and accepted what had become a foregone conclusion. The bill passed 32 to 3.

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[135] *Religious Freedom in the Constitution State* available at www.bridgeportdiocese.com/column4.28.07.shtml

[136] Senate Session Transcript for 04/25/2007 at p. 102, 108, 114, 123.

[137] Ibid at p 118-121.

[138] Ibid at p. 106

The lopsided margin in the Senate was matched by a large majority vote in the House of Representatives on May 2, 2007: 113 to 36. Acceptance of Plan B by Catholic bishops in New York and elsewhere was frequently repeated.[139] Dr. Davidoff's unchallenged expert testimony was strongly advanced.[140] At least one other representative, picking up on Dr. Davidoff's assurance that there is no scientific evidence to support an interceptive effect, suggested that almost two years of turmoil was based on a factual mistake and that "Plan B shouldn't represent a problem from a theological standpoint."[141] Opponents repeated arguments based on religious liberty, alternative availability of Plan B and a feared interceptive effect of Plan B. Proposed amendments that would have allowed LH testing were voted down. One proponent of the bill challenged a staunch defender of the Church's liberty who had asserted that the Catholic Church had always opposed abortion. Her disjointed, at times irrelevant and disturbing ramble provides an example of unjustifiable intrusion by state actors into the internal affairs of a religious body:

> [I]n the Catholic tradition, St. Thomas of Aquinas held that life began at 16 weeks, which is quickening. It was only in the 16th century when the microscope was invented and our ability to measure changed that a number of theologians started talking about faith in different ways.
>
> A lot of the considerations, particularly in the 19th century from Pope Pius the IX against abortion stemmed from his distrust of science, which is really not so unhealthy. Sometimes we Americans make a religion of science.

[139] House Session Transcript from 05/02/2007 at p. 95, 97,100, 114, 134..

[140] Ibid at p. 102 and following.

[141] Ibid at p. 164-165.

> But the truth is, it was 1854 that the doctrine of the Immaculate Conception was promulgated. It was in 1870 that Vatican One codified the infallibility of the Pope.
>
> It was not from time immemorial that any of the decisions about an issue such as this Bill would be codified. In fact, I don't see the issue of abortion anywhere in this Bill.
>
> It's preventing pregnancy, which to me is central, which is in the strong tradition on our faith.[142]

On the same day as the House vote Archbishop Mansell published "Plan B"[143] in which he repeated the Church's position and expressed his astonishment that the bill as written would prohibit something as simple as an LH test thereby prohibiting physicians from obtaining more information about their patients.

On May 9 the Bishops of Connecticut sent a letter to Governor Rell asking her to veto the bill. However, on May 16 she signed the bill which had an effective date of October 1, 2007. Two days later Archbishop Mansell commented that the bill's signing "augurs poorly for the state of religious freedom in the Constitution State."[144]

On June 10, 2007 Archbishop Mansell hinted that a legal challenge to the Plan B law might be in the offing on the basis of the state's Religious Liberty Act. He also took issue with the claim that Bishops in New Jersey and Minnesota had accepted laws similar to the one passed in Connecticut:

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[142] Ibid at p. 142.

[143] The Catholic Transcript, May 2, 2007 available at www.catholictranscript.org/index.php?option=com_content&task=view&id=270&Itemid=45.

[144] *Bishops Call Plan B Law an Assault on Religious Freedom*, The Catholic Transcript, May 18, 2007 available at www.catholictranscript.org/index.php?option=com_content&task=view&id=285&Itemid=999999.

> During the legislative debate these past few months, statements were made that Minnesota and New Jersey were facing similar issues and that the Catholic bishops of those states were "going along." I spoke with Archbishop Harry Flynn of St. Paul-Minneapolis and Archbishop John Myers of Newark, N.J., and they assured me that the positions of the Minnesota and New Jersey bishops are the same as ours. I spoke also with Cardinal Sean O'Malley of Boston, who reported that the bishops of Massachusetts hold the same position. A few years ago, Massachusetts enacted the law over the objections of the bishops, but Massachusetts has a conscience exemption. Connecticut does not.[145]

Although the statement did not address claims that the New York Catholic Conference had endorsed a similar bill, and thus did not fully resolve the dilemma expressed by many legislators, it went a long way in demonstrating that Connecticut's Bishops were very much in the hierarchical mainstream.

