Reply to Fr. Austriaco

To the Editor: In the Autumn 2010 issue of the Journal, in his reply to my letter concerning his review of my book *Vital Conflicts in Medical Ethics*,[1] Fr. Austriaco seems to me to create confusion by subsuming therapeutic abortions under the heading of "vital conflict." However, cases of vital conflict, as I treat them in my book, are *distinguished* from therapeutic abortion, which I reject as morally illicit.

Therapeutic abortion, as I use the term, means to choose the killing of an embryo or a fetus in order to save the mother's life or to avoid some damage to her health. Therapeutic abortion, as I describe it, is direct—that is, intentional—killing, because it involves a choice against the baby's life, a choice in which the mother's survival or health is *preferred* to the life of the baby. Cases of vital conflict, instead, are characterized by a peculiar constellation: the baby is not only lost in any case but its continued presence in the mother's womb will also certainly and immediately cause the mother's death; if an action of removal of the embryo or fetus, which will immediately kill the baby, is omitted, *both baby and mother will die*. Unlike cases of therapeutic abortion, cases of vital conflict—most typically craniotomy—constitute *a conflict for the physician* who, committed to saving life, would feel responsible by his inaction for not having saved at least the only life that *could* be saved. In cases of therapeutic abortion, the physician instead makes a choice of which life he wants to save, preferring the mother's survival and thereby choosing to destroy the life of the child who otherwise could have had a chance to survive.

Cases of vital conflict are cases in which *everything* has been done to save the child and in which the child's death is imminent—that is, there is nothing else that can be done except saving the mother *in extremis*, though with an intervention which is physically directly lethal for the child—or else cases such as tubal pregnancy in which it is clear from the outset that nothing can be done for the embryo and that the embryo has no chance of survival but represents, however, an imminent danger to the mother's life. In such cases, I argued, the action which is immediately lethal for the child is not an act of intentional and thus direct killing because the death of the child, though knowingly caused by the intervention, is not chosen as a means to save the mother. It remains *praeter intentionem* and can thus be considered as an unintended side effect. From this *follows*—it is not an argument—that the surgical intervention is objectively nothing other than an act of saving the mother's life.

Fr. Austriaco does not accept this way of putting things. He refers to a case that occurred during his service as a chaplain in a hospital in New York City. On the grounds of his narrative, the concrete configuration of the case remains unclear. The case from Phoenix, Arizona, that Fr. Austriaco mentions is also difficult to assess on the basis of the available public information. After having read media reports and consulted various specialists, I understand it rather to be a case in which the standard medical literature recommends what is called "therapeutic" abortion. (In the meantime, however, a report by M. Therese Lysaught was published, which actually presents it as a case of vital conflict.[2]) The discussion of these matters has become complicated now that Fr. Austriaco has adopted the—in my view unfair—strategy of subsuming therapeutic abortion under the heading of vital conflict,

which is not my terminology and therefore leads to confusion.

Fr. Austriaco seems also to overlook what I have constantly emphasized, namely, that classic manuals of moral theology have advised confessors to leave in good faith doctors who have performed a craniotomy. I agree with Fr. Austriaco that—as he wrote in his reply—a physician "may never intend, choose, or seek—even reluctantly, remorsefully, or tragically—the death of the unborn child as a means to save the mother's life" (432). The whole problem is, what does it mean to "intend," "choose," or "seek" the death of an unborn child? Fr. Austriaco seems to presuppose that by intentionally crushing the skull of a baby, a surgeon inevitably chooses, intends, and seeks its death. "In doing so," Fr. Austriaco says, repeating what he already wrote in his review of my book, "he necessarily intends—probably reluctantly, remorsefully, and tragically—the death of the going-to-die-anyway child, unjustly depriving him of his life" (432–433). (The same argument is repeated later on 433.)

As I see it, in this account everything is either false or unwarranted. First, the narrative is wrong. Admittedly, in a case of therapeutic abortion a surgeon "reluctantly and remorsefully" kills a (viable) child in order to save the mother, because he thinks the survival of the mother is, after all, more desirable, although he really deplores the death of the child. In the case of vital conflict, such as a craniotomy, however, the narrative is totally different. Here it is not the *death of the child*, but the *whole constellation as such* which is to be called deplorable and sad, and which might also be deplored by both the physician and the mother. This is why the physician will be happy to be able to save at least the mother by removing the baby from her womb; if this causes him sadness it is not for the same reason as in a case of therapeutic abortion, where the baby and its future are intentionally sacrificed for the good of the mother. In a case of vital conflict, the physician will consider the baby's death as something already decided, imposed by natural causes rather than by his choice. In this case, the mother will have no reason to feel guilty of having deprived her child of its birth and its future life; because there was absolutely no prospect of such a future life of the baby, no injustice was done. She will certainly suffer for having lost her baby, but there will be no need for her to morally justify what was done by the physician (with her consent). By presenting a false narrative, Fr. Austriaco thus obscures what is at issue.

