

Citation for the following article:

Richard Fehring, "Is Breast Feeding the Moral Equivalent of Emergency Contraception in Inducing Early Pregnancy Loss," *Proceedings of the Nineteenth University Faculty for Life Conference at the University of St. Thomas School of Law, Minneapolis MN (2009)*, ed. Joseph W. Koterski, S.J. (Washington, D.C.: University Faculty for Life, 2013), pp. 55-64.

This essay is an extended version of a paper originally published in *The Linacre Quarterly*. It is reprinted here by permission of the author. This article includes new data from Marquette University not treated in the earlier paper.

Is Breastfeeding the Moral Equivalent of Emergency Contraception in Inducing Early Pregnancy Loss?

Richard J. Fehring

ABSTRACT: This paper provides a counter-argument to the notion that breastfeeding acts as an abortifacient and is thus the moral equivalent of abortion-causing drugs, e.g., Plan B or what is referred to as emergency contraception. Those who make this comparison do so in order to ridicule health professionals who refuse to prescribe or refer abortifacient-type contraceptive drugs and to ridicule laws that protect this right of conscience for healthcare professionals. In this paper I will provide evidence that breastfeeding does not induce early pregnancy loss and that it is not the moral equivalent to the administration of abortifacient-type drugs.

William Saletan, a political columnist for the online website *Slate* (see www.slate.com), recently wrote a letter to Michael O. Leavitt, the former Secretary of the U.S. Department of Health and Human Services, concerning the administration's proposal to eliminate financial aid to healthcare institutions that violate the right of healthcare providers who, for reasons of conscience, refuse to participate in abortion and the prescribing of potentially abortifacient contraceptive methods.¹ Throughout his letter Mr. Saletan ostensibly supported the administration's proposal. He urged that the government should not only protect healthcare providers who refuse to participate in abortion but also provide protection for employees who are involved in other potentially

¹ W. Saletan, "Breast-Feeding Kills: The Pro-life Case against Birth Control, Nursing and Exercise," *Slate*, posted 5 August 2008; accessible at: <http://www.slate.com/toolbar.aspx?action=print&id=2196784>.

abortifacient activities, e.g., those employees who promote and teach breastfeeding, those who are involved with the manufacture or selling of coffee in any capacity, and those who are involved with promoting exercise. He provided studies and evidence that all three of these activities are potentially abortifacient. Presumably his proposed extension of the right of healthcare professionals to refuse, for reasons of conscience, to participate in abortion by recommending breastfeeding, coffee, and exercise was full of sarcasm and is a type of *reductio ad absurdum*.

Other—more serious—authors and scientists have proposed that breastfeeding and the use of natural methods of family planning are the physical and moral equivalents of the use of abortifacient contraceptive measures. They do so on the argument that these natural behaviors cause early pregnancy loss by a similar mechanism that equally applies to emergency contraception and the hormonal birth control pill.² Many pro-life healthcare professionals refuse to prescribe or refer for emergency contraception and hormonal birth-control because of the possibly abortifacient effect. Authors who try to make natural family planning and breastfeeding as the moral equivalents obfuscate the issue. I will attempt to show in the paper that (1) there is little evidence that breastfeeding causes early pregnancy loss, (2) there is evidence that breastfeeding does not cause early pregnancy loss, and (3) that breastfeeding is not the moral equivalent of hormonal contraceptive methods that can act as abortifacients.

STUDIES SUPPORTING EARLY PREGNANCY LOSS

The study that Saletan cited for evidence that breastfeeding can act as an abortifacient was conducted by a group of researchers (including NFP professional nurse teachers) at the Pontifical Catholic University of Chile

² J. Trussell, “Mechanism of Action of Emergency Contraceptive Pills,” *Contraception* 74 (2006): 87-89.

(i.e., Pontificia Universidad Catolica de Chile) and published in 1992.³ The study involved a comparison of 49 fully breastfeeding post-partum women and 25 non-nursing women who had regular menstrual cycles. The researchers measured plasma estradiol (E) and progesterone (P) levels twice a week up to the second postpartum menses. They found that the first post-partum menstrual cycles of the breastfeeding women had longer follicular phases but shorter luteal phases, and lower E and P levels than the non-nursing women. The luteal phase for the breastfeeding women was on average 9.2 days (SD = 0.5) in length and for the non-nursing women 13.3 days (SD = 0.4). Since about one-fourth of the non-nursing women became pregnant during the study's time-period, but only 7% of the breast-feeding women, the authors speculated that the reason for such a difference was due to interference with implantation of the embryo associated with luteal phase defects.

