RELIGIOUS LIBERTY AND MORAL COURAGE: THE RIGHT TO FIGHT

*By Thomas J. Davis, Jr., JD, LLM, MA**

I shall not submit to injustice from anyone.

Mahatma Gandhi

Happiness depends on being free, and freedom depends on being courageous.

Pericles' Funeral Oration in History of the Peloponnesian War by Thucydides

Introduction

"This case is an ominous sign."[1] That ominous warning introduces Justice Alito's dissent from the Supreme Court's recent refusal to hear a challenge to Washington State's mandate that pharmacies distribute emergency contraception (EC) drugs[2] despite religious or moral objection to their abortifacient potential.[3] A federal judge took the extraordinary step of enjoining enforcement of the rule after finding the "great weight of evidence" demonstrated the "predominant purpose" of the regulatory scheme was to "stamp out the right to refuse" and amounted to a "religious gerrymander" directly targeting religious and moral objectors.[4] Normal constitutional tolerance of incidental burdens on religious free exercise occasioned by neutral laws is abrogated in such circumstances, giving way to heightened scrutiny in defense of liberty because "a law that discriminates against religiously motivated conduct is not 'neutral.' "[5]

** The author is an assistant attorney general of the State of Connecticut, a deacon in the Melkite Catholic Church, and Director of The Pope John Paul II Bioethics Center at Holy Apostles College & Seminary in Cromwell, Connecticut.*

[1] *Stormans, Inc. v. Wiesman*, 579 U. S. ____ (2016) 1 Alito, J., dissenting, available at http://www.supremecourt.gov/opinions/15pdf/15-862_2c8f.pdf.

[2] The principal EC drugs are levonorgestrel (LNG)(LNG is marketed as "Plan B", "Plan B One-Step", "Next Choice" and several other generic brands), and ulipristal acetate (UA)(UA is marketed as "ella").

[3] "Ominous" understates the threat. The regulations prohibit referral of a customer to other nearby pharmacies that willingly distribute the drugs, of which there were "more than 30" within five miles of the plaintiff's store. Id. at 2. An industry was being brought to heel by the by the zealotry of a radical Governor and a Human Rights Commission that threated pharmacy board members with personal liability if they permitted religious objectors to make referrals to cooperating pharmacies in lieu of direct distribution. Id. at 3. In fact, the inflexible scheme was imposed despite *stipulation* that referrals posed no threat to timely access to EC. Id. at 5.

[4] Id at 3-5, 8 fn. 3; 854 F. Supp. 2d 925 (findings of fact and conclusions of law); *Stormans Inc.* v. *Selecky*, 844 F. Supp. 2d 1172 (WD Wash. 2012) (opinion granting injunction).

[5] *Stormans*, supra, at 8, citing *Church of Lukumi Babalu Aye, Inc.* v. *Hialeah*, 508 U. S. 520, 523 (1993).

An appellate court reversed and petition to the Supreme Court followed.[6] The Court's refusal to hear the constitutional challenge points to increasingly necessary reliance by religious objectors on non-constitutional protections of religious liberty. Legislative protection of religious liberty was the foundation of *Burwell v. Hobby Lobby*[7] where a federal mandate for EC coverage in health insurance policies[8] violated RFRA.[9] That holding has significant implications in states with parallel religious liberty laws.[10] Several mandate EC related services for rape victims and three require EC distribution upon request regardless of religious/conscience objection.[11] Evolving knowledge of the mechanism of action (MOA) of EC

[6] The denial of the petition, known as a writ of certiorari, tells much thanks to Justice Alito's dissent, which was joined by Justice Thomas and Chief Justice Roberts. It demonstrated the void left by Justice Scalia's passing as he would likely have joined Alito thereby securing the necessary fourth vote required to accept a petition for full review by the court, even if the ultimate outcome would have remained uncertain. Moreover, it suggests that First Amendment challenges to religious or morally objectionable health care related mandates, ranging from pharmacy distribution rules like those in Washington, to emergency contraception rape treatment protocols and employee health insurance coverage for everything from *in vitro* fertilization, surgical sterilization, sex reassignment surgery and related hormone treatment, and even elective abortion will fair poorly in federal courts.

[7] 573 U.S. ____ (2014) available at http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf.

[8] Patient Protection and Affordable Care Act of 2010, 124 Stat. 119. The Act requires employers with 50 or more full-time employees to offer "a group health plan or group health insurance coverage" that provides "minimum essential coverage." 26 U. S. C. §5000A(f)(2); §§4980H(a), (c)(2). Congress did not itself specify what types of preventive care must be covered but left that determination to the Health Resources and Services Administration (HRSA), a component of the Health and Human Services Administration. HRSA promulgated the Women's Preventive Services Guidelines which provided that nonexempt employers are generally required to provide "coverage, without cost sharing" for Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling. 77 Fed. Reg. 8725. In view of those mandates, the court correctly identified the underlying factual and moral issue driving the religious liberty challenge, one equally at issue with respect to state law sexual assault treatment mandates: "Although many of the required, FDA approved methods of contraception work by preventing the fertilization of an egg, four of those methods (those specifically at issue in these cases) may have the effect of preventing an already fertilized egg from developing any further by inhibiting its attachment to the uterus. … The owners of the companies involved in these cases and others who believe that life begins at conception regard these four methods as causing abortions, but federal regulations, which define pregnancy as beginning at implantation, see, e.g., 62 Fed. Reg. 8611 (1997); 45 CFR §46.202(f) (2013), do not so classify them." Burwell, 573 U.S. ____ at fn. 7.

[9] RFRA is the Religious Freedom Restoration Act of 1993, 107 Stat. 1488, 42 U. S. C. §2000bb et seq.

[10] At least twenty-one states have adopted a state version of the federal RFRA: Alabama, Ala. Const. Art. I, sec. 3.01; Arizona, Ariz. Rev. Stat. sec. 41-1493.01; Arkansas, 2015 Senate Bill 975, enacted April 2, 2015; Connecticut, Conn. Gen. Stat. §52-571b; Florida, Fla. Stat. §761.01, *et seq.;* Idaho, Idaho Code §73-402; Illinois, Ill. Rev. Stat. Ch. 775, §35/1, *et seq.*; Indiana, SB 101 (March 26, 2015) and SB 50 (April 2, 2015); Kansas, Kan. Stat. §60-5301, *et seq.;* Kentucky, Ky. Rev. Stat. §446.350; Louisiana, La. Rev. Stat. §13:5231, *et seq.;* Mississippi, Miss. Code §11-61-1; Missouri, Mo. Rev. Stat. §1.302; New Mexico, N.M. Stat. §28-22-1, *et seq.;* Oklahoma, Okla. Stat. tit. 51, §251, *et seq.;* Pennsylvania, Pa. Stat. tit. 71, §2403; Rhode Island, R.I. Gen. Laws §42-80.1-1; South Carolina, S.C. Code §1-32-10, *et seq.*; Tennessee, Tenn. Code §4-1-407; Texas, Tex. Civ. Prac. & Remedies Code §110.003; and Virginia Va. Code §57-1. See http://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx.