Second, by arguing that "he necessarily intends the death" of the child, Fr. Austriaco confounds "intentionally doing something"—which is doing something *knowingly* and *on purpose*—and "doing something with a determinate intention." Of course a surgeon performing a craniotomy *knows* that he immediately kills the baby, and he does what he does *on purpose*. So he intentionally does something which immediately causes the baby's death. This does not imply, however, that he does what he does *with the intention* of killing the baby, choosing its death as a means to achieve the end of saving the mother. There is no such intention and thus no choice of killing the baby, because there was never a choice against the baby's survival.

Of course, *considered physically*, the death of the baby is a direct effect of the crushing of its skull. If we consider hysterectomy or other forms of "indirect" killing that fall under the principle of double effect (like the killing of a fetus as the effect of therapeutically necessary chemotherapy), we must acknowledge that in these cases, too, the surgeon *knows* that the medical procedure he *intentionally* does effectuates necessarily—by a chain of natural causes—the child's death. There is a necessary and foreseen causal chain resulting in the baby's death. So *considered physically* (as required by Fr. Austriaco's approach), the physician who extracts a cancerous uterus or performs chemotherapy on a pregnant woman *knowingly* and *intentionally* causes the baby's death, because *what he intentionally does* necessarily kills the baby—though in an indirect way. If Fr. Austriaco's argument were correct, the whole and only point of "direct" and thus illicit killing would be that the death of the child follows *physically* in

a direct and immediate way from what one knowingly and on purpose does.

But this physical understanding of direct killing contradicts the fact that one can also intentionally (and illicitly) kill a baby by (physically) only *indirectly* causing its death. For example, one might extract the uterus without a therapeutic reason, seeking to end the pregnancy; this, of course, is intentional and therefore *direct killing*, as also in the case of applying chemotherapy without urgent need (hoping in this way to achieve a "camouflaged" abortion, which would then be declared "indirect."). So the reason why a killing is to be called direct is not the reason Fr. Austriaco indicates—what one intentionally (that is, purposefully and knowingly) does; it instead has to do with *what one really chooses and thus intends in doing something*. This is why Fr. Austriaco's critique of my argument begs the question. His critique *presupposes* from the outset that the baby's death is chosen as a means; he does not demonstrate this, but constantly uses this unwarranted affirmation as an *argument*.

Finally, in the above-quoted sentence, Fr. Austriaco asserts that in removing a child from the mother's womb by crushing its skull, a surgeon is "unjustly depriving him of his life" (433, where the assertion is later repeated.) It is, of course, morally illicit to "unjustly deprive someone of his life." Yet whether a craniotomy actually does violate justice was precisely the question I asked in my book and tried to resolve by providing a detailed argument. I do not think that Fr. Austriaco has really challenged this argument so far. He simply restates over and over again that a craniotomy means to "unjustly deprive a child of his life." With this he simply begs the question I investigated in my book. This is why in my view the debate on the real issue has not yet started.

In his reply, Fr. Austriaco also refers to Pope Pius XII and his affirmation that the life of an innocent child is "untouchable, and therefore any act directly tending to destroy it is illicit" (433).[3] He thus suggests that my position is in contradiction to this statement. He fails to mention that in my book I have discussed at length the teachings of Pius XII on the direct killing of an unborn child, showing that "directly" here can only be understood in the sense of "intentional killing" *which implies a choice against the baby's life, preferring the survival (or the health) of the mother*. Therefore, his attempt to bring my position into conflict with the magisterium of Pius XII (an approach mirrored in his confusion of distinct cases of vital conflicts and therapeutic abortion) is not successful.

In a short letter like this one not everything can be explained in detail. As similar arguments against my view can be found in Fr. Benedict Guevin's essay "Vital Conflicts and Virtue Ethics,"[4] to which I will reply in more detail in a forthcoming article in the *NCBQ*, I refer to that more complete future defense of my view.