Very little public comment circulated in the summer of 2007 but as the effective date of the bill approached many wondered if Catholic Hospitals would file suit. While a constitutional challenge would encounter significant hurdles in view of the Supreme Court's 1990 decision in *Smith*, a state statutory claim was well positioned given the "compelling government interest – least restrictive means" test set forth in Conn Gen Stat. § 52-571b.

On September 27 the Bishops, together with the leaders of the Catholic hospitals in the state, announced their choice for "reluctant compliance".[146] Recognizing the

[145] Religious Exercise, The Catholic Transcript, June 10, 2007 available at www.catholictranscript.org/index.php?option=com_content&task=view&id=286&Itemid=45.

[146] The full text of the Bishops statement is available on line at http://www.ctcatholic.org/Bishops-Statement-Plan-B.php.

serious doubts[147] raised by scientific research they essentially acknowledged that Plan B is not a proven interceptive. Accordingly, in the absence of definitive magisterial teaching resolving the matter, Catholic hospitals in Connecticut would provide Plan B as EC without an LH test. After all, if Plan B is not an interceptive, rape victims have a right in justice to claim access to its anovulant and, if existent, other non interceptive actions. Equally compelling would be the obligation in justice and charity implicitly contained in Fr. Austriaco's observation that victims of sexual assault should be provided with all of "the compassion they expect from disciples of Jesus Christ. All must be done to care for these women without sacrificing the lives of innocent human beings."[148]

One part of the statement that generated a good deal of commentary appears to have been vastly over analyzed. It reads: "To administer Plan B pills without an ovulation test is not an intrinsically evil act." Of course, if Plan B is an interceptive, its administration in given cases (e.g. when it actually operates as an interceptive) would be intrinsically evil, regardless of intention or knowledge, imputability being an entirely different question. Given the uncertainties surrounding Plan Bs mechanisms of action, it may have been better to make the critical distinction, as Bishop Lori did two days later, that "*the Church does not teach* that it is intrinsically evil to administer Plan B without first giving an ovulation test…" [149]

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[147] But c*ontra*, see Yeung, et. al., (footnotes 108 and 116-118, *supra*, and accompanying text) who maintain that "a conclusion – or even a strong suggestion – against [Plan B's] abortifaciant mechanism of action is scientifically unsustainable and misleading."

[148] Rev. Austriaco, footnote 103 *supra* at p. 219.

[149] Bishop Lori's Blog, *A Perspective on "Plan B"*, September 29, 2007, www.bridgeportdiocese.com/external-bishopsblog.shtml (emphasis added).

PRUDENTIAL JUDGMENT

The Bishops statement also provides that the entire matter would be reopened "[i]f it becomes clear that Plan B pills would lead to an early chemical abortion in some instances".[150] This expressed willingness to follow the science where it leads is commendable. Where developing scientific research appears to challenge a previously presumed certainty, it seems evident that intellectual honesty requires a re-examination of related positions. That appears to be precisely what occurred.

In addition to the underlying scientific debate over mechanisms of action, a lingering moral debate revolves around where the burden of proof should rest. Some would maintain that in the face of existing doubts about Plan B and the gravity of potential harm, it should not be administered. Others assert that research to date satisfies the standard of moral certitude that Plan B will not operate as an interceptive and should be provided to those victims who want it. The formula by which the Bishops' statement addresses this issue suggests that they find the evidence of interceptive potential thin and place the burden of proof on those asserting it since it provides for reopening the issue if interceptive action "becomes clear."

