I wish my first Washington Insider offering included more positive news. However, recent policy and judicial developments, especially in the month of June, have been quite alarming for the rights and dignity of human life and for the right of conscience.

Escalating Violations of Conscience Rights

On June 21, the US Department of Health and Human Services Office of Civil Rights (OCR) declared that the State of California may continue forcing all health plans under its jurisdiction to cover elective abortions—in violation of the plain text of a federal law known as the Weldon amendment.[1]

This egregious violation of Weldon began in August 2014, when California's Department of Managed Health Care began requiring all health plans under its jurisdiction—including those sponsored by churches and other religious organizations—to cover elective abortions. Religious employers filed a complaint with OCR and waited nearly two years to be told that, in OCR's view, California's coercive law doesn't violate Weldon.[2] Sadly, Weldon provides no other recourse for aggrieved parties when OCR refuses to enforce the law.

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1. For the most recent codification of the Weldon amendment, see sec. 507(d) of division H of the 2016 Consolidated Appropriations Act, Pub. L. 114-113: "(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

2. Jocelyn Samuels, director of Office for Civil Rights, to Life Legal Defense Foundation and others, June 21, 2016, available at http://www.adfmedia.org/.

OCR provided three reasons for its decision. First, it said that the amendment's protections "extend only to health care entities and not to individuals … that are insured by such entities." As such, the complainants do not meet the 'health care entity' definition." But this ignores the text of the Weldon amendment. Weldon prohibits the government from discriminating against a "health care entity" that "does not provide, pay for, provide coverage of, or refer for abortions," and the amendment defines "health care entity" *to include health plans*. The State of California discriminates against health plans that don't cover abortion by driving them out of existence. Plan sponsors aggrieved by such a violation should be able to obtain redress from OCR.

Second, OCR claims that Weldon is intended to protect only health care entities "that object to the provision of abortions … whose objections are made on religious or moral grounds." Wrong. Weldon's text is plain and unambiguous. It says nothing about religious or moral objections, and its application is not conditioned on the existence of such an objection.

Third, OCR claims that enforcing Weldon might require the government to rescind all funds appropriated to California under the Labor/HHS appropriations bill, which it says might be unconstitutional. It is not OCR's job to determine the constitutionality of an act of Congress. Its job is to enforce laws enacted by Congress to the greatest extent allowed by the Constitution.

Another disturbing violation of the Weldon amendment was announced on June 21 by Skagit County Superior Court in Washington State. The court ruled that public (that is, state and municipal) hospitals that provide maternity care must find a way to provide abortions even if their physicians are unwilling to perform the procedure. In 2015, the ACLU of Washington sued Skagit Valley Hospital, saying it violated the state's 1991 Reproductive Privacy Act. The act requires public hospitals that provide women with maternity care to also provide "substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies."[3]

The hospital had been referring women wanting abortions to Planned Parenthood because the hospital had no physicians or nurse practitioners willing to perform them, and under state law cannot force medical professionals to participate in them. The judge said that referring women elsewhere for abortion is not enough to comply with state law. Although "individual providers may choose either to provide or not provide" abortions, the judge said, public hospitals "must comply with [their] responsibility" under the state's Reproductive Privacy Act and find a way to provide abortions on site.[4]

To make matters worse, a 2013 opinion by Washington's Attorney General applies this policy even to a public hospital district that subsidizes a Catholic health care provider offering maternity care.[5]

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3. Wash. Rev. Code § 9.02.160 (approved November 5, 1991), http://app.leg.wa.gov/RCW/.

4. *Coffey v. Public Hospital District No. 1*, no. 15-2-00217-4 (Wash. Super. Ct. June 20, 2016).

5. Washington State Office of the Attorney General, AGO 2013 No. 3 (August 21, 2013), http://www.atg.wa.gov/ago-opinions/.