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[1]See Martin Rhonheimer, letter, and Nicanor Pier Giorgio Austriaco, reply, *National Catholic Bioethics Quarterly* 10.3 (Autumn 2010): 429–434. Fr. Austriaco's review of *Vital Conflicts in Medical Ethics* appeared in the Spring 2010 issue of the *NCBQ*.

[2]M. Therese Lysaught, "Moral Analysis of Procedure at Phoenix Hospital," *Origins* 40.33 (January 27, 2011): 537–549.

[3]Pope Pius XII, Discourse to the Italian Medical Biological Union "San Luca" (November 12, 1944).

[4]*National Catholic Bioethics Quarterly* 10.3 (Autumn 2010): 471–480.

Deacon Davis on Plan B

To the Editor: I would like to express my appreciation to Rev. Deacon Thomas J. Davis Jr. for his outstanding work in the Winter 2010 issue of the *NCBQ*.[1] His article, "Plan B Agonistics: Doubt, Debate, and Denial," as well as his letter, "Plan B Debate Not Resolved," make an unprecedented contribution to the literature on this topic. In the ongoing controversy surrounding the mechanisms of action (MOAs) of Plan B and similar drugs, and in particular these drugs'

abortifacient effects, the issues at stake have become much clearer thanks to Deacon Davis's extremely thorough research.

In recent years, in various issues of the *NCBQ* and other journals, Rev. Nicanor Austriaco, OP, Sandra Reznik, MD, Ron Hamel, and Rev. Daniel Sulmasy, OFM, MD, have cited studies and advocated the position that levonorgestrel emergency contraception is not, or is unlikely to be, abortifacient.[2] Davis provides a very detailed analysis of the referenced medical studies as well as an analysis of the logic of the arguments provided by these authors, who claim it is acceptable to provide Plan B and similar drugs to victims of sexual assault.

Of particular note is Davis's commentary on the significance of the research done by Patrick Yeung Jr., MD, Erica Laethem, and Rev. Joseph Tham, LC, MD, regarding levonorgestrel administered before ovulation.[3] Davis's extensive research supports the conclusions of Yeung, Laethem, and Tham, particularly that when levonorgestrel is given in the *preovulatory* phase, it is *precisely* the time when it might result in postfertilization effects *after* ovulation that interfere with implantation.[4] Davis later observes that levonorgestrel is estimated to act as an abortifacient *3 to 13 percent of the time* when it is administered in the preovulatory period. Extrapolating from these numbers, he notes that the Yeung model would predict a postfertilization MOA occurring in as many as *sixteen thousand women annually* in the United States alone.[5] While the loss of even a single human life is unacceptable, these findings clearly challenge the premise of those who claim that postfertilization MOAs are insignificant or rare.

Davis further substantiates the abortifacient MOAs with his detailed chronology of the FDA approval process of Plan B and related drugs over a ten-year period (1999–2009). He carefully documents the concerns raised by the regulating agencies and medical reviewers about postfertilization MOAs, and what should be included in the subsequent drug labeling, such as consumer warnings on the outer packaging, more detailed package inserts, and prescribing information. The very real evidence of postfertilization MOAs articulated throughout the approval proceedings clearly makes the case for informed consent. This has serious implications for emergency personnel who may be involved in the treatment of victims of rape. We must not forget that there are women who, despite their attempts to prevent a pregnancy, would simultaneously find abortion an unthinkable option. If medical professionals were to withhold information about the postfertilization effects of Plan B and similar drugs—either deliberately or simply out of ignorance, because they were not fully informed themselves—then women would be done a great disservice.

It is also important to heed Davis's warning about the emergence of ulipristal acetate, marketed under the trade name ella, which is a known contragestive drug marketed for use as emergency contraception.[6] He cautions that as over-the-counter access to Plan B becomes more widespread, advocacy groups will lobby for the prescription drugs ella and RU-486 (mifepristone) to be the standard treatment in state-mandated rape protocols, claiming greater efficacy at preventing pregnancy despite their established abortifacient properties.