In reassessing scientific evidence upon which prudential judgments affecting life issues must be made, a recent papal statement regarding brain death offers this insight:

> In these years science has accomplished further progress in certifying the death of the patient. It is good, therefore, that the results attained receive the consent of the entire scientific community in order to further research for solutions that give certainty to all. In an area such as this, in fact, there

[150] Bishops' Statement, footnote 146 *supra*.

> cannot be the slightest suspicion of arbitration and where certainty has not been attained the principle of precaution must prevail.[151]

Certainly all agree that precaution must govern. The question concerns how high a threshold to establish. While the circumstances differ, an analogous application to Plan B suggests that the principle of precaution would prohibit Plan B *if* serious risk is recognized following pre-ovulatory use, as proposed by Yeung, et. al. Professor Griesz has suggested that unrestricted use of EC when interceptive effects cannot be ruled out leaves open the question of conditional acceptance of abortion.[152] Ashley, DeBlois and O'Rourke certainly view the principal of precaution as adequately respected by the pregnancy test approach given their view that "[a]lthough there is very remote risk that implantation might be affected, the risk is not substantial."[153] Fr. Austriaco would agree. Yeung, et. al would not.

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[151] *Address of His Holiness Benedict XVI to Participants at an International Congress Organized by the Pontifical Academy for Life*, November 7, 2008 available at www.vatican.va/holy_father/benedict_xvi/speeches/2008/november/documents/hf_ben-xvi_spe_20081107_acdlife_en.html.

[152] See Germain Grisez, *The Way of the Lord Jesus*, Vol. 3 *Difficult Moral Questions*, 296-298; See also Kara Crawford, *Catholic Health Care Providers and the Issue of Emergency Contraception* available at Professor William May's web page www.christendom-awake.org/pages/may/karacrawford.htm. The recent Congregation for the Doctrine of the Faith Instruction on Bioethics specifically provides that "anyone who seeks to prevent the implantation of an embryo which may possibly have been conceived and who therefore either requests or prescribes such a pharmaceutical generally intends abortion." *Dignitas Personae* n. 23. While the text unquestionably refers to "morning after pills" and clearly condemns actions joined to an intention to prevent implantation, some questions remain given other ambiguities in the Instruction. See footnote 155 and accompanying text, *infra*.

[153] Ashley, DeBlois & O'Rourke, *Health Care Ethics, A Catholic Theological Analysis*, p. 86 (2007). They also point out that the Committee on Doctrine and Pastoral Practices of the USCCB has examined the

Reference to "double effect" is occasionally encountered in the debate. Fr. O'Donnell correctly observes that there is no possibility of resort to principals of double effect since any given administration of EC "does not have two effects, but only one of two [or perhaps more] possible effects".[154] Double effect always requires that at least two effects be anticipated: one good and intended the other evil and while foreseen, not intended. That is never the case in the either/or action of Plan B as an anovulant or an interceptive. If an anovulant effect is actualized interception is obviously impossible. The two effects are mutually exclusive.

The recent Congregation instruction on bioethics refers to morning after pills and affirms the absence of "complete knowledge of the way that different pharmaceuticals operate" although it also asserts that "scientific studies indicate that the effect of inhibiting implantation is certainly present…"[155] While those comments seem to echo

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issue and concluded that rape treatment protocols that rely on pregnancy testing rather than LH surge testing prior to administration of anovulant medications do not violate Directive 36 of the ERDs.

[154] Rev. Thomas O'Donnell, S.J., *Medicine and Christian Morality*, at p.196-197 (3rd rev. ed., Alba House, 1996). Furton and Moraczewski provide an excellent summary of double effect noting that it "governs situations in which one action is followed by two effects, one good (and intended), the other evil (foreseen but not intended). Health Care Ethics: A Manual for Ethics Committees, Double Effect, p. 21 (NCBC). See also Catholic Principles and Guidelines for Clinical Research, a joint publication of the Catholic Medical Association and the National Catholic Bioethics Center, Guidelines Appendix, pp. 16-17.

