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The Christian and Oral Contraceptives: An Investigation into Moral Permissibility

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Pro-life Christians of various stripes have been undeniably united in their opposition to abortion in the post *Roe vs. Wade* era. They have consistently sought to advocate for the unborn by defending the position that human life begins at conception and, because of its inherent value as an image-bearer of the Creator, is deserving of full protection. Yet the solidarity of the pro-life movement is not what it might seem at first glance, for there are several issues upon which pro-life Christians disagree. Speaking of what he sees as the most significant schism within the pro-life camp, Dennis Sullivan sums up the state of the union nicely when he says "[there is] an unresolved debate within the pro-life family about the morality of oral contraceptives."[1] Indeed, this unresolved debate has in some instances become more like trench warfare, with neither side budging on what it sees as the terms and central issues of the disagreement. This schism has not just occurred at the popular level but also manifests in deep-seated disagreement amongst Christian physicians, leading Susan Crockett and company to lament that "the controversy regarding the mechanism of action of the commonly used [oral] contraceptives has threatened to split the pro-life medical community."[2] The issue of oral contraceptives is thus deeply divisive and must be further addressed in order to develop greater unity within a pro-life movement which cannot afford endless splintering if it is to make a greater impact upon society at large.[3]

Additionally, the use of oral contraceptives should be further addressed because, practically speaking, Christian couples face the question of which, if any, contraception to use, and "the pill" is often the default contraceptive of choice. Yet it seems that many Christians are unaware of the issues surrounding oral contraceptives, particularly the striking claim in question that they may have abortifacient effects. Randy Alcorn has done much to bring this concern to the fore, and he summarizes the stakes of the discussion thus:

> About fourteen million American women use the Pill each year. Across the globe it is used by about sixty million. The question of whether it causes abortions has direct bearing on untold millions of Christians, many of them

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prolife, who use and recommend it. For those who recognize God as the Creator of each person and the giver and taker of human life, this is a question with profound moral implications.[4]

The fact that many Christians are unaware of the possibility that oral contraceptives can act as abortifacients, and the thought that believers are potentially (albeit unknowingly) aborting their unborn children, is enough to convince us that the stakes are indeed as high as Alcorn and others claim. Thus, this article will seek to address this pressing issue for Christian couples and dividing point within the pro-life community by exploring the question: is it morally permissible for the Christian to use oral contraceptives? To anticipate, I will ultimately argue, based on the lack of definitive evidence that oral contraceptives act as abortifacients, that (1) their use is presently morally permissible and (2) their use (or not) ought to be considered an issue of conscience grounded in Christian freedom unless such definitive evidence emerges.

Some Background Information

We must begin with an overview of the pertinent information for understanding the issue. Indeed, much misunderstanding occurs around the issue of oral contraceptives because individuals are misinformed regarding basic terminology and pertinent physiology. First, some key terms: "oral contraceptives" or "hormone contraceptives" are the medical terms for what is popularly known as "the pill," that is, the birth control pill. However, the pro-life community has often maintained an important distinction between contraception and birth control: contraception applies only to the prevention of conception, while birth control can refer to any means of preventing the birth of a child (including post-fertilization and post-implantation abortion). This difference in terminology is not without political implications, for whether one refers to "the pill" as a form of birth control or as a contraceptive often reveals which side of the debate one is on (e.g., Alcorn, as an opponent of the pill, refers to it as birth control, while Sullivan, an advocate of the pill, refers to it as a contraceptive). We will primarily use the terminology of "oral contraceptive" here in order not to beg the question at hand and to align with the most common usage within the medical community.

Second, we must distinguish between the various types of "pill" available; indeed, not all pills are created equal. We should say first that the purview of this article involves evaluating oral contraceptives which seek to *prevent conception*; pills such as RU-486 (mifepristone) are deemed ethically unacceptable by pro-life Christians, for they operate with the intention of eliminating an *already conceived and implanted* human being and thus their use is rightly considered a form of abortion.[5]

However, even oral contraceptives which seek to prevent conception are not alike. For one, not all of them are "oral;" the (less common) terminology of "hormone" or "chemical" contraception refers to forms of contraception that seek to influence a woman's body chemistry in a way similar to the more popular contraceptive pill. These include Lunelle injections, Ortho Evra contraceptive patches, NuvaRings, Depo-Provera, intrauterine devices (IUDs) and progesterone implants (Norplant, Implanon, Jadelle).[6] Due to space constraints we cannot consider these forms of contraception here, except to say in general that they seem to be less preferable choices for the pro-life Christian than certain oral contraceptives that are available.

