Holy Alliance

Serving The Divine Physician

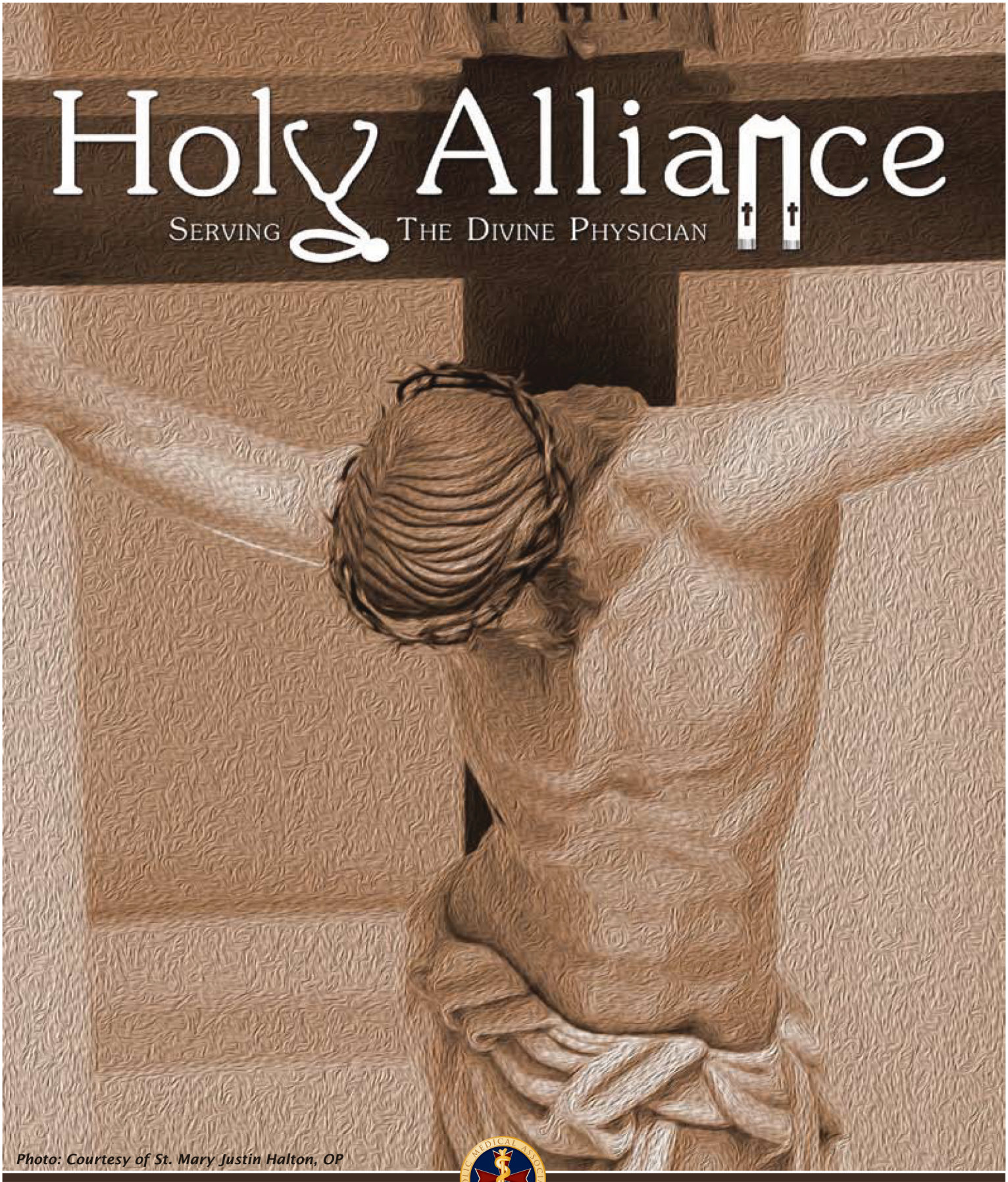

Photo: Courtesy of St. Mary Justin Halton, OP

CATHOLIC MEDICAL ASSOCIATION

Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine

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SERVING THE DIVINE PHYSICIAN

The Holy Alliance Project Description

The Holy Alliance Project/Program seeks to develop a strong alliance among priests and physician members of the Catholic Medical Association. The unity of faith and reason is under direct assault in our world today. As Catholics, we acknowledge with certainty that the truths of science and the truths of the Faith have one and the same Source. There can never be a conflict between faith and reason. The controversial moral issues of our day all have a medical or bioethical component. Our priests and faithful Catholic physicians must join forces to counter the false claims and seductive arguments that our secularized culture is using to advance the bifurcation of faith and reason.