Davis's explanation of the moral implications of using levonorgestrel as emergency contraception also supports the premise of my essay "Emergency Contraception: Can It Be Morally Justified?" in the Spring 2010 issue of the *NCBQ*. It is wrong to proceed in doubt (and administer emergency contraception to victims of sexual assault) when a human life may be at stake. Davis's research demonstrates that reasonable doubt about the postfertilization MOAs of levonorgestrel does indeed exist. He cites Germain Grisez' suggestion that "unrestricted use of emergency contraception when postfertilization effects cannot be substantially ruled out leaves open the question of conditional acceptance of abortion."[7] This is affirmed in *Dignitas personae*:

> It is true that there is not always complete knowledge of the way that different pharmaceuticals operate, but scientific studies indicate that *the effect of inhibiting*

> *implantation is certainly present*, even if this does not mean that such interceptives cause an abortion every time they are used. . . . It must be noted, however, that anyone who seeks to prevent the implantation of an embryo which may possibly have been conceived and who therefore either requests or prescribes such a pharmaceutical, generally intends abortion. . . . As is known, abortion is "the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth." Therefore, the use of means of interception and contragestation fall within the *sin of abortion* and are gravely immoral.[8]

Deacon Davis is to be commended for the great care with which he has undertaken and presented his very thorough research. His work sheds tremendous light on the issues at stake in the Plan B controversy. There are serious soteriological implications. His article "Plan B Agonistics: Doubt, Debate, and Denial" should be considered essential reading for all who would be guided by the light of truth.

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[1]Thomas J. Davis Jr., "Plan B Agonistics: Doubt, Debate, and Denial," *National Catholic Bioethics Quarterly* 10.4 (Winter 2010): 741–772, and his letter, "Plan B Debate Not Resolved," in the same issue, 641–644.

[2]Davis examines these authors' positions extensively, with multiple citations, in his article.

[3]Patrick Yeung Jr., Erica Laethem, and Joseph Tham, "Argument Against the Use of Levonorgestrel in Cases of Sexual Assault," in *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton (Philadelphia: National Catholic Bioethics Center, 2009), 144, 148.

[4]Davis, "Plan B Agonistics," 743, original emphasis.

[5]Ibid., 768, emphasis added.

[6]Ibid., 772.

[7]Ibid., 770, citing Germain Grisez, *The Way of the Lord Jesus*, vol. 3, *Difficult Moral Questions* (Quincy, IL: Franciscan Press, 1997), 296–298.

[8]Congregation for the Doctrine of the Faith, *Dignitas personae* (September 8, 2008), n. 23, original emphasis.

Levonorgestrel Is Often Not an Anovulant

To the Editor: In his critique of Allison LeDoux's essay, "Emergency Contraception: Can It Be Morally Justified?" Rev. Nicanor Austriaco, OP, criticizes LeDoux's claim that levonorgestrel used as an emergency contraceptive (LNG-EC) acts against life.[1] As an obstetrician-gynecologist, I would like to clarify some of the terminology used in this debate and explain further the findings of some very significant studies on the mechanisms of action of this drug.

For any emergency contraceptive to be effective, it must have several different mechanisms of action. When used in a Catholic facility in cases of rape, the drug would be moral only if it acted as a *contraceptive*, by preventing fertilization of the oocyte by the sperm. Therefore, it could prevent ovulation, penetration of the cervix by the sperm, or capacitation of the sperm so fertilization could not take place.

Fertilization occurs around twenty-four hours after ovulation, at which point a human life exists. Any drug that would have an effect on the survival of the conceptus after fertilization would be illicit. Over the next three and a half days, the conceptus travels through the fallopian tube and arrives in the uterine cavity. Any deficiency in the development of the conceptus, which at this stage is dependent on its maternal cytoplasmic inheritance, will end the pregnancy. Genetic control is then transferred to the blastocyst, and the conceptus, prior to implantation, is stimulated by a number of growth factors. Once the blastocyst enters the uterus, it is bathed in maternal secretions.

Any drug or action that interferes with this process would be considered *interceptive*, which includes any impairment of the function of the corpus luteum. Seven to nine days after fertilization, attachment of the conceptus to the endometrium takes place, followed by invasive implantation. Any drug or action that interferes with this process would be called *contragestive*. Finally, once implantation has occurred, any action or drug that disrupts a previously implanted embryo would be *abortifacient*.[2]

A woman has a fertile window of six days in each cycle: the five days prior to ovulation and the day of ovulation. The five days prior to ovulation are the days of sperm survival and are referred to as days -5 to -1. The day of ovulation is day 0. Supporters of LNG-EC have declared that this drug works chiefly as a contraceptive and therefore can be used in Catholic emergency rooms, but that is not what the research has shown.