Oral contraceptives (proper) are divided into two main categories: combination oral contraceptives (COCs) and progesterone-only pills (POPs). COCs can be further divided into three categories: monophasic, biphasic, and triphasic. These refer to the number of variations in the amount of estrogen and progesterone that the woman takes per cycle (either one, two, or three). For the most part it seems that these three variations of the combination pill have no significance for the question of COCs' abortifacient possibilities; they should all be evaluated together, for the variations simply have to do with which hormone combination will be best for the woman taking it.[7] The same cannot be said for the difference between COCs and POPs; the consensus of the pro-life community

at both the popular and medical level is that POPs are "riskier in terms of possible pregnancy or an abortifacient action" than COCs.[8] This is because POPs "have a considerably higher breakthrough-ovulation rate than combination methods do."[9] Since the primary goal of oral contraceptives is to prevent ovulation, COCs have made POPs obsolete; if the Christian is morally permitted to use an oral contraceptive (which is the question at hand), it should be a COC rather than a POP.

This brings us to another important aspect of this article, which is to briefly describe how an oral contraceptive works. As just stated, the primary function of an oral contraceptive is to prevent ovulation. But how is this done? Essentially, it is accomplished by interfering with the natural menstrual cycle which post-pubescent, pre-menopausal women experience around every month, manipulating the amounts and the timing of various chemical releases within the female body (including follicle stimulating hormone, or FSH, luteinizing hormone, or LH, estrogen, and progesterone). The complex chemical intervention of the pill seeks to prevent FSH pulses from being issued by the pituitary gland, which are what develop and release a mature egg into the fallopian tubes for fertilization. In order for this prevention to occur, the women must absorb enough estrogen to prevent FSH release and enough progesterone to stabilize the uterine lining to prevent excessive bleeding (progesterone also blocks the production of LH which can trigger ovulation even in a woman with reduced FSH pulses). Ideally, the pill ensures that the appropriate amounts of estrogen and progesterone are absorbed by the woman's body to prevent the development and release of eggs—that is, to prevent ovulation. And of course, if there is no ovulation there can be no conception, and thus the contraceptive will have accomplished its task.

However, oral contraceptives have other effects on the woman's body that lie at the heart of the controversy.[10] For if oral contraceptives only prevented ovulation, there would be widespread acceptance of their use among the pro-life community, for no eggs would ever be fertilized and thus in danger of abortion. But the chemical intervention of the pill causes the woman's body to respond in other ways, and because oral contraceptives sometimes fail in their effort to prevent ovulation (in what is known as "breakthrough-ovulation"), these other effects are relevant.

The effect that forms the center of the controversy and delineates the two sides of the debate is the reduced uterine lining (endometrial tissue) that is caused by the low levels of estrogen in the woman's body. Normally when an egg is fertilized and a woman becomes pregnant, estrogen levels skyrocket, causing the uterine lining to grow into a lush landing pad where the developing embryo can effectively implant. An oral contraceptive keeps estrogen levels consistent, but lower than normal pregnancy levels. If there is no fertilized egg (because ovulation has been prevented, or because sperm are unable to reach an egg that has broken through), this is no problem for those with pro-life concerns. But in the case of breakthrough ovulation where sperm are able to make it through the hostile cervical environment (which can happen, evidenced by the fact that, on occasion, women who are consistent in taking oral contraceptives become pregnant), this reduced uterine lining becomes a major concern for those with pro-life convictions, for the embryo may not be able to implant due to human intervention (and thus oral contraception would have an indirect abortifacient effect). William Cutrer and Sandra Glahn pose the concern well: "Does this [reduced uterine lining effect] mean the developing embryo will find a hostile landing zone once it reaches the uterus? This is an important question. And Christian experts in many fields differ on the answer."[11]