[11] Connecticut (Conn. Gen. Stat. § 19a-112e; New Mexico (N.M Stat. Ann. § 24-10D-3), and South Carolina (S.C Code Ann. § 16-3-1350(B). At least 16 states and the District of Columbia require hospital emergency rooms to

presents a quandary. Passive, even reluctant, compliance with EC mandates[12] threaten authentic catholic identity.[13] State RFRAs provide a mechanism for a challenge.[14] The Supreme Court's denial of review in the Washington pharmacy case signals a narrowing of constitutional protection. State RFRAs are the last best legal hope to preserve what credibility remains of a shattered catholic health care identity shredded by a decade of retreat, compromise, and cooperation with morally impermissible EC mandates. This essay presents the principal factual and legal foundation for that challenge.

The Conundrum

Connecticut legislates the standard of care for licensed health care facilities providing examination or treatment of female victims of rape. They must provide victims with "medically and factually accurate and objective information" about EC, inform of its use, efficacy and availability, and provide it at the facility on request.[15] It prohibits any compliance protocol from requiring testing for anything other than pregnancy, including tests previously utilized to determine if LNG would be offered to rape victims.[16]

Four days before the law's effective date the catholic bishops of Connecticut reversed their long-standing refusal to accept the exclusion of such testing and acquiesced to the mandate. In announcing that decision, the bishops explained that "doubt about how Plan B pills and

---

provide EC related services ranging from providing information about EC to actually dispensing EC. One state, Pennsylvania, specifically allows a hospital to refuse provision of EC on religious, moral, or conscience grounds. See http://www.ncsl.org/research/health/emergency-contraception-state-laws.aspx#c. Thirteen states and the District of Columbia require provision of EC to victims of sexual assault at emergency rooms. http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf.

[12] Certain elements of EC mandates are unobjectionable, such as permissive pregnancy testing. But mandates that provide for otherwise unrestricted access to EC, such as in Connecticut, desolate catholic identity.

[13] The threat extends to the any religious denomination or person with doctrines matching those of Catholicism related to he inviolability of human life and the necessity of moral certainty that voluntary acts do not result in culpable killing.

[14] See Davis, *Plan B and the Rout of Religious Liberty*, Ethics & Medics, NCBC, December 2007.

[15] Connecticut permits a facility to contract with a third party "independent provider" but must permit the provision of EC in its facility. Conn. Gen. Stat. 19a-112e(a)(6) and 19a-112e(b)(c). Such independent providers must be licensed as a physician, physician's assistant, APRN or RN, or nurse-midwife and must be trained to conduct a forensic exam in accordance with specified sexual assault guidelines.

[16] Connecticut catholic hospitals previously utilized an ovulation test protocol which detected Luteinizing Hormone (LH) surge, a marker that ovulation is imminent and cannot be suppressed by LNG. Proponents of its use in EC protocols maintain that a negative test provides additional assurance that Plan B will operate to suppress ovulation rather then interfere with implantation whereas a positive result indicates certain ovulation, thereby exponentially increasing the risk of an abortifacient MOA should fertilization occur. Other tests precluded would include ultrasound visualization and measurement of ovarian follicles, which, together with other indicia, have substantial predictive value for likely ovulation. See, Bonelli, Johannes, et. al. 2014. Empfehlungen zur Handhabung der Notfallkontrazeption ("Pille danach") bei Frauen nach einer Vergewaltigung, (Recommendations for handling of emergency contraception ("morning after pill") in women after being raped). Institute fur medizinische Anthropologie und Bioethik (IMABE), Imago Hominis: 21(1):68-72. www.imabe.org/index.php?id=2049. Accessed 19 Feb. 2016. (German language text).

similar drugs work" led them to reconsider their stance.[17]

Doubt about MOA had long been at the heart of the debate over EC treatment of rape victims in Catholic facilities.[18] In 2007 that debate was closely associated with the Food and Drug Administration's (FDA) mandated product literature disclosures.[19] The carton text and consumer insert stated that Plan B worked "mainly" by preventing ovulation and may prevent implantation. The FDA required the disclosure to assure informed consent.[20] In 2007 the dominant view was that LNG was *principally* an anovulant and that post fertilization MOA was theoretically possible but rare. At about the same time several articles and a politically tinged commentary appeared in the professional literature that seemed to some to exclude any serious

[17] The 2007 statement was originally posted on September 27, 2007 on the web site of the Connecticut Catholic Conference but is no longer available on that site. It is available in its entirety at: http://www.catholicculture.org/culture/library/view.cfm?recnum=7836.

[18] One strain of "catholic" assessment of EC treatment following rape that predated the 2007 developments in Connecticut is presented by Peter Cataldo and Albert Moraczewski, OP in the National Catholic Bioethics Center's *Catholic Health Care Ethics: A Manual for Practitioners* (First Edition) in which they present the view that LNG-EC operates "only as an anovulant in the majority of cases". (Id., Part III, Beginning of Life Issues, Chapter 11, Pregnancy Prevention After Sexual Assault, p. 11/14). They reinforce that view several times by referring to the drugs at issue as "anovulatory hormonal intervention" and "anovulatory hormonal treatment", thereby stressing the widely held view that treatment typically prevents ovulation. Id p. 11/17. In fact, it was precisely anovulant typicality that propelled their view that harm to innocent human life was "improbable". Cataldo presented essentially the same rationale in the 2009 second edition of the popular manual. My own *Plan B Agonistics* (NCBQ winter 2010), which was written before the publication of Noe's 2010 article, similarly accepted anovulation as the primary MOA, although I corrected that position promptly upon publication of the startling Noé data. See Davis, letter in NCBQ summer, 2011, 213-216. As recently as June, 2011 a well-researched and carefully developed catholic analysis by Berg, Hilliard and Stegman noted that " [m]ost scientific studies of LNG demonstrate that the primary mode of action of the drug, if taken within 72 hours of intercourse, is the prevention of ovulation." *Emergency Contraception & Catholic Healthcare: A New Look at the Science and the Moral Question*, The Westchester Institute, 2:1, June, 2011 available online at http://bdfund.org/wordpress/wp-content/uploads/2012/06/westchester_whitepaper_ec_final.pdf.

[19] A comprehensive presentation of the debates that drove the development of the product labeling and product inserts for Plan B through the FDA scientific review regulatory process is set forth in Davis, *Plan B Agonistics: Doubt, Debate, and Denial*, NCBQ, winter 2010.

[20] James Trussell & Elizabeth Raymond, Emergency Contraception: A Cost-Effective Approach to Preventing Unintended Pregnancy, http://ec.princeton.edu/questions/ec-review.pdf at p. 7 (this 2014 version of Trussell and Raymond's article contains the same recommendation for disclosure as the 2007 version); Trussell & Davidoff, *Plan B and the Politics of Doubt*, 296 JAMA 1775, October 11, 2006. Both endorse disclosure of a possible post fertilization MOA. When commenting on the specific evidence regarding MOA, Trussell and Raymond present their analysis as drawing on the most recent data. While crediting review articles that support their agenda and discount post fertilization MOA (such as Gemzell-Danielsson K, et. al., *Emergency contraception - mechanisms of action*, *Contraception*. 2013;87:300-8) they wholly ignore the most significant peer reviewed scientific contribution demonstrating the consistency of existing data with a post fertilization MOA. See B.Mozzanega and E.Cosmi, *How Do Levonorgestrel-Only Emergency Contraceptive Pills Prevent Pregnancy? Some Considerations*, Gynecological Endocrinology, 27.6 (June 2011): 439–442.

risk that LNG had a post fertilization MOA.[21] Various catholic ethicists had previously arrived at that opinion.[22] Common to most was the assumption that LNG operated primarily by suppressing ovulation, a view shared by the Connecticut bishops. However, they also held that breakthrough ovulation poised a substantial risk of post fertilization interception. One Connecticut bishop articulated that position at the height of the 2007 debate:

> For women who have been victimized by rape … [o]ur Catholic hospitals administer an ovulation test ... If the woman is … not ovulating, Plan B … may be administered as a contraceptive, preventing ovulation. When the woman is ovulating, Plan B can act as an abortifacient by preventing the fertilized ovum from adhering to the wall of the uterus.[23]

The view that LNG "can act as an abortifacient", especially in the latter part of the fertile window, carried strong echoes of the position advocated by the Pontifical Academy of Life which asserted, "the proven 'anti-implantation' action of the morning after pill is really nothing

[21] 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. N. Novikova, et. al., *Effectiveness of levonorgestrel emergency contraception given before or after ovulation – a pilot study*, Contraception 75:112 (2007); F. Davidoff and J. Trussell, *Plan B and the Politics of Doubt*, 296 JAMA 1775, October 11, 2006.