A third significant assault on conscience rights occurred one week after the OCR and Skagit decisions. On June 28, the US Supreme Court declined to hear a case brought by pharmacists in Washington State who are being forced to violate their religious beliefs by stocking and dispensing emergency contraceptives like Plan B, which can cause an early abortion by preventing an embryo from implanting in a womb.[6]

In 2007, the Washington State Board of Pharmacy issued regulations saying that pharmacies may not "refuse to deliver a drug or device to a patient because its owner objects to delivery on religious, moral, or other personal grounds."[7] One pharmacy owner and two pharmacists filed a lawsuit arguing that the regulations suppress religious belief or practice in violation of the free-exercise clause.

Following a twelve-day trial in 2015, a federal district court enjoined the regulations, concluding that they were adopted with "the predominant purpose" to "stamp out the right to refuse" to dispense emergency contraceptives for religious reasons.[8] Washington appealed to the US Court of Appeals for the Ninth Circuit, which concluded that the regulations do not violate the free-exercise clause and reversed the lower court's decision.[9] The plaintiffs—along with five national and thirty-three state pharmacist associations, the United States Conference of Catholic Bishops (USCCB), and the Washington State Catholic Conference, all appearing as amici (friends of the court)—asked the Supreme Court to review the case. The Court's refusal to do so leaves intact the Ninth Circuit's ruling upholding Washington State's pharmacy regulations.

Dissenting from the Court's decision not to take the case, Justice Samuel Alito, joined by Chief Justice John Roberts and Justice Clarence Thomas, warned that "this case is an ominous sign. … If this is a sign of how religious liberty claims will be treated in the years ahead, those who value religious freedom have cause for great concern."[10]

The Conscience Protection Act

One positive note in the battle for conscience rights occurred on July 13 when the US House of Representatives passed the Conscience Protection Act (CPA) on a bipartisan vote of 245 to 182. For procedural and political reasons, the House brought the conscience bill to the floor using what might be called the shell of an unrelated bill already passed by the Senate, S. 304, and replacing its entire text with the slightly modified text of the Conscience Protection Act, H.R. 4828.[11]

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6. *Stormans v. Wiesman*, 579 U.S. ___, *cert. denied*, https://www.supremecourt.gov/.

7. Washington State Respondents' Brief in Opposition, quoted in *Stormans*, 579 U.S., slip op. at 3 (Alito, J., dissenting).

8. *Stormans v. Selecky*, 844 F.Supp.2d 1172 (W.D. Wash. 2012), available at http://www.becketfund.org/wp-content/uploads/2012/02/Stormans-Opinion-from-Judge-revised.pdf.

9. *Stormans v. Wiesman*, 794 F.3d 1064 (9th Cir. 2015), available at http://www.becketfund.org/wp-content/uploads/2015/07/Stormans-op.pdf.

10. *Stormans,* 579 U.S., slip op. at 1 (Alito, J., dissenting).

11. The text of the bill is available at https://www.congress.gov/114/bills/hr4828/BILLS-114hr4828ih.pdf.

The CPA was introduced in the House (H.R. 4828) by Reps. John Fleming, MD (LA) and Vicky Hartzler (MO) on March 22, 2016, and is a slightly modified version of the Abortion Non-Discrimination Act (ANDA) of 2015.[12] A Senate version of the CPA (S. 2927) was introduced on May 12 by Senators James Lankford (OK), Jerry Moran (KS), and Roy Blunt (MO). The CPA would make more effective and permanent the protections of the Weldon amendment, approved by Congress as part of the Labor/HHS appropriations bill every year since 2004. It would also ensure that victims of discrimination under that policy, and under the Church amendment of 1973, have a right of action in court.

Sadly, the Obama administration issued a statement the day before the House vote saying the President would veto the bill if it came to his desk. The Senate is another obstacle to enactment of the CPA, as there are insufficient votes to overcome a filibuster of the bill. (Sixty votes are needed.) As with ANDA last year, however, both the Senate and House will be urged to include the CPA in must-pass appropriations legislation.

Supreme Court Returning to Strict Scrutiny on Abortion Laws?

On June 27, the Supreme Court dealt a serious blow to unborn human rights and women's health with its first abortion-related ruling in nine years.[13] In *Whole Woman's Health v. Hellerstedt*, the Court issued a 5-to-3 decision striking down a very modest Texas law that required abortion clinics to meet the safety standards of ambulatory surgical centers and required doctors performing abortions to have hospital admitting privileges.[14] The majority opinion was written by Justice Stephen Breyer, joined by Justices Anthony Kennedy, Sonia Sotomayor, Elena Kagan, and Ruth Bader Ginsburg. Chief Justice Roberts and Justices Alito and Thomas dissented.