Opposing Positions

This leads us, then, to the two positions currently vying for acceptance or rejection of oral contraceptives within the pro-life camp. The *first position* is that oral contraceptives are morally permissible for the Christian because the evidence that oral contraceptives act as abortifacients is ultimately *inconclusive*. The typical starting point, as articulated by Sullivan, is that "the scientific evidence for an abortifacient effect of [oral] contraceptive agents . . . concludes that such an effect is yet unproven."[12] Representatives of this position tend to argue that, while more research needs to be done, the evidence points in the direction that the reduced uterine lining (which is an empirical fact) may not actually have an abortifacient effect for eggs fertilized after breakthrough-ovulation.

Along these lines, Cutrer and Glahn raise concerns with the abortifacient theory on two levels. On one level, they argue that a thinner endometrium does not automatically mean an abortifacient effect is present; the fact that embryos implant in other structures that have no endometrium (e.g., fallopian tubes) demonstrates that an endometrium of a certain thickness is not necessary for successful implantation. On the other level, they argue that current research does not "support . . . the hypothesis that [oral contraceptives] cause a thinning effect on the uterine lining *even when breakthrough ovulation occurs*."[13] They ask: "if enough messenger hormone gets through to cause ovulation in the first place, won't enough estrogen . . . and enough progesterone be released after ovulation to counteract the pill's negative effect on the uterine lining?"[14] And, of course, the greatest evidence that they see against the abortifacient theory is the fact that "most obstetricians have delivered babies that were conceived while the mothers were taking [oral contraceptives]."[15]

Crockett and company concur with these lines of argument, noting in summary fashion that "the abortifacient theory [regarding oral contraceptives]. . . . fails to account for the essential information about ovulation and its effect on the uterine lining. The concept of 'hostile endometrium' is contrary to the known

physiologic effect of ovulatory estrogen and progesterone on the uterine lining."[16] Sullivan, taking a more statistical approach, concludes his survey of the literature by noting that opponents of oral contraceptives

> must make a difficult statistical case: (1) In instances of breakthrough ovulation (a rare event), a significant number of sperm must penetrate the thickened cervical mucous (presumably a rare event) . . . and (2) If fertilization does occur, an embryo must fail to implant in an endometrium at least somewhat prepared for it, or if it implants, fail to continue to term, and this failure rate must be greater than the 70% that occurs naturally.[17]

Now we turn to the *second position*, which interestingly argues from the same starting point (evidence that oral contraceptives can act as abortifacients is ultimately inconclusive) but concludes that oral contraceptives are *not* morally permissible for the Christian. Representatives of this position tend to argue that, while more research needs to be done, research to date seems to point in the direction that reduced uterine lining is likely to have an abortifacient effect on eggs fertilized after breakthrough ovulation. So, for instance, John Wilks cites research establishing that "there is a critical thickness of the endometrium needed to sustain implantation of a human embryo" and that "if breakthrough ovulation were to occur, implantation might fail, because of an endometrium that is too thin."[18] Walter Larimore, after citing the FDA approved *Physician Desk Reference* which states that "although the primary mechanism of action is inhibition of ovulation, other alterations include . . . changes in the endometrium which reduce the likelihood of implantation," notes that opponents of oral contraceptives view this as "an FDA admission of the abortifacient effect of the pill."[19]

In the midst of scientific evidence that is often overwhelmingly difficult to integrate and interpret, pro-life opponents of the pill insist that in these kinds of scientific gray areas we must always "err on the side of life," believing that inconclusive evidence means we should discontinue use of oral contraceptives until evidence definitively ruling out abortifacient action can be provided. In this sense, oral contraceptives are understood to be "guilty until proven innocent," and as such those who hold this position urge us to "put away the pill" so that we avoid the "horrid irony . . . [of being] followers of Christ [who] speak out against surgical abortions, yet repeatedly make choices that result in chemical abortions of [our] own children."[20] Continuing with the vivid imagery, Larimore concludes his article by posing a thought experiment that consolidates the concerns of this second position:

> It is reasonable to hypothesize that if the Pill was in development today and if the preborn child was considered truly human under the law, then it would be unlikely that the FDA would allow the Pill to be approved for public use until the manufacturers had studied and established whether or not (and, if so, how often) the Pill causes the death of preborn children.[21]