Another study conducted by researchers from The Johns Hopkins University concluded the same thing.⁴ They monitored 60 breastfeeding women from Baltimore and 41 from Manila (Philippines) by having them provide urine samples for E, P, LH, and human chorionic gonadotropin (HCG) on a daily basis. They found that 41% of the first ovulation cycles had luteal phase defects. They also found a 6% pregnancy rate in the first cycle after the first menses. These researchers did not report the actual luteal phase lengths. In another study, an Australian research group analyzed the P levels of 89 breastfeeding women by daily salivary samples.⁵ They defined a deficient luteal phase when P levels were less

³ S. Diaz, P. Miranda, H. Cardenas, et al. "Relative Contributions of Anovulation and Luteal Phase Defect to the Reduced Pregnancy Rate of Breastfeeding Women," *Fertility and Sterility* 58 (1992): 498-503.

⁴ P.R. Lewis, J.B. Brown, M.B. Renfree, R.V. Short, "The Resumption of Ovulation and Menstruation in a Well-Nourished Population of Women Breastfeeding for an Extended Period of Time," *Fertility and Sterility* 55 (1991): 529-36.

⁵ R.H. Gray, O.M. Campbell, R. Apelo et al., "Risk of Ovulation during Lactation," *The Lancet* 335 (1990): 25-29.

than 40 pg/mL and a short luteal phase as a period of 11 days or less from ovulation to menstruation. They found only 32% of the women had adequate luteal phases after their first menstruation. Another earlier study by an Australian group found with 55 post-partum breastfeeding women that, after the first menses, 40% had anovulatory ovarian activity, 25% experienced ovulation but with short luteal phases, and 16% had normal ovulations with deficient luteal phases, i.e., luteal phase lengths less than 11 days.⁶

It is clear from the evidence provided by the above studies that there are many (25%-40%) deficient (hormonally) and short (by days) luteal phases in the first post-partum menstrual cycle. There also is evidence that the pregnancy rate of women during the first post-partum menstrual cycle is much lower than expected in normal cycling women, i.e., 6-7% compared to 25%. The most logical explanation is that luteal phase defects cause a failure in implantation of the embryo. However, all of this evidence is indirect. None of these studies compared the pregnancy rate or the luteal phase parameters with post-partum non-breastfeeding women. However, an earlier study from Ireland monitored the daily salivary estrogen and P levels of 30 post-partum breastfeeding and non-breastfeeding women.⁷ As expected, they found that the return of first menstruation among the 20 breastfeeding women was much longer than the non-lactating women, i.e., a mean of 127 days compared to 57 days. The researchers also found that 44% of the breast-feeding women and 40% of the non-lactating women had abnormal luteal phases. There was no evidence for differences in the amount of luteal phase defects in the first menstrual cycle post-partum among the breastfeeding and non-

⁶ J.B. Brown, P. Harrisson, M.A. Smith, "A Study of Returning Fertility after Childbirth and during Lactation by Measurement of Urinary Oestrogen and Pregnanediol Excretion and Cervical Mucus Production," *Journal of Biosocial Science* 9 (1985) Suppl.: 5-23.

⁷ I.I. Bolaji, D.F. Tallon, F.P. Meehan et al., "The Return of Postpartum Fertility by Enzyme-Immunoassay for Salivary Progesterone," *Gynecology Endocrinology* 6 (1992): 37-48.

breastfeeding women. In both groups 50%-56% of the first cycles were anovulatory. Therefore, the luteal phase deficiency might not be due to breastfeeding but rather to the hormonal readjustment that occurs during the post-partum time frame. Furthermore, the decreased pregnancy rates for post-partum breastfeeding women might largely be due to anovulatory menstrual cycles, i.e., menstrual cycles with no chance of fertilization.