The case is significant in at least two ways. First, the majority opinion repudiates rules of decision that were adopted in some of the Court's prior abortion cases, returning the Court to a more searching level of judicial scrutiny than was applied in *Planned Parenthood v. Casey* and later cases.[15]

While it claims to be following *Casey*'s undue burden test, for example, the majority applies a balancing test. Under the latter, the Court decides, almost as if exercising the function of a legislature or medical review board, whether the benefits of the challenged requirements outweigh their burdens: "Whatever scrutiny the majority applies to Texas' law," Justice Thomas concludes, "it bears little resemblance to the undue-burden test the Court articulated in [*Casey*]." He notes later that "the majority's undue-burden test looks far less like our post-*Casey* precedents and far

12. For more on the battle to enact the CPA/ANDA, see Richard Doerflinger's Washington Insider in the Spring 2016 issue.

13. The earlier case is *Gonzales v. Carhart*, 550 U.S. 124 (2007), upholding the federal ban on partial-birth abortion.

14. *Whole Woman's Health v. Hellerstedt*, 579 U.S. ___ (2016), https://www.supremecourt.gov/opinions/15pdf/15-274_p8k0.pdf.

15. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

more like the strict-scrutiny standard that *Casey* rejected, under which only the most compelling rationales justified restrictions on abortion."[16]

Likewise, when it upheld the federal partial-birth abortion ban in 2007, the Court made clear that it was not its role to resolve competing claims of medical experts.[17] In the Texas case, however, the Court expresses little reservation about resolving competing medical claims. While there was evidence of the health benefits of ambulatory surgical center and admitting privileges requirements, the majority ignores or overlooks them.[18] "Today's opinion," Justice Thomas writes, "tells the courts that, when the law's justifications are medically uncertain, they need not defer to the legislature, and must instead assess medical justifications for abortion restrictions by scrutinizing the record themselves."[19]

Second, the majority opinion is another illustration of the tendency of federal courts, and of the Supreme Court in particular, to depart from settled jurisprudential rules whenever a case involves abortion. Faced with a severability clause, for example, federal courts usually strike down only as much of the law, or as many of its applications, as are unconstitutional. Here the majority strikes down the Texas law in its entirety, even though many of its provisions, as Justice Alito puts it, "could not plausibly impose an undue burden."[20]

Justice Alito elaborates, quoting sections of the law that was struck down:

> For example, surgical center patients must "be treated with respect, consideration, and dignity." … That's now enjoined. Patients may not be given misleading "advertising regarding the competence and/or capabilities of the organization." … Enjoined. Centers must maintain fire alarm and emergency communications systems … and eliminate "hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma." … Enjoined and enjoined. When a center is being remodeled while still in use, "temporary sound barriers shall be provided where intense, prolonged construction noises will disturb patients or staff in the occupied portions of the building." … Enjoined. Centers must develop and enforce policies concerning teaching and publishing by staff. … Enjoined. They must obtain informed consent before doing research on patients. … Enjoined. And each center "shall develop, implement, and maintain an effective, ongoing, organization-wide, data driven patient safety program." … Also enjoined. These are but a few of the innocuous requirements that the Court invalidates with nary a wave of the hand.[21]

16. *Whole Woman's Health*, 579 U.S., slip op. at 2, 10 (Thomas, J., dissenting).

17. *Gonzales*, 550 U.S. at 164 ("Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts") and at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty").

18. See *amici curiae* brief of the US Conference of Catholic Bishops et al. in support of respondents, *Whole Woman's Health v. Hellerstedt*, February 1, 2016, at 12–19, http://www.usccb.org/about/general-counsel/amicus-briefs/upload/Whole-Woman-s-Health-v-Hellerstedt.pdf.

19. *Whole Woman's Health*, 579 U.S., slip op. at 6 (Thomas, J., dissenting).