Key Doctrines and Resources

Before we can attempt to offer a perspective on the debate, we do well to acknowledge what key doctrines might further influence our understanding of this important question. Our work in this article is explicitly and unapologetically theological, for as with many bioethical issues concerning the beginning (and end) of life, we must ground our presuppositions and methodology theologically, allowing the Word of God to shape our understanding of the question and point the way toward an answer. David VanDrunen rightly insists that "the bioethical decisions that [Christians] make . . . ought to reflect a proper understanding of the truths and way of life revealed in Scripture" and that bioethical issues such as this one not be treated as "isolated moral problems" but instead "in the context of broader Christian faith and life."[22]

One such doctrine that is quite relevant but perhaps underleveraged would be our doctrine of sin. Pro-life Christians are often united in expounding a robust doctrine of creation which understands everything that exists as "good" and as belonging to the One who made it all *ex nihilo*. They are relatively consistent in applying their theological anthropology which affirms that humanity has been uniquely created in the image of God and is thus of inestimable, inherent worth. But when it comes to tracing out the implications of the fact that this world, in the words of Cornelius Plantinga, is no longer "the way it's supposed to be," there is often much less consistency and thus much less clarity about how we ought to live in this good-*yet-fallen* world (and how we ought to act amidst the innumerable moral quandaries we will inevitably find ourselves in because of its, and our, fallen nature).[23] I believe more work needs to be done in further understanding how the noetic effects of sin are at play as we attempt to address bioethical issues such as this one; particularly, we need to better recognize where we might be blind to the truth of the matter because our minds (along with our hearts, bodies, and the entire world around us) are under the curse of sin. Especially pertinent would be a greater articulation of how to distinguish between issues of sin and issues of conscience ("disputable matters" among believers). For instance, although sections of Romans 14–15, 1 Corinthians 8–10, and 1 Timothy 4 (among other places) make it clear that there are non-sinful but disputed behaviors in which Christians can engage because of their freedom in Christ as dictated by their conscience, it is not as clear that the category of "issues of conscience" has played a central enough role in helping Christians think through the bioethical issues of our time.

One resource that might assist us in bringing "issues of conscience" more to the fore is the tri-perspectival framework of John Frame, who in his *Medical Ethics* proposes that bioethical issues (as with all ethical issues) require us

to see the interrelations between three perspectives: the normative (God's Word), the existential (the human person), and the situational (contours of the world). He argues that while non-Christians are unable to hold all three perspectives together (and thus tend to fixate on one of them), Christians have a God "who guarantees the coherence of His Word with His creation and with the needs of persons made in His image."[24] This perspective can help nuance the discussion between pro-life Christians regarding oral contraceptives, one that often becomes polarizing because the *complexities* of the issue are not fully acknowledged and because the possibility that it may not be a sin issue has not been sufficiently reckoned with. Evangelical debate on oral contraceptives has tended to become fixated on the normative perspective (though, as we have acknowledged, there are still more depths of Scripture to plumb) while neglecting the existential (e.g., decisions regarding the pill are issues of conscience which will differ from Christian to Christian based upon various formative life experiences) and the situational (e.g., inconclusive evidence should generate both further inquiry as well as respect for those whose interpretations of the currently available evidence differ from our own). We would do well to take Frame's advice and ensure that all three perspectives are being brought to bear on our deliberation of the pill's moral permissibility.

But further grappling with our doctrine of sin and the importance of conscience issues leads us to recognize a second doctrine to greater leverage in this debate: our doctrine of the church. Though Roman Catholic pro-lifers are often well informed by a robust ecclesiology (and often express opposition to *any* forms of artificial contraception based on magisterial teaching), evangelicals often find themselves with a rather anemic ecclesiology that fails to help them see how the bioethical issues that they are facing should be framed by their participation in the Body of Christ. Ben Mitchell has done much to make the case that this evangelical lacuna must be remedied, arguing that "a theological medical ethic which neglects the role of the church neglects God's primary instrument for the care of his people."[25] This conviction prompts his assertion that "part of the task of the church is to create a moral community and, beacon-like, display to the world what such a community looks like."[26] Yet, many believers face the complex scientific data and moral labyrinth of oral contraceptives alone, failing to consult the community of faith (e.g., pastors, small group leaders, better-informed brothers and sisters in their congregation, including physicians) or think about the implications of their decision for the church's witness to the world.[27] Pastor and academic theologians alike must lead the charge by modeling this community orientation for their churches, bringing (often unspoken) issues such as oral contraceptives out in the open to be elucidated, discussed, evaluated, and prayed over with the collective wisdom of the church.