[22] See e.g., D.P. Sulmasy, *Emergency Contraception for Women Who Have Been Raped: Must Catholics Test for Ovulation, or Is Testing for Pregnancy Morally Sufficient?* Kennedy Institute of Ethics Journal Volume 16, Number 4, December 2006; Hamel, Ronald and Michael Panicola, Emergency Contraception and Sexual Assault. *Health Progress* 83 (5):12-19 (2002). Both accepted the since debunked notion that LNG operates primarily as an anovulant. On that basis alone their analysis has been rendered largely immaterial. However, Sulmasy's influence in 2007 and until the emergence of more recent scientific data was substantial. But even granting his mistaken assumptions regarding primary MOA, his statistical analysis is subject to significant critique as shown by Hilliard, Marie, Letter. *National Catholic Bioethics Quarterly* 8 (1):9-12 (2008). See also Davis, Thomas J., *Plan B Agonistics: Doubt, Debate, and Denial*, *National Catholic Bioethics Quarterly* 10:741-772 (2010).

[23] Archbishop Henry Mansell, *Plan B*, The Catholic Transcript, May, 2007, available at http://www.archdioceseofhartford.org/writings2/archbmansell_column_07-05-01.htm

other than a chemically induced abortion."[24] That position was challenged at the legislative hearing on the Connecticut mandate by a former FDA advisory committee member who had recently published an influential commentary asserting that Plan B was primarily an anovulant, the efficacy of which could be explained without reference to post fertilization modalities. He maintained that the Academy's claim of a "proven" abortifacient MOA found no support in science.[25]

It is now clear that as the effective date of the legislation approached, the breadth and depth of the existing scientific data were more fully appreciated by the Connecticut bishops. Reassessment concluded that any potential post fertilization MOA was sufficiently doubtful that

[24] The Pontifical Academy of Life Statement on the So-Called "Morning-After Pill", issued in 2000, distinguishes MOA based on the timing of intake and appears to attribute an anovulant MOA to early fertile window use: "The *morning-after pill* is a hormone-based preparation (it can contain oestrogens, oestrogen/progestogens or only progestogens) which, within and no later than 72 hours after a presumably fertile act of sexual intercourse, has a predominantly "anti-implantation" function, i.e., it prevents a possible fertilized ovum (which is a human embryo), by now in the *blastocyst* stage of its development (fifth to sixth day after fertilization), from being implanted in the uterine wall by a process of altering the wall itself. The final result will thus be the expulsion and loss of this embryo. Only if this pill were to be taken several days before the moment of ovulation could it sometimes act to prevent the latter (in this case it would function as a typical "contraceptive").
http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pa_acdlife_doc_20001031_pillola-giorno-dopo_en.html. The recognition that timing of intake within the fertile window is significant is supported by the most recent data. It is virtually undisputed that Plan B has no effect on ovulatory process, including suppression of ovulation, if administered at or after LH surge. Trussell and Raymond (see footnote 20, supra) note that MOA labeling of NorLevo, a 1.5mg LNG-EC product available outside the United States that is identical to Plan B One-Step, has been modified to remove the claim that it was primarily an anovulant and substituted the following statement: "The primary mechanism of action is blockade and/or delay of ovulation via suppression of the luteinizing hormone (LH) peak. **Levonorgestrel interferes with the ovulatory process only if it is administered before the onset of the LH surge. Levonorgestrel has no emergency contraceptive effect when administered later in the cycle**" (emphasis added). Accordingly, the most ardent advocates of LNG-EC now advance the theory that suppression or delay of ovulation is the primary MOA only in the pre-LH surge fertile window. That, on its face, offers strong support for the distinction based on timing of intake advocated by the Pontifical Academy of Life and the Connecticut bishops during and before the 2007 EC debate. However, it fails to acknowledge the significant percentage of ovulation that occurs even with pre-LH surge intake or explain the 100% efficacy of LNG-EC taken throughout the fertile window reported in the Noé data.

[25] Davidoff and Trussell, *Plan B and the Politics of Doubt*, Journal of the American Medical Association 296.14 (October 11, 2006): 1777. The authors also proposed several pre-fertilization MOAs, all of which have since been shown to be insignificant or inapplicable, and in an extraordinary digression claimed that the existing scientific data supported the notion that "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." In other words, they asserted that Plan B may actually promote successful implantation when administered *after* the preovulatory fertile phase, a result presumably at odds with any EC users intention. While that proposition is contradicted by more recent data (Noé, 2010 demonstrated 100% efficacy at preventing pregnancy defined as implantation regardless of ovulation), its suggestion in 2006 demonstrates the extremes to which proponents of Plan B would go to resist any suggestion that it may have a post fertilization MOA.

compliance with the mandate was morally possible.[26] Acknowledging "serious doubt about how Plan B pills work" while characterizing the preclusion of ovulation testing as "seriously flawed", the bishops reversed ground and concluded that the mandate's defects were insufficient "to bar compliance with it at the present time." In a personal blog two days later, one bishop confirmed:

> What's really at issue here is how much testing is appropriate to ensure that Plan B does not induce the chemical abortion of a fertilized ovum. There is uncertainty about how Plan B works. Its effect is to prevent fertilization of the ovum.[27] Some believe, however, that in rare instances Plan B can render the lining of the uterus inhospitable to the fertilized ovum, which must implant in it in order to survive and grow; many other experts dispute this.[28]

The bishops' statement insisted that the matter remained subject to future review:

> If it becomes clear that Plan B pills would lead to an early chemical abortion in some instances, this matter would have to be reopened.[29]

One bishop offered similar assurance:

> In the course of this discussion, every possible option was discussed at length with medical-moral experts faithful to the Church's teaching, with legal experts especially in the area of constitutional law, and with hospital personnel. "Reluctant compliance" emerged as the only viable option. ... At the same time, we remain open to new developments in medical science which hopefully will

[26] The bishops' position thus veered from one extreme ("proven abortifacient") to another ("primarily" anovulant), whereas a properly undertaken critical reassessment, carefully attendant to the full corpus of scientific data then available, should never have concluded that prudent doubt concerning post fertilization MOA had not been overcome. But the unfortunate debacle had reached a zenith and the damage was done. The statute has remained unchallenged ever since.

[27] This curious reference is ambiguous at best. It may refer to a presumed anovulant MOA, which, by preventing ovulation, prevents fertilization. It may refer to a presumed post ovulatory MOA, which prevents fertilization, such as, inhibited migration, retarded capacitance, prevention of sperm-egg binding, or interference with acrosome reaction. In any event, we now know that these potentials do not explain LNG efficacy at preventing clinical pregnancy.