20. Ibid., slip op. at 41 (Alito, J., dissenting).

21. Ibid. at 41–42.

As Justice Alito concludes, the majority's "patent refusal to apply well-established law in a neutral way is indefensible and will undermine public confidence in the Court as a fair and neutral arbiter."[22]

NIH Wants to Fund Human–Animal Chimera Research

On August 4, the National Institutes of Health (NIH) announced a proposal to lift its September 2015 moratorium on funding human–animal chimera research and to begin spending taxpayer dollars on the creation and manipulation of new beings whose very existence blurs the line between humans and animals.[23] We're not talking about using a pig's heart valve to fix a human heart. Nor are we talking about growing human cancer tumors in mice to study disease processes. These uncontroversial practices have been going on for decades and don't pose any serious ethical problems.

Furthermore, as the USCCB said in its comment letter to NIH, "Catholic morality does not object in principle to the respectful use of animals in research that can benefit humanity. But because of the unique dignity of the human person, there are limits to what can morally be done along this line."[24]

The research NIH wants to fund is ethically problematic for several reasons. First, it involves the use of stem cells harvested from the killing of humans at the embryonic stage of development. Second, it involves the production of animals that could have partly or wholly human brains. Third, it involves the production of animals that could have human sperm or eggs (with a stipulation that precautions are taken so such animals are not allowed to breed).

Finally, introducing human embryonic stem cells into very early animal embryos will make it very difficult to know the extent to which human cells contribute to the final organism. This is the key moral problem with the NIH proposal: if researchers can't know for certain whether the resulting being has human status or characteristics, they won't know what their moral obligations may be toward that being.

Furthermore, NIH proposes to transcend this very serious ethical boundary having apparently given little, if any, consideration to the ethical and moral implications. When NIH issued its moratorium in September 2015, it pledged to "undertake a deliberative process to evaluate the state of the science in this area, *the ethical issues that should be considered*, and the relevant animal welfare concerns associated with these types of studies."[25]

Yet in announcing its intention to rescind the moratorium on August 4, 2016, NIH mentioned holding only one workshop, in November 2015, "to review the state of the science and discuss animal welfare issues." It mentioned nothing about any

22. Ibid. at 3.

23. National Institutes of Health, NOT-OD-16-128, August 4, 2016, and Notice NOT-OD-15-158, September 23, 2015, https://grants.nih.gov/.

24. USCCB Office of General Counsel to NIH Office of Science Policy, September 2, 2016, http://www.usccb.org/.

25. NIH NOT-OD-15-158, emphasis added.

discussion of the ethical issues involved in the creation and manipulation of partly *human* animals.[26]

On top of all of this, NIH allowed a mere thirty-three days for the public to submit comments on a new area of research that is highly complex and poses new and serious ethical concerns.

Congress Poised to Approve IVF Funding for Veterans

Legislative proposals to provide federal funding for in vitro fertilization (IVF) for military veterans have surfaced numerous times over many years, but in recent years proponents have gotten much more aggressive in their advocacy. The USCCB and some other pro-life groups have fought such efforts successfully until this year. Congress seems poised, this year or perhaps next, to *formally* appropriate federal funding to pay for IVF for the first time in history. I say "formally" because the Department of Defense initiated a pilot program in 2010 allowing IVF, but without Congressional approval.

This summer, the Senate approved a rider to the Veterans Affairs appropriations bill that would provide $88 million to fund fertility treatments using "assisted reproductive technology," including IVF, to address the needs of veterans with a service-related procreative disability. The House took a different approach. Rather than authorizing the government to pay for fertility treatments, it would have provided monetary compensation for veterans that could be put to any use (medical treatment, adoption, foster care, etc.) as is the case with other service-related injuries.

Unfortunately, when the two Houses reconciled their respective bills in conference committee, the Senate version prevailed with a couple of modifications: funds can be used for adoption expenses, and it applies the Dickey-Wicker amendment, which prohibits the destruction, for research purposes, of any embryos produced under this program. The House has already passed the conference committee version, but the Senate has yet to do so, having gotten hung up on a separate fight over funding levels for fighting the mosquito-born Zika virus.