A study by Gabriella Noe and colleagues further elucidates the mechanisms of action of LNG-EC and illustrates that this drug is a poor contraceptive.[3] Participants in this study were 388 women between the ages of eighteen and thirty-eight years who were within 120 hours of non-contracepted sexual intercourse. These women also had regular menstrual cycles of twenty-one to thirty-five days. After receiving a single dose of 1.5 mg of levonorgestrel, the participants in whom pregnancy was suspected had blood drawn and levels of estradiol, luteinizing hormne, progesterone, and human chorionic gonadotropin evaluated. Cervical mucus was inspected for sperm, and an ultrasound was performed to look at follicular development. Subsequent follow-up depended on whether participants were in the fertile window at the time of enrollment.

For 51 women, the data were unclear as to where they were in the cycle, and they were excluded. Of the remaining 337 women, 215 received the drug during the infertile time and were thus excluded. This means that 63.7 percent of the women were given the drug unnecessarily. Of the remaining 122 women, 87 received the drug on days -5 to -1 and 35 on day 0. Of the 87 women treated prior to ovulation, 15 did not attend follow-up exams. Fifty-seven of the remaining 72 women, or 79 percent, ovulated. Therefore, this drug has to be considered a poor anovulant. The authors concluded that a mechanism other than suppression of ovulation prevented pregnancy. These mechanisms would have to be either interceptive or contragestive or both and thus would act against human life once it has begun. Once fertilization has occurred, the drug does not seem to prevent pregnancy, but that is the time when progesterone levels are rising normally.

In an article by Chun-Xia Meng and colleagues, which Austriaco cites to support his position that LNG-EC does not act against life, the drug was given in a single dose on day 0 to day +3.[4] The authors found minor or no alterations in markers of endometrial receptivity, but the drug was being given at a time when progesterone would be expected to be having an effect.

In contrast, Marta Durand and colleagues, in a similarly designed study on previously sterilized women, found that when LNG-EC was given on days -5 to -2, progesterone levels were significantly lower and serum glycodelin, a major secretory progesterone-regulated glycoprotein of the human endometrium, which is believed to play a role in the feto-maternal defense mechanism, rose earlier.[5] Expression of endometrial glycodelin-A was weaker than when the drug was given on day -1 or day 0. Therefore, the drug would also be having a contragestive effect.

The mechanism of action of LNG-EC is akin to the fable of the six blind men and the elephant. It depends on where the woman is in her cycle at the time the drug is administered and whether the immediate or delayed effects are being measured. However, it is becoming clear that LNG-EC is not working as an anovulant in most circumstances, and therefore is working to destroy the survival of the conceptus as it makes its journey to the endometrial cavity. Thus, it is interfering with the process of implantation in an extremely complex process of establishing a clinically detectable pregnancy.

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[1]Allison LeDoux, "Emergency Contraception: Can It Be Morally Justified?" *National Catholic Bioethics Quarterly* 10.1 (Spring 2010): 61–73; and Nicanor Pier Giorgio Austriaco, "Using Morally Controversial Human Cell Lines after *Dignitas personae*," *National Catholic Bioethics Quarterly* 10.2 (Summer 2010): 265–272.

[2]Martin H. Johnson, *Essential Reproduction,* 4th ed. (Oxford: Blackwell Publishing, 177–195).

[3]Gabriela Noe et al., "Contraceptive Efficacy of Emergency Contraception with Levonorgestrel Given Before or After Ovulation," *Contraception* 81.5 (May 2010): 414–420.

[4]Chun-Xia Meng et al., "Effects of Oral and Vaginal Administration of Levonorgestrel Emergency Contraception on Markers of Endometrial Receptivity," *Human Reproduction* 25.4 (April 2010): 874–883.

[5]Marta Durand et al., "Late Follicular Phase Administration of Levonorgestrel as an Emergency Contraceptive Changes the Secretory Pattern of Glycodelin in Serum and Endometrium during the Luteal Phase of the Menstrual Cycle," *Contraception* 71.6 (June 2005): 451–457.

We Do Not Know When Life Begins

To the Editor: Some Catholics presume to know when human life begins and disdainfully criticize those who question this. Unlike in Eastern philosophy where all sentient life is sacred and to be protected, in Western tradition, we are selective about what we can and cannot kill. Having a soul makes all the difference! This is what distinguishes me from my steak dinner, why I go to heaven and my dog does not, and why it is okay to kill innocent cows and not innocent humans.

While Western religious thought and the Judeo-Christian tradition specifically recognize that to be human is to have a soul, there is no absolute teaching on when ensoulment takes place or even what exactly a soul is. As my atheistic Jewish aunt once said to me, "Show me the soul. Prove to me I have one."