[155] *Dignitas Personae*, n. 23. The precise language of the instruction carefully avoids a declaration that that Plan B is a proven interceptive. A footnote to the relevant passage (n. 23) reads: "The interceptive methods which are best known are the IUD (intrauterine device) and the so-called "morning after pills" (footnote 43) seems definitive. However, as noted in the text above, it does not distinguish between varying formulas used in different kinds of morning after pills – specifically combined estrogen and progestin pills (the "Yuzpe regimen") and progestin only (Plan B). The expression "the effect of inhibiting implantation is certainly present" is very strong. However, it cannot be separated from its context which is specified by the preceding expression "scientific studies indicate". That expression avoids a definitive conclusion and suggests knowledge of the model proposed by Yeung, et. al. (see footnotes 116-118 *supra*

Yeung, et. al., they do ant resolve the issue and additional time and reflection will be needed to assess that statement in view of its ambiguity occasioned by, *inter alia*, absence of distinction between variable hormonal formulas used in different morning after pills and the unsettled and emerging scientific evidence that continues to roil the debate.

A PRESSING DILEMMA

The Connecticut statute requires that rape victims be provided with "medically and factually accurate and objective information relating to emergency contraception", including its use and efficacy". [156] The statute defines "medically and factually accurate and objective" as "verified and supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable."[157] Accordingly, hospital rape treatment protocols may, arguably must, provide rape victims with information on the mechanism of action of Plan B. Davidoff and Trussell's *Plan B and the Politics of Doubt*[158] was published in a highly respected peer-reviewed journal. Their statement that women provided with Plan B should be told that it may inhibit implantation, even while being told that its ability to prevent pregnancy (given their definition of "pregnancy") may be fully explained by mechanisms that do not interfere with post-fertilization events, poses a serious dilemma for Catholic health care. The problem is only heightened by Trussell's recent update of

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and accompanying text) which does not posit proof of interception but rather demonstrates the compatibility of an interceptive mechanism with the indications of existing scientific research.

156 Conn. Gen. Stat. sec 19a-112e (b)(1) and (2).

157 Conn. Gen. Stat. sec 19a-112e (a)(3).

158 See text accompanying footnotes 76-80 supra, (emphasis added).

his online article *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy*[159] which forcefully declares that women receiving Plan B "must know that ECP's [emergency contraceptive pills] … may prevent pregnancy by … inhibiting subsequent implantation of a fertilized egg."[160] Both authors specify that informed consent requires no less. As ardent proponents of EC, they cannot be dismissed as anti-choice extremists trying to frighten emotionally fragile rape victims.

Informed consent in Connecticut obliges caregivers "to provide the patient with that information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy."[161] To lessen the subjectivity of the legal test Connecticut recognizes four elements of necessary disclosure: 1) the nature of the procedure; 2) the risks and hazards of the procedure; 3) the alternatives to the procedure; and 4) the anticipated benefits of the procedure.[162] The *National Protocol for Sexual Assault Medical Forensic Examinations* issued by The U.S. Department of Justice Office of Violence Against Women provides that informed consent be obtained for medical treatment of sexual assault and recognizes "reproductive health services" as a treatment option for victims at risk for pregnancy.[163] Given Davidoff and

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[159] Trussell and Raymond, *Emergency Contraception, A Last Chance to Prevent Unintended Pregnancy*, at p. 5, October, 2008 available online at http://ec.princeton.edu/questions/ec-review.pdf.

[160] Trussell makes the same statement for all regular hormonal contraceptives including birth control pills, the implant Implanon, the vaginal ring NuvaRing, the Evra patch, and the injectable Depo-Provera. Trussell & Raymond, note 156 *supra* at p. 5.

[161] *Logan v. Greenwich Hospital*, 191 Conn 288,292-93 (1983)

[162] *Alswanger v. Semgo*, 257 Conn. 58, 67-68 (2001).