EVIDENCE NOT SUPPORTING EARLY PREGNANCY LOSS

Evidence from other recent studies also raises some questions about whether breastfeeding might cause a disruption in implantation due to luteal phase defects. A study, reviewed earlier in this publication, showed that among normal menstrual cycles, implantation (as determined by HCG levels) can occur as early as the fourth day post-partum.⁸ The researchers gave a normal range of 5-14 days for the time of implantation after the day of ovulation. The 11-day post-partum mean reported for breastfeeding cycles (i.e., as reported in the above studies) fits well into this range. Bukulmez and Arici questioned the wisdom of diagnosing a luteal phase defect and preferred to view it as an ovulatory defect.⁹ The authors point out that luteal phase defects are poorly defined and often diagnosed in women with proven fertility.

At Marquette University we have developed a protocol for women who are breastfeeding and not ovulating and who wish to track their fertility in order to avoid pregnancy. The protocol uses an electronic hormonal fertility monitor that measures a threshold level of estrogen and luteinizing hormones (LH) in the urine. The monitor provides the user with a low, high, and peak fertility reading. The peak fertility indicates an LH surge and probable ovulation. The beauty of the protocol is that we have data on the first few menstrual cycles during the

⁸ L.A. Cole, D.G. Ladner, F.W. Byrn, "The Normal Variabilities of the Menstrual Cycle," *Fertility and Sterility*, 2008.

⁹ O. Bukulmez and A. Arici, "Luteal Phase Defect: Myth or Reality?" in *Obstetrics and Gynecology Clinics of North America* 31 (2004): 727-44.

transition from not ovulating to ovulating and having menstrual cycles (see Table One).

Table One: Menstrual Cycle Parameters and Luteal phase length of the first 3 menstrual cycles post resumption of ovulation (N = 10) with regular cycling controls (N=10).

	Total Cycle Length	Follicular Length	Luteal Length	Range
Cycle Zero	NA	NA	8.5 (SD=3.3)	4-14
Control	NA	NA	11.3 (SD=2.9)	4-14
1st cycle	33.2 (SD=6.3)	23.0 (SD=5.5)	10.7 (SD=2.4)	9-13
2nd cycle	31.6 (SD=5.2)	18.7 (SD=4.9)	13.0 (SD=1.4)	10-13
3rd cycle	28.4 (SD=4.1)	15.0 (SD=1.4)	13.3 (SD= 1.5)	7-15
Total	30.5 (SD=4.9)	14.9 (SD=5.2)	11.8 (SD=3.4)	3-20

What is interesting is the post-ovulatory phase length. According to our data, although the luteal phase is somewhat shorter in the first menstrual cycle, the overall length is within the parameters of normal. In fact, the only luteal phase that might be problematic (i.e., a length of 3 days) was from the fifth menstrual cycle after the first ovulation. The overall mean of the 22 menstrual cycle from 10 breastfeeding women was 11.86 (SD = 3.4; Range 4-20). These parameters are well within the norm of menstrual cycles (see Table 1). This provides further evidence that breastfeeding is not a direct cause of early pregnancy loss.

MORAL DIFFERENCES

Even if breastfeeding caused luteal phase deficiencies and impaired the implantation of human embryos, it would not be the moral equivalent of the use of hormonal contraception to prevent pregnancy. Breastfeeding is done primarily for the intent of providing adequate nutrition for the

neonate. Breastfeeding is natural and healthful for both the baby and the mother and is recommended, for at least one year, by the American Pediatric Association. Breastfeeding is better than artificial nutrition. Although a secondary effect of breastfeeding is the suppression of ovulation and a help in spacing children, the suppression of fertility is a natural process. The baby is the child of the mother, and the natural order is to feed and protect the child. Therefore, breastfeeding is a natural process that is good for the woman and baby even if it might have an unintended effect of disrupting implantation of an embryo. Breastfeeding is a good and natural act for the purpose of a good end that also (at times) might result in an unintended death of embryos.

Hormonal contraception, on the other hand, is used for the purpose of suppressing a natural process (i.e., fertility) for the intended effect of avoiding pregnancy and having intercourse without any consequences. Hormonal contraception deceives the naturally fertile rhythms of the woman. Even though breastfeeding could be viewed as an external hormonally suppressing process, the child's need for nutrition is not. Breastfeeding is the natural way for the child to receive nutrition. The ingestion of steroidal hormones frustrates the natural fertility of the woman. Furthermore, the suppressing effect of breastfeeding diminishes as the baby grows and starts to utilize solid foods and liquids. The use of and the need for hormonal contraception continues throughout the entire reproductive life of the woman. Hormonal contraception involves the use of an unnatural means (and some believe a bad means) for the purpose of the desired end (i.e., suppressing fertility so as to plan a family and, for some, merely to avoid a pregnancy) that also has bad consequences for the woman (and her partner and society) and might cause the demise of embryos on a monthly basis.