Ultimately, whether or not IVF funding is included in the Veterans Affairs appropriations bill this year may depend on how Congress decides to fund the government beyond this fiscal year, which ends September 30. If Congress is unable to pass specific appropriations bills, which seems likely, it can pass an "omnibus" appropriations bill that includes all the appropriations bills not passed by Congress before the end of September. Or Congress can pass a "continuing resolution" to fund the budget to some point in the future at the current spending levels, usually without adding any new programs or funding. If the former occurs, the IVF funding could be included. If the latter occurs, it is unlikely that IVF funding would be included.

In our opposition to federal funding of IVF, the USCCB points out a number of serious ethical problems and policy concerns with IVF:

26. NIH NOT-OD-16-128.

- IVF is enormously wasteful of human lives, with any embryo it produces having only a 10 to 15 percent chance of surviving to live birth. Survival is even lower, perhaps 2 percent, if the embryos are subjected to preimplantation diagnosis to detect genetic abnormalities before transfer to a womb: some are discarded if a defect is found, and others are harmed by the diagnostic procedure itself.
- Now that enough children have been born from the procedure to make reliable studies possible, it is known that IVF substantially increases a child's risk of serious birth defects. This is especially true for children conceived by the direct injection of a sperm cell into an egg (intracytoplasmic sperm injection, or ICSI), used in cases of infertility due to male factors, which are the factors often affecting veterans because of service-related injuries.
- IVF clinics commonly transfer two, three, or more embryos to the womb to increase the likelihood that one will survive. In cases where a viable pregnancy does result, the probability of carrying two, three, or more children is higher than with natural pregnancy, increasing the risks of premature birth and low birth weight. Many clinics offer abortion ("selective reduction") to destroy one or more of the unborn children.
- Health risks to the mother (or to a woman hired to produce eggs for a couple) include ovarian hyperstimulation syndrome from the drugs used to make her produce many eggs at once for the IVF procedure. The syndrome can lead to infertility and even death.
- Clinics routinely fertilize many eggs at once, discard some embryos, transfer one or more to a woman's womb, and freeze the others that are developing, in case they are needed later. The freezing and thawing process also carries a high death rate. Many thousands of embryos remain frozen indefinitely, as parents either have a child or give up trying IVF. Scientists want to obtain some of these embryos for lethal experiments. The federal government has never engaged in producing and freezing newly conceived human beings and has no policy to address such issues.
- Every year since 2005, congresses and presidents of both parties have approved the Dickey-Wicker amendment to the Labor/HHS appropriations bill, forbidding federally funded research that harms or destroys human embryos. The amendment effectively forbids the use of IVF at the National Institutes of Health, because IVF cannot meet the safety standard (no greater risk of harm or death than is allowed for the same unborn child in a mother's womb).
- Congress has not approved IVF in any federal health program. It was explicitly excluded from the basic benefits package in the Clinton health care reform plan and is not an "essential benefit" in the Affordable Care Act.

AMA Considers Neutrality on Doctor-Prescribed Suicide

The American Medical Association has a long-standing policy in opposition to doctor-prescribed suicide and euthanasia. In 1993, the AMA formally adopted a policy that says, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would

pose serious societal risks."[27] In 1998, the AMA applied the principle to public policy saying, "Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer."[28]

Advocates of doctor-prescribed suicide, primarily a group called Compassion and Choices (formerly the Hemlock Society), have tried on numerous occasions over many years to lobby the AMA to change its policy from one of opposition to one of neutrality. Thankfully, these efforts have been unsuccessful, but Compassion and Choices is unceasing in lobbying the AMA, its state affiliates, and other medical groups to adopt a neutral stance. Neutrality, in effect, gives a green light to state legislatures to move forward to legalize.

In June, the AMA House of Delegates debated the issue of doctor-prescribed suicide for the first time in several years. Two resolutions were submitted for consideration. One was submitted by the Louisiana State Medical Society and proposed that the AMA "not change its policies on opposition to physician assisted suicide or euthanasia to policies of neutrality or endorsement on the issue of physician assisted suicide or euthanasia." The proposal was rejected by the House of Delegates.