[163] *A National Protocol for Sexual Assault Medical Forensic Examinations*, p. 39-40, 111 (2004). The protocol makes no specific recommendation regarding EC, a fact prompting a letter to DOJ's Office of

Trussell's admonitions concerning informed consent, a substantial case can be made under these standards that disclosure of the nature of proposed EC treatment requires disclosure of its potential interceptive effect. Moreover, given the statutory mandate to provide "medically and factually accurate and objective information" any ambiguity as to whether such information is required should be resolved in favor of disclosure.

Currently, Connecticut largest Catholic hospital advises rape victims that EC does not cause an abortion.[164] At another most practitioners merely advise women that Plan B will prevent ovulation thereby preventing pregnancy.[165] None disclose that Plan B may prevent implantation. The unqualified advice that Plan B does not cause an abortion or that it will prevent ovulation should be reconsidered. EC treatment, if offered, should be accompanied by a clear explanation of its potential mechanisms including interceptive action.

Violence Against Women urging its inclusion signed by many of the organizations and individuals forming the coalition of mandatory EC supports. www.aclu.org/reproductiverights/contraception/12743res20050106.html. Model letters urging state authorities to adopt the DOJ protocol with additional provision recommending that EC be offered to victims at their initial medical examination are maintained on the ACLU's website. www.aclu.org/reproductiverights/contraception/23529res20060119.html.

[164] Author's interview with Emergency Department nursing staff. Part of sexual assault intervention includes offering the victim the services of sexual assault victim services organizations. These outside organizations respond directly to emergency rooms to meet with, educate, counsel and support victims. Currently, St. Francis Medical Center (Hartford) maintains working guidelines for sexual assault intervention that identifies CONNSACS as the outside agency to contact or to which victims are referred. See *Sexual Assault, Care of the Patient with Actual or Suspected (Guideline) 1/01/08.* Note that CONNSACS is a member of NARAL-CT's "Coalition for Choice". See footnote ___, *supra*. It is clear that education, training and staffing of sexual assault victim counselors is an area of health ministry Catholic agencies (such as Catholic Charities or the hospitals themselves) have not sufficiently developed. As a result, counselors from organizations evidencing hostility to Catholic teaching end up in the front line of intervention on behalf of emotionally distraught and understandable fragile victims at Catholic hospitals.

[165] Author's correspondence with hospital administration.

Two related difficulties remain.

First, if Plan B is approved for OTC marketing without age restriction it will no longer be a prescription drug and thus fall outside the definition of "emergency contraception" in the statute. Should that happen without amendment of the definition some of the approximately fifty chemical means of EC would need to be assessed for possible interceptive or contragestative action. For example, RU-486 can be used as EC but it also disrupts implanted pregnancies and is designed to do so. [166] It may be favored by some proponents of EC because it has a higher efficacy rate than Plan B. Accordingly, attempts to amend the statutory definition may be resisted by some who see an opportunity to compel known abortion modalities at Catholic facilities should Plan B no longer be a prescription drug. Similarly, emergency insertion of a copper IUD would be unacceptable since its very high effective rate can only be explained by post fertilization action.

Second, if the finding of Novikova, et. al. relating to *post* ovulation use of Plan B is confirmed, it would strongly suggest that LNG is not interceptive when given *after* ovulation. That would limit any possible interceptive effect to use during the *pre*-ovulatory fertile window, thereby rendering LH urine test almost certainly useless as a meaningful method of identifying the scope of interceptive risk. A positive result would

[166] *Dignitas Personae* identifies RU-486 as one of the "principal means of contragestation" *DP* n. 23, fn 43. However, it is also operates as an interceptive with an established EC history: "Mifepristone [RU-486] is a first-generation progesterone receptor modulator that is approved for use in many countries for early first-trimester medication abortion. Mifepristone has been shown to be highly effective for use as emergency contraception, with few side effects (delayed menstruation following the administration of mifepristone is one notable side effect). However, the use of mifepristone as an abortion pill may limit its widespread acceptability for use for emergency contraception. Trussell and Raymond, footnote 159, *supra* at p. 2.