The Hebrew word for soul is *nefesh*, the root meaning "breath." God breathed into Adam's nostrils, and Adam became what has traditionally been translated a "living soul" (Gen. 2:7). This Semitic phrase could as easily be translated as "living breath." It implies that when we take our first breath we become fully human as we receive the gift of breath, *nefesh*, from God. Thus, although Judaism is generally against abortion, if there is a choice between the life of the mother and the life of the unborn child, then the mother's life has precedence.

St. Thomas Aquinas believed ensoulment took place forty days after conception, a belief based in part on the philosophical understanding of hylomorphism, which sees matter and form as the constitutive causes of being and holds that matter has to be suitable for and capable of receiving form. Thus it is not unreasonable to postulate that a certain amount of growth and development must take place in the fetus (matter) before ensoulment takes place (receiving form). Notice that this is a philosophical notion and has nothing to do with medieval embryology. Other Catholics, possibly in reaction to liberal Catholic politicians who quote Aquinas to support a pro-choice position, have pushed ensoulment to the time of conception.

As a physician I offer these considerations: The zygote, the earliest product of conception, has no brain and no heart. As in all mammalian embryology, at this stage one cannot distinguish what will become a living being and what is destined to become placenta (afterbirth). The zygote is capable of splitting in half, forming identical twins that share the same DNA but are not identical persons, suggesting that ensoulment is more than paternal and maternal DNA combining. While most agree that having a soul is what distinguishes us from other life forms and makes us uniquely human, the Vatican, in its "Declaration on Procured Abortion," states that "there is not a unanimous tradition on this point" as to when ensoulment takes place.[1]

The question is not just when life begins but when an embryo truly becomes human. I would argue that, while science may provide some insights, this is primarily a philosophical and religious debate for which there is no definitive answer even within the Catholic Church, much less in the larger Judeo-Christian culture.

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[1]Congregation for the Doctrine of the Faith, "Declaration on Procured Abortion," note 19,

in Edward Furton, ed., *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton et al. (Philadelphia: National Catholic Bioethics Center, 2009), 316.

The Editor replies: Catholic tradition has a definite philosophy, rooted in Western intellectual tradition. Within that tradition, all living things have souls. Thus, the difference between me and my steak dinner is not that one has a soul and one does not, but rather that one has a rational soul and one does not.

Dr. Sheldon (and his aunt) err by thinking that the soul is something mysterious. Although it is true that the soul is something mysterious when we consider it in its depths (it is the source of intellect and will), its existence is not mysterious. The existence of the soul is apparent in everything that lives. It is what distinguishes the living from the nonliving. To Sheldon (and his aunt) I would simply say, "Look at me, I am alive." This is proof for the existence of the soul.

Aquinas followed the science of his time; we do the same today. His embryology was defective. Modern embryology shows us that life begins at conception. We do not take this position about the beginning of life "in reaction to liberal Catholic politicians," but because of what science tells us. Ours is not a reactionary response.

Sheldon states that the zygote "has no brain and no heart." This is true, but the zygote has a human soul. The possibility of twinning does not show that there is no human being from conception, but only that there are two human beings later on. Surely, it is more likely that a second human being is twinned from the first, and not that there is no human being at all until the time of twinning. Embryological development reveals no point of substantial change after the moment of conception. The human brain is programmed into the embryo from the beginning.

It is striking that Sheldon seeks support for his skepticism from the "Declaration on Procured Abortion." The document insists repeatedly that we must view the zygote as a human being. Although it is technically true that the Church has not issued a definitive statement in regard to the moment of personhood, the question hardly bears on the matter at hand. The killing of a human being, at any stage, is immoral. The Declaration makes this clear.[1]

Sheldon's insistence that ensoulment "is primarily a philosophical and religious debate for which there is no definitive answer" shows a fundamental misunderstanding of Catholic philosophy. He seems to think that philosophy is a realm of private opinion that cannot arrive at any objective truth. This is false. When properly formulated, philosophy is more certain than science. Thus we can know for certain that there is a God. This is a truth that the Church affirms can be known by philosophic reason. This truth will never change. That a human embryo is a human being is equally evident.

Edward J. Furton, MA, PhD
Editor-in-Chief

[1]See n. 6: "The tradition of the Church has always held that human life must be protected and favored from the beginning, just as at the various stages of its development." See also n. 7, "In the course of history, the Fathers of the Church, her Pastors, and her Doctors have taught the same doctrine—the various opinions on the infusion of the spiritual soul did not introduce any doubt about the illicitness of abortion." Congregation for the Doctrine of the Faith, "Declaration on Procured Abortion" (November 18, 1974).