Here we might point particularly to the work of VanDrunen (especially his *Bioethics and the Christian Life*), whose ecclesial-centric advocacy of the virtues within evangelical ethics provides a much-needed complement to a more individualist "case-studies" approach. VanDrunen's work sheds light on how the conundrum that the issue of oral contraceptives poses to pro-life Christians points to a greater need for our theological ethics to be more informed by the insights of virtue ethics exercised in community, particularly its emphasis on formative *telos* over methodological *techne*. This perspective rightly emphasizes the need for believers to be better formed into the kind of people who make wise, God-honoring decisions no matter the complexity of the ethical quandary before them. VanDrunen's proposal that *wisdom*, rather than mere information, come more to the fore as we engage complex bioethical issues cannot be seconded enough; indeed, the capacity "to perceive how one's virtues and principles can come to proper expression in particular circumstances" has been conspicuously absent in recent attempts to provide moral guidance regarding the pill.[28] There is no better context to increase in that perception than the community of God's people gathered under the Word and called to patiently grow in grace and truth together. Pressing into such a context may not only help us better discern the pertinent content necessary for deciding the moral permissibility of oral contraceptives; it might also help us to recognize the extent of legitimate disagreement which can occur between

Christians seeking to faithfully live out a biblical ethic.

Conclusions

Now that the issue has been introduced, the opposing sides stated, and key doctrines and resources identified, what may we conclude in seeking to further resolve the disputed question of the moral permissibility of oral contraceptives? The challenge to answering this question is obvious: two pro-life positions regarding oral contraceptives look at the same (often convoluted) evidence and come to very different conclusions. Linda Bevington (in my view, rightly) attributes this divide and the ethical complexities we have come to associate with the pill as stemming from the fact that the essential scientific information regarding this issue is *firmly in dispute*. This leads her to ask: "How should we develop an ethical position on a life-or-death issue when the scientific data required to draw a definitive conclusion is controversial or not yet available?"[29] One camp answers that until all the data is available and definitive, we must abstain from using oral contraceptives; the other camp argues that the lack of definitive evidence allows the Christian to proceed with its usage. One camp says that the pill is "guilty until proven innocent," while the other camp insists that it is "innocent until proven guilty." Which one is right, and how should we proceed and advise believers when it comes to this crossroads of perspectives and the question of the pill's moral permissibility?

First, it is important to emphasize that any conclusions we come to in this regard are tentative because, as both parties recognize, there is more research that still needs to be done. We thus affirm with Cutrer and Glahn that "we have a responsibility to be informed [and] prayerful . . . Those who choose to use the pill need to keep up with any new information that might either reveal new concerns or lay to rest current fears."[30]

Second, we note that while the nature of the evidence is currently inconclusive regarding whether oral contraceptives ever act as abortifacients, there is increasing reason to question the legitimacy of the theory that the reduction of uterine lining associated with oral contraceptive use actually harms the fertilized egg. Sullivan, for instance, while admitting that the endometrium is thinner during use of oral contraceptives, calls into question whether this would be the case by the time that a breakthrough fertilized egg implants (which typically happens around six days or so after fertilization). He makes his case by granting, for the sake of argument, that a thinner endometrium is less hospitable for implantation, but then goes on to note that "if [breakthrough] ovulation takes place, a completely different hormonal milieu comes into existence [because] ovulation leaves behind the corpus luteum, a rich source of estrogen and progesterone. After the six days required for the embryo to travel down the uterine tube into the uterus, these hormones [would] have transformed the endometrium, [making it] receptive for implantation."[31] In short, Sullivan argues that we have good reason to think that the "hostile endometrium" pointed to by the pill's opponents is, by the time of implantation, actually transformed into a sufficiently "hospitable" one.