[28] On September 29, 2007 then Bishop of Bridgeport William Lori posted these comments on his personal blog, formerly accessible through the web site of the Diocese of Bridgeport. Several of Bishop Lori's blogs have been migrated to the web site of the Archdiocese of Baltimore where Archbishop Lori is currently the ordinary. Unfortunately, no primary source for the September 29, 2007 writing could be located. However, its content is available at the following independent web sites:

http://www.creativeminorityreport.com/2007/10/bishop-lori-blogs-on-plan-b-decision.html and
http://www.freerepublic.com/focus/religion/1905953/posts

[29] Footnote 17 supra.

bring greater clarity to this matter." [30]

The Revolution

Subsequent developments have brought "greater clarity", undermining fundamental assumptions about MOA, the policy of "reluctant compliance", and the moral analysis advanced by the Connecticut bishops. Studies published in 2010 and 2011 ("Noé data) demonstrate conclusively that LNG is a poor anovulant when taken in the critical fertile window.[31] They plainly show that despite ovulation rates in excess of 80%, fertile window administration of LNG resulted in 100% efficacy at preventing clinical pregnancy.

Subsequent analysis of the Noé data noted that "[t]he dominant follicle persisted for at least 5 days in 14.6% (7/48) of LNG cycles, not different than placebo (4%)."[32] Stated otherwise, in 85.4% of cases, LNG did not prevent ovulation. In view of this remarkable data, leading EC researchers acknowledge that "in the late follicular phase … LNG cannot delay or block ovulation any better than placebo, and follicular rupture occurs shortly and similarly after treatment with LNG or placebo."[33] While the study suggests that LNG may have anovulatory properties in some cases when administered *earlier* in the fertile phase in combination with other drugs, follicular rupture (FR) still occurred in the majority of those cases (55%). When administered prior to ovulation, "women did not become pregnant in spite of the fact that follicular rupture following treatment", which can only mean that a post-ovulation MOA "must also play a role in the efficacy of LNG EC."[34] But the Noé data demands more than timid revision. The FR rate in excess of 80% demolishes prior claims of MOA and makes it indisputable that LNG prevents pregnancy primarily by postovulatory effects. While several postovulatory yet pre-fertilization MOAs have been proposed, most have been debunked[35],

---

[30] Footnote 28 supra.

[31] G. Noé, H. B. Croxatto, et al, *Contraceptive efficacy of emergency contraception with levonorgestrel given before or after ovulation*, Contraception 81 (2010) 414-420 and G. Noé, H. B. Croxatto, et al, *Contraceptive efficacy of emergency contraception with levonorgestrel given before or after ovulation*, Contraception 84 (2011) 486–492.

[32] Brache, Croxatto, et al, *Ulipristal acetate prevents ovulation more effectively than levonorgestrel: analysis of pooled data from three randomized trials of emergency contraception regimens,* Contraception 88 (2013) 611–618 at 614.

[33] Id. at 616.

[34] Id. at 617.

[35] do Nascimento, Josiane A., Markku Seppala, Antero Perdigão, Ximena Espejo-Arce, Maria José Munuce, Laura Hautala, Riitta Koistinen, Liliana Andrade and Luis Bahamondes. 2007. In vivo assessment of the human sperm acrosome reaction and the expression of glycodelin-A in human endometrium after levonorgestrel-emergency contraceptive pill administration. Human Reproduction 22.8: 2190–2195; Peck, Rebecca, Juan Velez. 2013. The Postovulatory Mechanism of Action of Plan B: A Review of the Scientific Literature. National Catholic Bioethics Quarterly 13.4:1-40; Mozzanega, Bruno and Erich Cosmi. 2011. How do levonorgestrel-only Emergency contraceptive pills prevent pregnancy? some considerations. Gynecological Endocrinology 27.6: 439–442; Davis, Thomas. 2010. Letter. National Catholic Bioethics Quarterly 10.4: 641-644; Davis, Thomas. 2010. Plan B Agonistics: Doubt, Debate, and Denial. *National Catholic Bioethics Quarterly* 10:741-772; Davis, Thomas. 2011. Letter. National Catholic Bioethics Quarterly 11:2: 212-216.11 ; Davis, Thomas. 2013. Letter. National Catholic Bioethics Quarterly 13:1:14; Davis, Thomas, Justo Aznar, Hanna Klaus, Judith Mascolo, Bruno Mozzanega, Dominic Pedulla, Julio

delimited to narrow percentage of cases[36], or shown to offer no more then theoretical biological plausibility.[37]

LNG's primary efficacious mechanism remains elusive, but the suggestion that post fertilization MOA would be "rare" because ovulation is "rare" has passed onto the ash heap of history.[38] And it is here that the integrity of Catholic health care is so seriously jeopardized. Like

---

Tudela, and Patrick Yeung. 2013. Letter. National Catholic Bioethics Quarterly 13.4: 582-586; Davis, Thomas, Justo Aznar, Kathleen Berchelmann, Donna Harrison, Bruno Mozzanega, Rebecca Peck, Dominic Pedulla, Kathleen Ravielle, Walter Rella, Julio Tudela, Juan Velez, and Patrick Yeung. 2015. Letter. National Catholic Bioethics Quarterly 15.1: 5-8.

[36] Peck, Rebecca, Walter Rella, Julio Tudela, Justo Aznar, and Bruno Mozzanega. 2015. *Does levonorgestrel emergency contraception have a post-fertilization effect? A review of its mechanism of action*, The Linacre Quarterly 82: 197-202; Rella, Walter, 2013, Letter, National Catholic Bioethics Quarterly 13.1: 7-10.

[37] Brache, Vivian, Leila Cochon, Maeva Deniaud and Horacio B. Croxatto. 2013. Ulipristal acetate prevents ovulation more effectively than Levonorgestrel: analysis of pooled data from three randomized trials of emergency contraception regimens. Contraception 88:611–618 at 617.