Just as medical professionals need the on-going moral guidance of their spiritual Fathers and shepherds, so also our priests have a need to be updated on the science behind the major moral medical issues of the day. Our priests must confidently speak to their flocks about issues such as the medical dangers of oral contraceptives and the science and success of NaProTechnology in dealing with infertility. The promotion of the misguided Advanced Directive/POLST by our society is one example of an area where our priests need to be well informed. When counseling those who come to them, our priests must be able to respond to those who have been told by a secular doctor that an immoral medical procedure is the "only option" available to them.

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Natural Family Planning

Case Study: A couple that a priest is preparing for marriage are living together and using birth control pills for contraception. After coming to understand the Church's teaching on marriage through the priest's counseling, they decide to live separately and chastely until marriage. They also want to learn about natural family planning and turn to the priest for further resources.

Natural family planning, or simply "NFP," is a holistic and healthy way of planning families. It includes the ability to monitor fertility, and to modify behaviors according to the intention of either achieving or avoiding pregnancy. When used properly, husband and wife share in the responsibility of knowing, understanding, and living with their combined fertility, instead of suppressing or destroying it. When couples understand and appreciate their fertility, they can then discern regularly whether to have or not have a baby, and accordingly adopt behaviors that will bring about those ends. NFP is more than just monitoring natural markers of fertility. NFP is linked to conjugal love and openness to new life.

Natural Indicators of Fertility

Natural family planning involves the ability to observe, interpret, and track naturally occurring signs of fertility. In this way, one can estimate the beginning, peak, and end of the six-day fertile window, which includes the day of ovulation and the five preceding days of sperm survival. The tracking of the natural signs of fertility has a certain flexibility, so as to be able to monitor the variability of that fertile window from month to month. For NFP to be effective and useful, women and couples need to be able to track fertility during the various stages of a woman's reproductive life such as the postpartum period; breastfeeding times; and the peri-menopause transitions. Many NFP methods provide this ability. The traditional natural signs of fertility tracked in some NFP methods have included basal body temperature elevation and changes in cervical mucus observations. Currently, in some newer NFP methods, changes in the woman's levels of estrogen and luteinizing hormone (both of which can help show when ovulation occurs) can also be measured with a urinary hormonal monitor, giving greater confidence in identifying the fertile window. Users and providers of NFP can also use calendar-based formulas, sometimes in combination with other markers of fertility, to estimate the fertile phase of the menstrual cycle.

Methods of NFP

The tracking of natural biological indicators of fertility has been used alone or in various combinations by health professionals and scientists for many years to develop useful natural methods of family planning. There are five basic methods of NFP:

1. *The Calendar Method* - relies on counting previous cycle length and a simple formula to determine the beginning and end of fertility.
2. *Basal Body Temperature (BBT)* - recording of the woman's daily waking temperature and observing the changing patterns.
3. *The Ovulation Method (OM)* - observing and recording the patterns and changes of cervical fluids.
4. *The Sympto-thermal Method (STM)* - combining daily waking temperature, changes in cervical fluid, cycle length, and other signs of fertility.

5. *Hormonal monitoring (HM)* – use of monitoring devices/technology to monitor urinary metabolites of female hormones, to estimate the fertile phase.

The term "natural family planning" usually refers to the latest methods of NFP, such as the Ovulation Method (OM), the Creighton Model OM (CrM) system, the Sympto-thermal Method (STM), and the Marquette Model Hormonal method (MM). Simplified methods include the Standard Days Method (SDM), a calendar-based method utilizing data on probability of conception on particular days of the cycle, and the Two-Day Method (TDM), which involves cervical mucus monitoring and two simple questions to determine fertility.

Effectiveness of NFP Methods

There are two effectiveness numbers often utilized for any method of family planning: (1) correct or perfect use of the method, and (2) typical or average use, when methods are not used consistently or according to instructions. The correct use rate ranges from 0–5% pregnancy rate, and the typical rate from 2–23%.