Murray Casey and Todd Salzman make the same case but with even more precision, at one point following Sullivan's tactic of granting for the sake of argument that "the endometrium [of a user of the pill] would likely be unreceptive to implantation of a conceptus" only to remind us that even if that were the case "COC[s] taken cyclically are so strongly contraceptive [that] fertilization rarely if ever occurs."[32] But, significantly, they go on to argue that there is actually *not* sufficient evidence to verify this negative effect on the endometrium in the first place, surveying several studies to conclude that "with respect to short-term endometrial effects, evidence is lacking as to whether therapeutic courses of either monophasic or multiphasic COC[s] . . . enhance endometrial integrity and stability or conversely render the endometrium unfavorable for implantation of early conceptuses if ovulation and then fertilization might rarely happen."[33] Their contention, if true, takes the wind right out of the sails of oral contraceptive opponents, for any concern about its abortifacient effects lies squarely with the (supposedly hostile) condition of the endometrium at the time of implantation. Casey and Salzman go on to assert that the "the paucity of evidence for ovulation, conception, and abortifacient activity when COC[s] are used faithfully and consistently" and the fact that "evidence for fertilization and pregnancy losses is insignificant or nil when monophasic COC formulations with at least 35 mg ethinyl estradiol are properly used" leads them to conclude that it is a "reasonable judgment based on presently available laboratory and medical science and high standards of clinical practice" that women may take COCs of the specific variety mentioned above without violating a pro-life conscience.[34]

Thus, while we are in agreement with the Christian Medical and Dental Associations' statement that "current knowledge does not confirm or refute conclusions that routine use of hormonal birth control causes abortion," it is reasonable to assure believers that the burden of proof lies with those who claim that oral contraceptives have abortifacient capacity, for at this point it seems to be a safe assumption that they have the onus of proving that a "hostile endometrium" is indeed caused by COCs and remains hostile at the critical moment of implantation.[35] This is because, in the words of Jeffrey Lewis and Dennis Sullivan, "the prevailing scientific conclusion about compliant COC use is that such agents do not have a measurable post-fertilization effect, and that moral concern over their abortifacient potential (even in light of the conception view of personhood) is unwarranted."[36]

It is this "unwarranted" determination that allows us to place use of oral contraceptives tentatively in the category of "issues of conscience" rather than "issues of sin." As stated above, such a distinction is vital to navigating life

in a fallen world where we do not have access to all the evidence (i.e., we do not have exhaustive knowledge) and where Christians will come to varying opinions about the best course of action in a particular circumstance and what it looks like to live wisely in this good-yet-fallen world. Opinions which vary from God's definitive statement in his Word regarding what is sin are to be rejected; opinions on those matters on which God has not spoken directly and which vary from believer to believer according to their differing consciences grounded in the freedom that is theirs in Christ are to be given space to operate.

Indeed, it is critical that we help believers better understand and discern the difference between sin issues and conscience issues amidst bioethical questions such as this one. Sullivan is right to note in this regard that when the evidence is underdetermined "ethical decisions should be based on personal convictions combined with the best possible scientific evidence . . . Scripture would call on all participants in this discussion to mutual respect and peace, and to apply the principles of Romans 14 as a guide to disputable matters."[37] Farr Curlin helps us envision what this looks like by framing the use of oral contraceptives as a conscience issue where "the work of the conscience is much like the work of a jury . . . [taking] into account the available evidence and the accompanying arguments in order to make a reasoned judgment . . . [which] can be reconsidered in light of new evidence and new arguments."[38] Until that definitive evidence is offered which can meet the necessary burden of proof that oral contraceptives do, in fact, have abortifacient effects, we are in a good position to leave the decision to use oral contraceptives (or not) up to the constraints of conscience.[39]