not distinguish between the beginning of LH surge, its peak or its decline and a negative result would not provide any useful information on whether a woman was in the pre-surge fertile window, the critical time according to the Yeung, et. al. model of impaired endometrial development. So what possible use could there be for ovulation phase testing? In *Plan B and the Politics of Doubt* Davidoff and Trussell raised the "undocumented possibility that Plan B used after ovulation" may actually increase the likelihood of successful implantation.[167] They, like Fr. Austriaco and Dr. Yeung, note that LNG is a progestational drug.[168] Naturally occurring progesterone from the corpus luteum immediately after ovulation is essential to implantation. In assisted reproduction LNG is used to increase rates of implantation.[169] The idea that LNG taken after ovulation may promote implantation is an entirely rational thought. Should it be established that Plan B can act in that manner (and even its logical suggestion may be enough) it is doubtful that informed rape victims would accept Plan B without knowledge of their ovulatory stage. That may suggest an independent basis for hormonal testing in the emergency room and raises additional informed consent issues.

WHERE TO FROM HERE

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[167] Davidoff and Trussell, footnote 91, *supra* at p. 1777: "Plan B used after ovulation might actually prevent the loss of at least some of the 40% of fertilized ova that ordinarily fail spontaneously to implant or to survive after implantation."

[168] Davidoff and Trussell, footnote 91, *supra* at p.1777; Rev. Nicanor P.G. Austriaco, footnote 101, *supra* at p.707; Yeung, et. al, footnote 114, *supra* at p. 2. LNG is actually a "progestin" which is a synthetic derivative of the progesterone molecule and has strong progesterone like action. It is usually avoided in assisted reproduction and infertility treatment due to concerns of a slightly increased risk of birth defects. Davidoff and Trussell maintain that LNG is "used therapeutically in assisted reproduction". See footnote 91 supra at p. 1777 and their citation to Berek JS. Novak's Gynecology, 13th ed.

[169] Ibid.

The impact of legislatively mandated intrusion into Catholic health care offers several lessons for the future.

First, it is essential in legislative public hearings on issues such as EC to present a powerful flow of information from medical and scientific experts, legal scholars, hospital administrators and staff, bioethicists, moral theologians. Clergy and religious should not be written off but actively recruited where they possess relevant expert knowledge (e.g. doctors, nurses, biochemists) which is often the case, particularly at Catholic colleges and universities. Their presence encourages lay participation and confidence and their expertise manifests to legislators and others that Church leaders reach decisions backed by well informed and astute advisors. Anonymity in this regard is not advisable. Witness selection and perpetration should be a priority for public hearings on controversial health care or bioethical topics such as embryonic stem cell research funding and related issues, EC rape treatment, proposals to legitimize assisted suicide, minors access to abortions, so-called comprehensive sexual education of youth, same sex marriage and civil union legislation and proposals mandating employee contraceptive insurance coverage, to name a few. Parish pro-life and social action committees, parochial parent-teacher associations, university student, Newman and pro-life clubs, diocesan respect life officials, Catholic Women's groups, Catholic Charities, Knights of Columbus Councils, Catholic medical, legal and social worker associations should be recruited to provide testimony. Legislators and their staff should be thoroughly briefed and supplied with appropriate supporting materials.

Second, on critical issues involving the moral life and internal management of the Church and Her allied institutions, be they hospitals, Catholic Charities, nursing homes or schools, uniformity between dioceses and state Catholic Conferences will avoid repetition of the single most difficult obstacle encountered in Connecticut when trying to explain the Church's position on EC - the presumption by policy makers and legislators (not to mention laity) that disparate positions across dioceses and conferences on a particular issue means that its resolution is malleable.