[38] Archbishop Lori's 2007 statement, referenced in footnote 28 supra and accompanying text, suggested the possibility, though disputed, of a "rare" abortifacient effect, a position unquestionably based on the view that ovulation itself was rare. That view cannot be sustained in view of the Noé data. If an abortifacient effect is real, it is not rare as ovulation is common. His further suggestion that Plan B's "effect is to prevent fertilization of the ovum" seems, in context, to assert a primary MOA. That could mean that fertilization was thought avoided through suppressed ovulation or it could mean that credence was given to other postovulatory MOAs, such as inhibited sperm migration, capacitance, sperm-egg binding, or ovum resistance to fertilization, but those explanations have, at best, marginal explanatory power. See fn. 35-37 supra. Either way, Bishop Lori's observation is plainly erroneous. The powerful 2010 Noé data has not precluded continued assertion that Plan B operates primarily by suppressing ovulation. In September, 2013, the Department Health and Human Services (HHS) maintained that Plan B "works mainly by stopping the release of an egg from the ovary" even while acknowledging a possible interceptive effect. Petition for Writ of Certiorari, *Kathleen Sebelius, Secretary of Health and Human Services v Hobby Lobby Stores, Inc.*, page 10, fn. 5. Available at http://sblog.s3.amazonaws.com/wp-content/uploads/2013/10/2013-0354.pet_.aa_1.pdf. That position evolved in the HHS *Hobby Lobby* brief, which claimed "Plan B … works principally by preventing ovulation **or fertilization** by altering tubal transport of sperm and/or ova; it may inhibit implantation." Brief of Petitioner at p. 9, fn. 4. Available at http://sblog.s3.amazonaws.com/wp-content/uploads/2014/01/01.12.14_brief_for_petitioners_doj.pdf. HHS's concession that the "principal" MOA could not be limited to anovulation carries the necessary implication of increased abortifacient potential as it must accept that ovulation is occurring. However, HHs failed to acknowledge what the Noé data make undeniable: anovulation is a minor player and postovulatory MOA dominates the field of LNG efficacy. HHS's suggestion that principal mechanisms include altered tubal transport is similarly troubling. That is not the case with sperm, which undermines retarded ova transport theories since sperm reaches the ampulla, where ova are deposited in the fallopian tube and where most fertilization occurs. Altered embryo transport may be operative, but that would be abortifacient. See Peck and Velez, *The Postovulatory Mechanism of Action of Plan B*, NCBQ 13(4):1-40; Kahleborn, Peck & Severs, *Mechanism of action of levonorgestrel emergency contraception*, The Linacre Quarterly 82 (1):18-33; Peck, Rebecca, Walter Rella, Julio Tudela, Justo Aznar, and Bruno Mozzanega. 2016, *Does levonorgestrel emergency contraception have a post-fertilization effect? A review of its mechanism of action*, The Linacre Quarterly 83 (1):35-51Ghazal, Sanaz, Jennifer Makarov, Christpher DeJonge, Pasquale Patrizio. 2014. *Egg Transport and Fertilization*, http://www.glowm.com/section_view/heading/Egg Transport and Fertilization/item/316; Kulp, Jennifer, Kurt Barnhart. 2008. *Ectopic Pregnancy: Diagnosis and Management*, *Women's Health* 4 (1):79-87. See also Justice Alito's reference to the HHS position in his majority opinion in *Hobby Lobby*, 573 U.S at ____, 134 S.Ct. at 2775 in which he called attention to Hobby Lobby's moral objection "to providing health insurance that covers methods of birth control that, as HHS acknowledges … may result in the destruction of an embryo." Ancillary issues abound in the long running EC battles and the *Hobby Lobby* case was

the HHS mandate, which requires insurance coverage for EC and other devices or treatments prohibited by Catholic doctrine, thereby implicating issues of impermissible material or formal cooperation with evil, the Connecticut mandate demands that catholic facilities intentionally cooperate[39] in the provision of drugs whose abortifacient potential cannot be excluded from

---

no exception. HHS floated an oft deployed slight of hand in its brief to rebut Hobby Lobby's contention that EC drugs destroy nascent life: "Although respondents describe these … drugs as "abortion-causing", federal law, which defines pregnancy as beginning at implantation, does not so classify them." HHS cited two federal regulatory provisions supporting its position that federal law defines pregnancy to require implantation and, absent implantation, no interruption of human life would constitute abortion. The first, 45 C.F.R 46.202(f) defines pregnancy as follows: "Pregnancy encompasses the period of time from implantation until delivery." The second, appearing in 62 Fed. Reg. 8611 (Feb. 25, 1997), was an FDA Notice titled "Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception." It contained the following statement: "Emergency contraceptive pills are not effective if the woman is pregnant; they act by delaying or inhibiting ovulation, and/or altering tubal transport of sperm and/or ova (thereby inhibiting fertilization), and/or altering the endometrium (thereby inhibiting implantation). Studies of combined oral contraceptives inadvertently taken early in pregnancy have not shown that the drugs have an adverse effect on the fetus, and warnings concerning such effects were removed from labeling several years ago. There is, therefore, no evidence that these drugs, taken in smaller total doses for a short period of time for emergency contraception, will have an adverse effect on an established pregnancy." The FDA's use of the terms "pregnant" and "established pregnancy" suggests the tension inherent in the definition game. At best the argument is wordsmithing. For a discussion of the FDA definition of pregnancy and its relationship to the EC debates, see Davis, *Plan B Agonistics*, supra at n. 59.

[39] An excellent discussion of material and formal cooperation is provided in an *amici curiae* brief submitted by 50 catholic theologians and ethicists in *Kubik v. Burwell*, http://www.scotusblog.com/wp-content/uploads/2016/01/50-Catholic-Theologians-and-Ethicists1.pdf. While not concluding that cooperation with the HHS mandate is impermissible material or formal cooperation, the brief maintains that the catholic petitioners challenging the mandate may reach such a conclusion in view of the catholic teaching on the topic. The brief summarizes catholic teaching on formal cooperation as follows: "Many theologians in the Catholic tradition have concluded that one who knowingly obeys a command to act in furtherance of a wrongful objective typically shares thereby in the intention to achieve the wrongful objective, even if the cooperation is performed reluctantly or under duress. On this view, obedience to such a command constitutes formal cooperation with wrongdoing, and it is not permissible, regardless of whether the wrongful objective is actually achieved." *Id*. at p. 3. That, of course, would raise fundamental questions about of the position "reluctant compliance" adopted by the Catholic bishops in response to the state EC rape treatment mandate. The brief summarizes the teaching on material cooperation as follows: "[A]pplying principles of Catholic moral theology, Petitioners can also reasonably conclude that complying with the Mandate via the "accommodation" would involve impermissible material cooperation in wrongdoing. Material cooperation occurs when the cooperator facilitates or assists in the performance of a forbidden action without sharing in the wrongful intention. Among other requirements, material cooperation must be justified by a "proportionate reason" to perform the cooperative action. … Several factors support the determination that such material cooperation would be impermissible. First, the forbidden actions in this case—abortion, contraception, and sterilization—are grave wrongs under the Catholic faith. The use of abortifacient drugs, in particular, involves the taking of innocent human life in the Catholic view, and thus it is particularly grave. Second, Petitioners can reasonably conclude that the "accommodation" threatens to make them "but-for" or essential causes of providing such services, which is viewed as an aggravating factor by many Catholic theologians. Third, the Catholic Petitioners in particular may reasonably infer from the Catholic bishops' categorical denunciations of the Mandate that Church authorities counsel against compliance with the Mandate in any form. Fourth, Petitioners can reasonably conclude that there is no proportionate reason that would justify their material cooperation in such very grave wrongs, such as the taking of human life." *Id*. at p. 4-5.

reasonable doubt.[40] While resistance to the obvious has been entrenched, this much is certain: the catholic tradition of moral analysis and doubt, properly applied, prohibits the unrestricted administration of EC, including Plan B, as currently mandated in Connecticut law and practiced in Connecticut's catholic hospitals.

In 2007 the Connecticut bishops were advised by constitutional law experts that every possible legal challenge to the mandate had been vetted and found wanting. But RAFA and its Connecticut analog set barriers to religious oppression higher than that required by current constitutional jurisprudence. Given the holding in *Hobby Lobby*, the emergence of the Noé data, and the promise to revisit "reluctant compliance" should conditions warrant, a challenge to the mandate should be reconsidered, either by affirmative litigation or by adoption of a nonconforming protocol, in which case Connecticut's RFRA may be asserted as a defense to any enforcement action brought by the state.[41]

The Connecticut Religious Liberty Act[42]

In order to understand the force of the challenge supported by *Hobby Lobby*, it is necessary to understand the history of Supreme Court jurisprudence related to the free exercise clause of the First Amendment and the Congressional response known as the Religious Freedom Restoration Act (RFRA).