Of course, as an issue of conscience, Scripture calls us to show deep respect to believers who interpret the evidence in such a manner as to make oral contraceptives morally impermissible *for them* (due to the convictions of their conscience). Indeed, we must remember as we seek truth that we are also called to seek unity with one another in the Body of Christ, even as we disagree about extremely important matters. A responsible monitoring of the literature, an engaged tri-perspectival framework, a mind that is guided by our theology (particularly our hamartiology and ecclesiology), a searching out of the collective wisdom of the church on how to live virtuously in our fallen world, and a prayerful heart that humbly interacts with and learns from others will all be required as we proceed. By seeking truth while respecting our brothers and sisters in Christ who come to different conclusions from ours, we will be formed more and more into the image of Christ, better enabled to (re)determine the moral permissibility of oral contraceptives as new evidence arises. After all, it is one of a myriad of ethical quandaries that the Christian will face in the "brave new world" of the twenty-first century with its rapidly advancing biotechnologies. But, as this article has attempted to show, it is a significant one for the unity of the pro-life movement, for Christian couples seeking wisdom and guidance in contraceptive use, and for demonstrating the particular importance of the category of "issues of conscience" grounded in Christian freedom. Further sharpening this "tool" in our Christian bioethical "tool belt" might be one of the ways we can better determine the moral permissibility (or lack thereof) of many ethical issues while we are only able to see "as through a glass darkly."

1 Dennis M. Sullivan, "The Oral Contraceptive as Abortifacient: An Analysis of the Evidence," *Perspectives on Science and Christian Faith* 58, no. 3 (2006): 189.

2 Susan A. Crockett, Joseph L. DeCook, Donna Harrison, and Camilla Hersh, "Using Hormone Contraceptives is a Decision Involving Science, Scripture, and Conscience," in *The Reproduction Revolution: A Christian Appraisal of Sexuality, Reproductive Technologies, and the Family*, eds. John F. Kilner, Paige C. Cunningham and W. David Hager (Grand Rapids, MI: Eerdmans, 1999), 196.

3 This essay will not be considering the ethics of contraception itself. For a recent assessment of the same from an evangelical Protestant vantage point see Dennis P. Hollinger, "The Ethics of Contraception: A Theological Assessment," *Journal of the Evangelical Theological Society* 56, no. 4 (2013): 683—96 and W. Ross Blackburn, "Sex and Fullness: A Rejoinder to Dennis Hollinger on Contraception," *Journal of the Evangelical Theological Society* 58, no. 1 (2015): 117—30.

4 Randy Alcorn, *Does the Birth Control Pill Cause Abortions?* 7th ed. (Sandy, OR: Eternal Perspective Ministries, 2004), 8. Undoubtedly those numbers have increased since this edition's publishing.

5 This is not to be confused with the "morning after pill," most commonly Plan B One-Step®, which is a high dose of levonorgestrel used as emergency contraception. There is growing evidence that Plan B is not abortive in its action; even if taken after fertilization has occurred, it does not appear to interfere with implantation. For a Christian pro-life perspective on the morning after pill, see Jeffrey D. Lewis and Dennis M. Sullivan, "The Abortifacient Potential of Emergency Contraceptives," *Ethics & Medicine* 28, no. 3 (2012): 113–20.

6 For a very helpful introduction to each of these forms of contraception, see William R. Cutrer and Sandra L. Glahn, *The Contraception Guidebook: Options, Risks, and Answers for Christian Couples* (Grand Rapids, MI: Zondervan, 2005), 113–27. I agree with their evaluation that each of these contraceptive options ought to be considered with extreme caution due to their greater potential for abortifacient action than the combination oral contraceptives. options ought to be considered with extreme caution due to their greater potential for abortifacient action than the combination oral contraceptives.

7 Cutrer and Glahn, *The Contraception Guidebook*, 92–93.

8 Cutrer and Glahn, *The Contraception Guidebook*, 100.

9 Cutrer and Glahn, *The Contraception Guidebook*.

10 Some effects such as cervical mucus thickening (which make it more difficult for sperm to survive and enter the uterus) and a change in cilia movement within the fallopian tubes (affecting egg transport) further serve the purpose of preventing conception. These well documented effects are thus of no ethical concern. It is only those effects which interfere with implantation of a fertilized egg that need to be considered in terms of any abortifacient capacity of oral contraceptives. See Gary P. Stewart et al., *Basic Questions on Reproductive Technology: When Is It Right to Intervene?* (Grand Rapids, MI: Kregel, 1998), 67.