A second resolution was submitted by the Oregon Medical Association, representing a state that legalized doctor-prescribed suicide in 1997. This resolution called on the AMA and its Council on Ethical and Judicial Affairs to "study the issue of medical aid-in-dying with consideration of data collected from the states that currently authorize aid-in-dying, and input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the [House of Delegates] at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician 'aid-in-dying.'" This proposal, sadly, was adopted by the House of Delegates.

Opposition to doctor-prescribed suicide by medical organizations has been critical to preserving laws against the practice. It is widely thought that the retreat from opposition to neutrality by state medical associations in Oregon, Vermont, and California was a key factor in the legalization of doctor-prescribed suicide in those states. Therefore, it is critically important that the AMA (and its state affiliates) be urged to maintain its opposition to doctor-prescribed suicide and euthanasia.

Ironically, just one week after the AMA decided to consider a study of neutrality, the British Medical Association voted 2 to 1 to reject neutrality on doctor-prescribed suicide.[29] Hopefully, the AMA will come to the same conclusion.

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27. American Medical Association (AMA), "Physician-Assisted Suicide," opinion 5.7 (issued December 1993, updated June 1996), *Code of Medical Ethics*, June 2016, http://www.ama-assn.org/.

28. AMA Council on Ethical and Judicial Affairs, "Physician-Assisted Suicide," policy H-270.965, Sub. Res. 5, I-98 (1998).

29. Peter Saunders, "BMA Rejects Attempt to Push It Neutral on Assisted Suicide by 2 to 1 Majority," *HOPE: Preventing Euthanasia and Assisted Suicide*, June 22, 2016, http://noeuthanasia.org.au/blog/2419.

Finishing Up with Inspiration

As we contemplate this rather discouraging report and the challenges that lie ahead, I am reminded of an admonition by Rev. Richard John Neuhaus, that as we face

> the storm that is upon us … we have not the right to despair. We have not the right and we have not the reason to despair if we understand that our entire struggle is premised not upon a victory to be achieved, but a victory that has been achieved. If we understand that, far from despair we have right and reason to rejoice that we are called to such a time as this, a time of testing, a time of truth. The encroaching culture of death shall not prevail, for we know, as we read in John's Gospel, "The light shines in the darkness, and the darkness has not overcome it." The darkness will never overcome that light.[30]

No one embodied these words more than our Church's newest saint, Mother Teresa of Calcutta. Here are a few of my favorite words from this blessed gift to humanity:

> I never look at the masses as my responsibility. I look at the individual. I can love only one person at a time. I can feed only one person at a time. Just one, one, one. You get closer to Christ by coming closer to each other. As Jesus said, "Whatever you do to the least of my brethren, you do to me." So you begin. … I begin. I picked up one person—maybe if I didn't pick up that one person I wouldn't have picked up 42,000. The whole work is only a drop in the ocean. But if I did't put the drop in, the ocean would be one drop less. Same thing for you. Same thing in your family. Same thing in the Church where you go. Just begin … one, one, one.[31]

> At the end of life we will not be judged by how many diplomas we have received, how much money we have made, how many great things we have done. We will be judged by "I was hungry and you gave me to eat. I was naked and you clothed me. I was homeless and you took me in." Hungry not only for bread—but hungry for love. Naked not only for clothing—but naked of human dignity and respect. Homeless not only for want of a room of bricks—but homeless because of rejection. This is Christ in distressing disguise.[32]

> God has created a world big enough for all the lives He wishes to be born. It is only our hearts that are not big enough to want them and accept them. … We are too often afraid of the sacrifices we might have to make. But where there is love, there is always sacrifice. And when we love until it hurts, there is joy and peace.[33]

Greg Schleppenbach

30. Richard J. Neuhaus, *Life Insight*, September 1993, reprinted in *The Anchor*, September 30, 1994, 9, available at https://issuu.com/the_anchor/docs/09.30.94.

31. *Words to Love By* (Notre Dame, IN: Ave Maria Press, 1989), 79.

32. Ibid., 80.

33. Speech to the Cairo Conference on Population and Development, September 9, 1994, available at https://www.ewtn.com/.