In 1990 the Supreme Court abandoned prior free exercise constitutional analysis that had

---

[40] Reasonable doubt and its relationship to moral certitude are defining issues for catholic assessment of the EC issues. This topic is more fully developed in Davis, et al, Letter, *Levonorgestrel and Moral Certitude*, National Catholic Bioethics Quarterly (spring 2015) at 5-8. The task of separating objective scientific data from the subjective opinion of researchers and commentators has yielded valuable insights and has thoroughly undermined prior claims of moral and/or scientific certitude about the MOA of Plan B. Making those critical distinctions, recent analysis from multiple sources has presented the scientifically sound case for a potential postfertilization MOA that explains the absence of pregnancy in Noé. See, Mozzanega, Bruno and Erich Cosmi. 2011. How do levonorgestrel-only Emergency contraceptive pills prevent pregnancy? some considerations. Gynecological Endocrinology 27.6: 439–442; Peck, Rebecca, Walter Rella, Julio Tudela, Justo Aznar, and Bruno Mozzanega. 2015. Does levonorgestrel emergency contraception have a post-fertilization effect? A review of its mechanism of action. The Linacre Quarterly 82: 197-202; Peck, Rebecca, Juan Velez, 2013, *The Postovulatory Mechanism of Action of Plan B: A Review of the Scientific Literature*, National Catholic Bioethics Quarterly 13.4:1-40; Kahlenborn, Christopher, Rebecca Peck and Walter Severs 2015, *Mechanism of action of levonorgestrel emergency contraception*, The Linacre Quarterly 82.1: 18-33; Ravielle, Kathleen, 2014, *Levonorgestrel in Cases of Rape: How Does it Work?* The Linacre Quarterly 81.2: 117-129.

[41] Conn. Gen. Stat. 52-571b(c) provides "A person whose exercise of religion has been burdened in violation of the provisions of this section may assert that violation **as a claim or defense** in a judicial proceeding and obtain appropriate relief against the state or any political subdivision of the state." (emphasis added).

[42] Because knowledge about the circumstances attendant to the adoption of the EC mandate in Connecticut is so plentiful and because the Connecticut bishops' explanation of the policy of "reluctant compliance" offers an extraordinary segue into the MOA issue, they have been given special attention herein. In addition to the religious liberty implication of the Connecticut statute, certain of its provisions raise troubling free speech and association issues. However, the analysis of state RFRA laws application to state EC mandates apply with equal vigor to possible challenges in South Carolina and New Mexico and perhaps elsewhere.

applied "a balancing test that took into account whether the challenged action imposed a substantial burden on the practice of religion, and if it did, whether it was needed to serve a compelling government interest."[43] In its place it adopted a rule allowing that "neutral, generally applicable laws may be applied to religious practices even when not supported by a compelling governmental interest" without violating the free exercise clause.[44]

In response to *Smith*, Congress passed RFRA[45] prohibiting any substantial burden on religious free exercise[46], even by neutral laws of general applicability, unless the burden furthers a compelling governmental interest by the least restrictive means available. Various states have adopted versions of RAFA[47] including Connecticut.[48]

The Connecticut Appellate Court has recognized that:

> the overarching purpose of [the state RFRA] was to provide more protection for religious freedom under Connecticut law than the *Smith* decision would provide under federal law. . . . The legislature illustrated its intent to reverse the effects of the *Smith* case by considering a number of specific situations in which its application would lead to the decreased protection of religious freedoms.[49]

The Court held that Connecticut's RFRA adopted "the strict scrutiny test" and that the legislature intended protection for religious practices beyond that mandated by the First Amendment "such as the ritualistic use of peyote at issue in *Smith*. . . . The legislative history is replete with examples of religious practices that the legislature intended to protect under [the] strict scrutiny test."[50] The Court cited examples from legislative hearings including "lighting of candles in church, the receiving of wine at holy communion, and wearing a yarmulke in court." Those references were in response to concerns that neutral laws of general applicability, such as fire codes and minimum age alcohol consumption laws, could suppress established religious practices that may not be protected by the constitutional analysis adopted in *Smith*.[51] The

---

[43] *Hobby Lobby* discussion by Alito

[44] *Employment Division v. Smith*, cite

[45] See fn. 9 supra.

[46] As passed, RFRA applied to the states as well as the federal government. In *City of Boerne v. Flores*, 521 U.S. 507 (1997) the Supreme Court held the act could not constitutionally be applied to the states.

[47] See fn.12 supra.

[48] Connecticut General Statute sec. 52-571b.

[49] *Rweyemamu v. Commission on Human Rights and Opportunities,* 98 Conn. App. 646, 660-61 (2006).

[50] Ibid, 664.

[51] Other examples included Amish in Minnesota who were compelled to place reflectors on their horse drawn buggies, something that violated their religious practice of shunning forms of adornment. In Michigan, the body of a Jewish man killed in an automobile accident was subjected to an autopsy despite the fact that his religious beliefs barred the procedure and his family had objected. *See*, Testimony of Robert Leikind before Connecticut Judiciary Committee, Bill No. SB-1343, Public Hearing March 1, 1993, transcript 1993JUD00301-R001500-CHR.HTM available at http://www.cga.ct.gov/. Ironies abound in legislative histories no less than in life. Of note is the odd fact that

examples point out that government regulation of licensed activities affecting public health or safety, normally subject to the rational relationship test, will be subjected to strict scrutiny where they burden the exercise of religion.

One court found a compelling government interest advanced by the least restrictive means where the state correctional department refused to adopt and inmates name change from "Vaughn Daryl Outlaw" to "Alhizquiyalishmawiyl Ibrahim Rabbial Hiramramzideen".[52] The significance of the decision is not mitigated by the *pro se* status of the plaintiff since the court correctly identified and applied the heightened strict scrutiny mandated by the act.

One case is clearly an anomaly. While upholding religiously neutral historical district land use regulations that had a secular purpose, the Appellate Court referred to the state RFRA in its description of the plaintiff's claims but then adopted the lower court opinion that relied exclusively on the First Amendment analysis in *Smith*. Notably absent was application of the strict scrutiny test.[53]

In another inmate case[54] the court denied a motion to dismiss claims that restrictions on preaching, teaching, and engaging in Christian fellowship violated the state RFRA. In addition, a state RFRA claim that denial of religious publications and the right to possess and privately use a Bible in common areas were other inmates were permitted secular materials also survived.

The Connecticut Supreme Court rejected the notion that Connecticut's RFRA benefits only natural persons and applied it to religious organizations, holding that it restored the balancing test rejected in *Smith*.[55] As applied to the EC mandate, the case supports the proposition that individual medical practitioners, sexual assault victims, and institutional health care providers (such as Catholic hospitals) have standing to pursue a challenge.

One U.S. District Court decision is especially significant.[56] Homeowners claimed that a local ordinance prohibiting prayer meetings of more than 25 people in residential homes violated Connecticut's RFRA. The court agreed. The decision, later reversed on unrelated grounds that

---

the principal religious opposition to the Connecticut Religious Freedom Act came from the Catholic Church. At the same public hearing an attorney representing the Connecticut Catholic 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" with respect to free exercise of religion, a clear reference to the *Smith* decision. That was made abundantly clear by ten pages of transcript in which the Catholic Conference's witness was questioned by at times surprised legislators, who were puzzled that the Catholic Church would oppose legislation designed to limit government intrusion into free exercise of religion.

[52] *Outlaw v. Warden*, 2001 WL 418561 (Superior Court, March 30, 2001).