11 Cutrer and Glahn, *The Contraceptive Guidebook*, 103.

12 Sullivan, "The Oral Contraceptive as Abortifacient," 189.

13 Cutrer and Glahn, *The Contraception Guidebook*, 107 (emphasis original).

14 Cutrer and Glahn, *The Contraception Guidebook*, 103.

15 Cutrer and Glahn, *The Contraception Guidebook*, 108.

16 Crockett et al., "Using Hormone Contraceptives is a Decision Involving Science, Scripture, and Conscience," 193–94.

17 Sullivan, "The Oral Contraceptive as Abortifacient," 192.

18 John Wilks, "The Impact of the Pill on Implantation Factors—New Research Findings," *Ethics & Medicine* 16, no. 1 (2000): 19.

19 Walter L. Larimore, "The Abortifacient Effect of the Birth Control Pill and the Principle of 'Double Effect,'" *Ethics & Medicine* 16, no. 1 (2000): 24–25.

20 Walter L. Larimore and Randy Alcorn, "Using the Birth Control Pill is Ethically Unacceptable," in *The Reproduction Revolution*, 190.

21 Larimore, "The Abortifacient Effect of the Birth Control Pill and the Principle of 'Double Effect," 29.

22 David VanDrunen, *Bioethics and the Christian Life: A Guide to Making Difficult Decisions*, (Wheaton, IL: Crossway Books, 2009), 39, 67.

23 Cornelius Plantinga, *Not the Way It's Supposed to Be: A Breviary of Sin* (Grand Rapids, MI: Eerdmans, 1995).

24 John M. Frame, *Medical Ethics* (Phillipsburg, NJ: P&R, 1989), 6.

25 C. Ben Mitchell, "Bioethics and the Church," in *Bioethics and the Future of Medicine: A Christian Appraisal*, eds. John F. Kilner, Nigel M. De S. Cameron, and David L. Schiedermayer (Grand Rapids, MI: Eerdmans, 1995), 124.

26 Mitchell, "Bioethics and the Church," 132.

27 Pertinent sections of Romans 12, Ephesians 4–5, Colossians 3 and 1 Peter 2 exhort us to live out every aspect of our lives (including making difficult bioethical decisions) in the context of the community of faith.

28 VanDrunen, *Bioethics and the Christian Life*, 92.

29 Linda Bevington, "Introduction," in *The Reproduction Revolution*, 178.

30 Cutrer and Glahn, *The Contraception Guidebook*, 108.

31 Sullivan, "The Oral Contraceptive as Abortifacient," 191-92.

32 Murray Joseph Casey and Todd A. Salzman, "Therapeutic, Prophylactic, Untoward, and Contraceptive Effects of Combined Oral Contraceptives: Catholic Teaching, Natural Law, and the Principle of Double Effect When Deciding to Prescribe and Use," *The American Journal of Bioethics* 14, no. 7 (2014): 24, https://doi.org/10.1080/15265161.2014.919364.

33 Casey and Salzman, "Therapeutic, Prophylactic, Untoward, and Contraceptive Effects of Combined Oral Contraceptives," 25.

34 Casey and Salzman, "Therapeutic, Prophylactic, Untoward, and Contraceptive Effects of Combined Oral Contraceptives," 26, 29.

35 Board of Trustees, "Possible Post-fertilization Effects of Hormonal Birth Control," Christian Medical and Dental Association, September 1998, https://cmda.org/position-statements/.

36 Lewis and Sullivan, "The Abortifacient Potential of Emergency Contraceptives," 114.

37 Sullivan, "The Oral Contraceptive as Abortifacient," 194.

38 Farr A. Curlin, "Caution: Conscience is the Limb on Which Medical Ethics Sits," *The American Journal of Bioethics* 7, no. 6 (2007): 31, https://doi.org/10.1080/15265160701347429.

39 John and Paul Feinberg helpfully provide a short introduction the importance of issues of conscience grounded in Christian freedom for bioethics, including eight questions that can guide the believer in discerning whether their conscience is "clear" regarding a particular course of action. See John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World* (Wheaton, IL: Crossway, 1993), 43–45.