A secondary reason for using hormonal contraception might be to enhance one's health or to treat a disease process. The hormones, however, might just as well cause health problems, such as increased risk for blood clots, stroke, heart attack, and breast cancer. Furthermore, the use of hormonal contraception prevents the integration of fertility within

the marital act of intercourse. The intention of hormonal contraception is to frustrate this integration. Hormonal contraception is not a holistic but a non-integrative and externally controlled act. Whereas breastfeeding diminishes fertility, especially in the first six months of use, the infertility that is established is not permanent and is more like the infertility that one experiences after menopause, i.e., it is a natural infertility. But probably the biggest difference between hormonal contraception and breastfeeding is that contraception takes fertility and procreation out of the picture altogether. It makes the contracepting individual susceptible to being an object of sex rather than a person deserving of love and acceptance of who they are—not who they are minus their fertility.

The use of hormonal contraception can lead to the view that fertility and the potential child are an enemy that needs to be avoided rather than cherished. This was the view of contraception that was put forth by Pope John Paul II in the encyclical *Evangelium Vitae*. The pope also felt that if fertility and the resulting unintended pregnancy are viewed as the enemy (something to be avoided by means of contraception or sterilization) and if an unintended pregnancy should happen, the pregnant woman would be more inclined to use abortion to terminate the pregnancy that she thought she had responsibly prevented.

To suggest that breastfeeding is morally equivalent to hormonal contraception in causing early pregnancy loss is absurd. Saying that breastfeeding is a cause of early pregnancy loss and that healthcare professionals should inform women of this process is tantamount to saying that we should warn women against living the good life. We should do this no more than a healthcare professional should warn a woman about driving a car simply because she might get into an accident and kill a pedestrian. As Miller points out in his essay on contraception, contraception is contrary to reason itself, and so it is immoral.¹⁰

¹⁰ K. Miller, “The Incompatibility of Contraception with Respect for Life,” *Life and Learning VII: Proceedings of the Seventh University Faculty*

Breastfeeding is not contrary to reason; rather, it is a good thing for a woman to nourish her child through breastfeeding.

The argument by Saletan is similar to those who say that the embryo wastage that occurs naturally during the transmission of human life is no different than what happens during *in vitro* fertilization (IVF) procedures. This was pointed out in the recent document from the Vatican entitled *Dignitatis Personae*, in which the Congregation for the Doctrine of Faith argues that the conclusion would be to avoid the transmission of life altogether.¹¹ This conclusion actually has been proposed by a bioethicist who argued that natural family planning method causes early pregnancy loss; since early pregnancy loss occurs naturally, he concluded that all transmission of human life should be done by IVF procedures and not by natural intercourse.¹² Saletan's opinion article is trying to argue that it is absurd for healthcare professionals to refuse to prescribe both the use of contraception and breastfeeding. However, his parallel absurdities do not logically work.

In summary, the evidence that breastfeeding is a cause of early pregnancy loss is weak. There is no evidence that there is any difference in the luteal phase in the first menstrual cycle post-partum when one compares non-lactating women with breastfeeding women. Furthermore, the reason for the low fertility rate in the first menstrual cycle might be due to anovulation rather than a diminished luteal phase. Even if breastfeeding were a cause of early pregnancy loss, breastfeeding is not the moral equivalent of hormonal contraception, which has among its potential effects the prevention of implantation of early embryonic human life. Breastfeeding with the intent of nourishing the child is a natural and healthy process for both the mother and child. The aim of

for Life Conference, ed. J. Koterski, S.J. (Washington, D.C.: University Faculty for Life, 1997): 80-124.

¹¹ Congregation for the Doctrine of the Faith, *Dignitas Personae: Instruction on Certain Bioethical Questions*, issued on 8 September 2008.

¹² L. Bovens, "The Rhythm Method and Embryonic Death," *Journal of Medical Ethics* 32 (2006): 355-56.

hormonal contraception, on the other hand, is the subverting of a natural process for the intent of preventing pregnancy. The idea that health professionals should inform women about the potential abortifacient effect of breastfeeding is absurd.