[53] *First Church of Christ, Scientist v. Historic District Commission of the Town of Ridgefield,* 55 Conn. App. 59 (1999). The lower court opinion is at 46 Conn. Supp. 90 (1998).

[54] *Ventura v. Connecticut Department of Corrections* 2004 WL 3049086 (Superior Court, 2004).

[55] *Cambodian Buddhist Society of Connecticut, Inc. v. Planning and Zoning Commission of the Town of Newtown,* 285 Conn 381 (2008).

[56] *Murphy v. Zoning Commission of the Town of New Milford,* 289 F. Supp. 2d 87 (D. Conn. 2003).

did not disturb its statutory analysis,[57] carries substantial intellectual weight. The court held that the zoning rule failed strict scrutiny analysis. While it advanced a "compelling government interest" in safety it did not utilize the least restrictive means.[58]

"The least-restrictive-means standard is exceptionally demanding," and it requires the government to "sho[w] that it lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion by the objecting part[y]."[59] "[I]f a less restrictive means is available for the Government to achieve its goals, the Government must use it."[60] When applied to Connecticut's RFRA, it requires a showing by the state that it lacks other means of achieving its desired goal without imposing *any* burden on the exercise of religion since the "substantial burden" standard of the federal act was abandoned in the state act in favor of mere "burden."[61]

Assertions of compelling interest will be subjected to perlustration and broadly formulated expressions will generally be insufficient. In *Holt v. Hobbs*, the Supreme Court was demanding.[62] An inmate desired to grow a beard as an expression religious faith but prison regulation prohibited facial hair. A compelling government interest in safety and security was asserted.

> The Department argues that its grooming policy represents the least restrictive means of furthering a broadly formulated … compelling interest in prison safety

---

[57] The United States Court of Appeals for the Second Circuit held that the homeowners clam not ripe for adjudication. See 402 F. 3d 342 (2d Cir. 2005).

[58] In addition, the court held that Connecticut's statute prohibited "burden" of religious exercise and not the elevated standard of "substantial burden" set forth in the federal RFRA. Id. at 115. This distinction between "burden" and "substantial burden" is itself substantial and portends advantage in litigation over the Connecticut EC mandate. "Substantial burden" has been explained in various ways by the courts. *Thomas v. Review Bd. of the Indiana Employment Sec. Div.* held that a substantial burden exists where the state "put[s] substantial pressure on an adherent to modify his behavior and to violate his beliefs." 450 U.S. 707, 718, 101 S.Ct. 1425, 1432, 67 L.Ed.2d 624 (1981). Sherbert v. Verner held that a substantial burden arises when a person is required to "choose between following the precepts of her religion and forfeiting benefits, on the one hand, and abandoning the precepts of her religion ... on the other." 374 U.S. 398, 404, 83 S.Ct. 1790, 1794, 10 L.Ed.2d 965 (1963). "Substantial burden" must be more than an inconvenience. *Hicks v. Garner*, 69 F.3d 22, n.22 (5th Cir. 1995). In order to satisfy the standard, "the government must either compel a person do something in contravention of their religious beliefs or require them to refrain from doing something required by their religious beliefs." *Id.* The strikingly different language in Connecticut requires only a "burden" and not a "substantial burden." Either standard is easily met with respect to the EC mandate imposed on catholic hospitals. However, the legislative choice to extend statutory protection to *any* "burden" on free exercise rather then "substantial burden" not only sweeps a broader universe of government action into the scope of the prohibition, but suggests a more rigorous protection of religious liberty then that provided by the federal act.

[59] *Hobby Lobby*, 134 S.Ct., at 2780.

[60] *United States v. Playboy Entertainment Group, Inc.,* 529 U.S. 803, 815, 120 S.Ct. 1878, 146 L.Ed.2d 865 (2000).

[61] See fn. 58, supra.

[62] *Holt v. Hobbs,* 574 U.S. ____ , 135 S.Ct. 853 (2015) involved application of The Religious Land Use and Institutionalized Persons Act (RLUIPA), 42 U.S.C. §§ 2000cc, *et seq*., a companion federal statute to RFRA, which applies the same strict scrutiny test as RFRA.

> and security. But RLUIPA, like RFRA, contemplates a more focused inquiry and requires the Government to demonstrate that the compelling interest test is satisfied through application of the challenged law to the person—the particular claimant whose sincere exercise of religion is being substantially burdened. RLUIPA requires us to scrutinize the asserted harm of granting specific exemptions to particular religious claimants' and to look to the marginal interest in enforcing the challenged government action in that particular context.[63]

With respect to the EC mandate, a challenge would assert that each of Connecticut's Catholic hospitals are within short distance of a secular hospital that can provide EC without imposing on the religious identity and mission the Catholic institutions.[64] The driving distance between the Catholic hospitals and their secular counterparts are 2.7, 1.5, and 2.4 miles.[65] Ambulance transport between the facilities would provide a less restrictive alternative. In fact, the Catholic hospitals offered to arrange such transposition in their legislative testimony in 2007. Subsequently, Plan B One-Step has become prescription free[66] and its administration requires no specialized knowledge. Ambulance crews could easily provide any desired access, as could a receiving secular hospital.

In *Holt* the court also found it significant that various other states and the federal government run prisons without the restrictions on beards:

> [T]he Department failed to show, in the face of petitioner's evidence, why the vast majority of States and the Federal Government permit inmates to grow ½ inch beards, either for any reason or for religious reasons, but it cannot. … While not necessarily controlling, the policies followed at other well-run institutions would be relevant to a determination of the need for a particular type of restriction.[67]

Several states with sexual assault EC treatment legislation only require provision of accurate information about EC but not the drug itself.[68] That suggests those states' interest were adequately met by educating victims who could pursue EC if they so desired. Other states provide specific exemption from a generally applicable EC mandate on the basis of religious or

---

[63] 574 U.S. ___, 135 S.Ct. at 863 (2015).

[64] When the EC standard of care was proposed in 2006 Connecticut's senior Senator, Joseph Lieberman, recognized the proximity of other hospitals and supported Catholic hospitals' objection to the mandate: "In Connecticut, it shouldn't take more than a short ride to get to another hospital." Although the report of Senator Lieberman's comments published in the New Haven Register is no longer available from that source, other sources provide the information. The sarcastic and thoroughly antagonistic "Connecticut Bob" site at http://ctbob.blogspot.com/2006/05/lieberman-vs-day-after-pill.html also reported the story.

[65] Id.

[66] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm358082.htm.

[67] *Holt v. Hobbs*, 135 S.Ct. at ___, (internal quotation marks omitted).

[68] For example: Colorado, Illinois, Oregon, and Texas.

moral objection tied to referral or transport to a willing provider.[69] *Holt* held that "when so many prisons offer an accommodation, a prison must, at a minimum, offer persuasive reasons why it believes that it must take a different course." A similar burden must be carried by states that mandate EC administration, especially in light of the non-prescription status of Plan B One-Step. When a plausible, less restrictive alternative is offered it is the Government's obligation to prove that the alternative will be ineffective to achieve its goals. Other alternative means could include state owned or licensed primary care delivery platforms in portable units maintained adjacent to the Catholic hospitals.

The Connecticut statute applies to licensed health care facilities that examine or treat rape victims[70], it does not extend to a private physician's office. That "exception by silence" means the state has determined that its "compelling" interest is satisfied even though some first line rape medical examiners (e.g. private office physicians) are not covered by the mandate. That can only mean that the claim of a compelling state interest is not quite so compelling or, at the very least, exemption of the small number of objecting hospitals would not undermine the states' asserted interest.