Third, greater clarity about Church teaching on contraception and annovulant treatment in cases of rape is desperately needed. Public discussion of this topic is a graced opportunity to present the fullness of Catholic teaching on human sexuality and full advantage should be taken. EC in rape should never be referred to as an exception to the Church's teaching on the intrinsic evil. Rather, it should be explained that the EC under such circumstances is not contraception at all. Two interwoven threads should be developed. The standard approach is to explain the victim's right to self defense. For example, no one would suggest that a woman who fights off an assailant after penetration but before ejaculation is contracepting.[170] However, to take greater advantage of the opportunity to explain the Church's vision of human sexuality, public statements and some witness testimony at legislative hearings should present the truth of conjugal acts as freely chosen mutual gifts exchanged between lovers who express through their bodies the unitive and procreative dimensions of sexual communion. The meaning of "unitive"

[170] See William E. May, *Catholic Bioethics and the Gift of Human Life*, p. 140-143 (Our Sunday Visitor)(2000); Germain Grisez, *The Way of the Lord Jesus*, Vol. 2 *Living A Christian Life*, p. 512 (Franciscan Press)(1993).

should be explained as something more than the mere joining of body parts, but rather involves a deeper spiritual interpenetration of persons. That approach makes it obvious that rape is not unitive since it is not free. By emphasizing that no unitive and procreative significance are joined in rape, the conclusion that annovulant treatment for the victim does not separate them - and therefore does not implicate the intrinsic evil of contraception - becomes self evident. Even those not persuaded by the Church's teaching on contraception and human sexuality would nonetheless appreciate the distinction by which the Church accepts annovulat treatment for rape victims.

Finally, state Restoration of Religious Liberty laws can play a significant role in protecting against mandated moral evil. The exacting "compelling state interest – least restrictive alternative" standard required by these laws to justify even incidental infringement of religious liberty is highly beneficial. They apply to all forms of state and local government action that burdens the exercise of religion, including neutral legislation and ordinances of general applicability as well as administrative actions. Accordingly, they provide greater protection than constitutional provisions and are a highly valuable weapon in battling morally offensive state mandates. They may protect against mandated compliance with an advance medical directive or surrogate decision maker instruction to withdraw or withhold ethically ordinary care at Catholic nursing homes or similar institution.[171] Similarly, they should apply to mandates for contraceptive coverage in

[171] For example, if a PVS patient had an advance directive instructing that all life support, including assisted nutrition and hydration, were to be withheld or withdrawn in the event of such diagnosis, Catholic facilities would be obliged to resist given the Congregation for the Doctrine of the Faith's Response to Certain Questions from the Bishops of the United States (2007). The issue can be even more complicated in formerly Catholic facilities that have agreed to operate under the ERDs but do not share the same convictions as expressed therein. Currently, Connecticut General Statute § 19a-580a provides

employee health insurance, even for secular employers, and may protect in the closer case of compulsory EC for rape victims. They are particularly important given the ascendency of universal health care proposals, some of which will likely mandate employer provided health insurance including coverage for all things "reproductive rights" related. They should also apply to state efforts to compel abortion procedures, tubal ligations, sex reassignment surgery or distribution of RU-486 at Catholic facilities, to name a few. Currently a small minority of states have such legislation on the books. Proposals to limit them should be vigorously opposed. Where they are absent, they should be introduced and promoted.[172]

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that any physician or health care provider who is unwilling to comply with the wishes of a patient or the patient's surrogate shall transfer care of the patient to a physician or health care provider who is willing to comply with the wishes of the patient. It is unclear if the statute envisions institutional transfer out of the Catholic facility or merely refers to individual practitioner transfer. The issue may be further complicated by federal and state funding issues associated with nursing homes.

[172] It remains one of the great ironies of religious liberty battles that the principal opponent to Connecticut's 1993 Religious Freedom Act was the Connecticut Catholic Conference. At the public hearing on the bill, an attorney representing the Conference specifically objected to the bill because it "would in effect be overturning the recent decisions of the United States Supreme Court in this area". That was a clear reference to the *Smith* decision, as made abundantly clear by ten pages of transcript in which the witness was questioned by at times surprised legislators who were puzzled that the Catholic Church would oppose legislation limiting government intrusion into free exercise. Bill No. SB-1343, Connecticut Judiciary Committee public hearing, March 1, 1993, transcript 1993JUD00301-R001500-CHR.HTM available at www.cga.ct.gov.