The Connecticut bishops opposed the mandate because it required administration of EC in circumstances where it *may* prevent implantation. Their opposition was grounded in the statutory preclusion of ovulation testing which they favored as a means to greater assurance that an abortifacient effect would not be operative. In the case of rape, health care directives for Catholic facilities permit treatment to prevent conception. However, they expressly prohibit treatments that have as their purpose or direct effect the interference with implantation. Directive 36 provides:

> 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. [71]

[69] Pennsylvania and Ohio.

[70] Licensed health care facilities include hospitals, outpatient clinics, mobile care units, and even school-based clinics. Several such entities are closely associated with the Catholic Church including the three state catholic hospitals, the outpatient clinic Malta House of Care and its mobile unit, and the infirmary at Fairfield University, which identifies itself as "a Jesuit and Catholic university."

[71] U.S. Conference of Catholic Bishops, *Ethical and Religious Directive for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009), Directive 36: "Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped 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

In 2007 the debate over testing assumed that Plan B was primarily an anovulant. The revolution overturning that presumption may suggest that negative ovulation testing cannot provide sufficient assurance precluding a post fertilization MOA and an outright ban on Plan B administration may yet emerge as the dominate catholic position.[72] Regardless, any scientifically valid analysis can no longer ignore the abortifacient potential given the normalcy of ovulation with LNG uptake, a potential that can no longer be ignored in application of ERD 36.

Given the legislative history of §52-571b and the related case law, a challenge to the EC mandate must be judged as having a reasonable chance of success. The elements of a successful action are present. Catholic hospitals in Connecticut are religion-based institutions. The mission of St. Vincent's Medical Center (Bridgeport) "is rooted in the healing and loving ministry of Jesus Christ. … Our health ministry is spiritually centers. … St. Vincent's Medical Center is a local Catholic health ministry." [73] St. Francis Medical Center (Hartford) describes itself as "*a health ministry of the Catholic Archdiocese of Hartford*."[74] The general introduction to the *Ethical and Religious Directives for Catholic Health Care Facilities (*ERDs*)* demonstrates the religious nature of Catholic health care ministry and its relationship to episcopal authority charged with the duty to preserve its moral and religious identity.[75] The ERDs are replete with references to Jesus's healing ministry and plainly state that health care and healing are a core element of Christianity. The provision of medication that is primarily anovulant but which may impede implantation of fertilized ova clearly implicates questions of faith and morals in Catholic teaching. While the Church has not issued a definitive teaching, the bishops of Connecticut have repeatedly voiced their objection to compulsory EC distribution in rape cases without adequate

---

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."

[72] Other protocols suggest LNG may be used after certain ultrasound examination of leading follicle diameter and endometrium thickness, LH testing, and examination of cervical mucus. See, Bonelli, Johannes, et al. 2014. Empfehlungen zur Handhabung der Notfallkontrazeption ("Pille danach") bei Frauen nach einer Vergewaltigung, (Recommendations for handling of emergency contraception ("morning after pill") in women after being raped). Institute fur medizinische Anthropologie und Bioethik (IMABE), Imago Hominis: 21(1):68-72. www.imabe.org/index.php?id=2049. Accessed 19 Feb. 2016. (German language text).

[73] St. Vincent's Mission Statement available at http://www.stvincents.org/aboutus/mission.cfm.

[74] St. Francis Care, "Our Mission and Core Values," http://www. stfranciscare.org/default.cfm?id=1676 (emphasis in original).

[75] ERDs, General Introduction, provides: "The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing. . . Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9: 35). . . . The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ. . . . Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop . . . ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese."

testing and have only agreed to "reluctant compliance."

Compelled Speech, Falsity, and Loaded Dice

Other infirmities with Connecticut's mandate warrant mention.[76] It compels speech that invades the patient–physician relationship and, potentially, the First Amendment and substantive Due Process. It requires disclosure of "medically and factually accurate and objective information relating to emergency contraception" to rape victims.[77] Requiring accurate information obviously furthers a legitimate government interest but the mandate does more. It defines "[m]edically and factually accurate and objective" as "verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable."[78] It is now well established that the "weight of research" appearing in peer-reviewed journals has long inaccurately reported the primary mechanism of LNG. Many of the leading articles forming the "weight of research" deny any interceptive or contragestative MOA, reflecting bias, manipulation of data, internally inconsistent conclusions, and avoidance of obvious inferences. Core elements of the previous dogma regarding MOA have been demolished and prominent EC researchers now acknowledge that when administered in the preovulatory fertile window it is no more effective at preventing ovulation than a placebo.[79] The restrictions on the sources and substance of "factually accurate and objective information relating to emergency contraception" jeopardize meaningful informed consent.

Some states go even further and grant a monopoly on the content of information provided to a patient. Minnesota requires provision of "factually accurate and unbiased written and oral medical information about emergency contraception from the American College of Obstetricians and Gynecologists" (ACOG). But ACOG is not an unbiased actor. Its current patient disclosure regarding EC fails to identify the potential post fertilization MOA that is recognized by the FDA.[80]

---

[76] Several of these issues are common to other state EC mandates and may provide fertile basis for attack even in states that have not adopted a RFRA.

[77] Conn. Gen. Stat. 19a-112e(b)(1).

[78] 19a-112e(a)(3).

[79] Brache, Vivian, Leila Cochon, Maeva Deniaud and Horacio B. Croxatto. 2013. *Ulipristal acetate prevents ovulation more effectively than Levonorgestrel: analysis of pooled data from three randomized trials of emergency contraception regimens*. Contraception 88:611–618.

[80] http://www.acog.org/Patients/FAQs/Emergency-Contraception#work. And at least as disturbing is ACOG's history of collaboration with Justice Elena Kagan when she was White House counsel in 1996 in the drafting of an ACOG statement in such a manner that it provided a misleading foundation for President Clinton's veto of a federal partial birth abortion ban, a statement later used to manipulate the Supreme Court when it struck Nebraska's partial birth abortion ban in *Stenberg v. Carhart.* The tawdry history of that episode is well documented by a series of National Review articles by Shannen Coffin, including the following: *Kagan's Abortion Distortion,* http://www.nationalreview.com/article/243362/kagans-abortion-distortion-shannen-w-coffin.

Application of Connecticut's RFRA to the EC mandate has long been proposed.[81] It remains one of the great ironies of religious liberty battles that the only religious opponent to Connecticut RFRA was the Connecticut Catholic Conference.[82] Fortunately, the bill sailed through the legislature and stands as the most realistic remedy to the mandate. Action is due. Inaction will inevitably sap the credibility of catholic health care and its guardians. *Hobby Lobby* may prove to be a redemptive element in this discordant affair.

---

http://www.acog.org/Patients/FAQs/Emergency-Contraception#work; *Questioning Elena Kagan*, http://www.nationalreview.com/corner/232608/questioning-elena-kagan-shannen-w-coffin; and *More on Kagan and Partial Birth Abortion*, http://www.nationalreview.com/corner/232619/more-kagan-and-partial-birth-abortion-shannen-w-coffin.

[81] Davis, *Plan B and the Rout of Religious Liberty*, Ethics & Medics, December 2007.

[82] Bill No. SB-1343, Connecticut Judiciary Committee public hearing, March 1, 1993, transcript 1993JUD00301-R001500-CHR.HTM available at www.cga.ct.gov.