Table of Perfect and Typical Use Unintended Pregnancy Rates* per 100 Women Over 12 Months of Use

Study	NFP Method	Indicators	Cycle Length**	Perfect	Typical
WHO[1]	Ovulation (OM)	Mucus	(25-32)	3	22
Howard, et al.[2]	Creighton (CrM)	Mucus	(25-32)**	0	14
Arevalo, et al.[3]	SDM	Calendar	(26-32)	5	12
Arevalo, et al.[4]	TDM	Mucus	(13-42)	4	14
European STM[5]	STM	Mucus/Temp	(25-35)	1	2
Fehring, et al.[6]	Marquette (MM)	Mucus/Monitor	(21-42)	2	13
Fehring, et al.[7]	MM	Mucus/Temp/LH	(21-42)	1	11
Fehring, et al.[8]	MM vs CrM	Mucus/Monitor	(21-42)	2	12/23
Fehring, et al.[9]	MM	Mucus/Monitor	(21-42)	2	9
Fehring, et al.[10]	MM	Monitor/Mucus	(21-42)	0	7/19
Bouchard, et al.[11]	MM Postpartum	Monitor	Variable	2	12
Fehring, et al.[12]	MM Perimenopause	Monitor/Mucus	Variable	1.5	5

* Range of length of menstrual cycles in study.

** Rate includes only those participants with regular cycle lengths from this study.

1. World Health Organization. "A Prospective Multicentre Trial of the Ovulation Method of Natural Family Planning. II. The Effectiveness Phase."
2. M. P. Howard, and J.B. Stanford. "Pregnancy Probabilities During Use of the Creighton Model Fertility Care System." *Archives of Family Medicine* 8 (1999): 391-402.
3. M. Arevalo, V. Jennings, and I. Sinai. "Efficacy of a New Method of Family Planning: the Standard Days Method." *Contraception* 65 (2002): 333-338.
4. M. Arevalo, et al. "Efficacy of the New TwoDay Method of Family Planning." *Fertility and Sterility* 82 (2004): 885-892.

5. P. Frank-Herrmann, et al. "The Effectiveness of a Fertility Awareness Based Method to Avoid Pregnancy in Relation to a Couple's Sexual Behavior During the Fertile Time: a Prospective Longitudinal Study." *Human Reproduction* 22 (2007); 1310-1319.
6. R. J. Fehring, et. al,. "Efficacy of Cervical Mucus Observations Plus Electronic Hormonal Fertility Monitoring as a Method of Natural Family Planning." *Journal of Obstetric Gynecologic and Neonatal Nursing* 36 (2007): 152-60.
7. R.J. Fehring, M. Schneider, and M.L. Barron. "Efficacy of the Marquette method of natural family planning." *MCN The American Journal of Maternal Child Nursing* 54 (2008): 165-170.
8. R.J. Fehring, et al. "Cohort Comparison of Two Fertility Awareness Methods of Family Planning." *Journal of Reproductive Medicine* 54 (2007); 165-170.
9. R. Fehring, Schneider, M, & Raviele, K. "Pilot Evaluation of an Internet-based Natural Family Planning Education and Service Program," *Journal of Obstetrics, Gynecology, and Neonatal Nursing.* 40(2011):281-91.
10. R. Fehring, Schneider, M., Raviele, K, Rodriguez, D & Pruszynski. J. "Randomized comparison of two Internet-supported fertility awareness based methods of family planning," *Contraception,* 88(2013): 24-30.
11. T. Bouchard, Schneider, M & Fehring, R. "Efficacy of a new postpartum transition protocol for avoiding pregnancy." *Journal of the American Board of Family Medicine*. 26 (2013): 35-44.
12. R. Fehring, & Mu, Q. "Cohort Efficacy Study of Natural Family Planning among Perimenopause Age Women." *J Obstet Gynecol Neonatal Nurs* 43(2014): 351-358.

Additional Resources for the Laity

Why the Church Is Right About Life and Love
http://www.ncregister.com/daily-news/why-the-church-is-right-about-life-and-love

Promoting Humanae Vitae and Natural Family Planning in the Parish-Janet Smith
http://www.lifeissues.net/writers/smith/smith_04hvandnfpinparishes.html

NFP Basic Information
http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/what-is-nfp/nfp-basic-information.cfm

Websites of Major NFP Programs:
Couple to Couple League International (CCL): www.ccli.org

Creighton Model and/or NaProTECHNOLOGY: http://www.naprotechnology.com; http://www.popepaulvi.com/; http://www.creightonmodel.com/; http://www.unleashingthepower.info/; and http://www.drhilgers.com/.

Marquette University College of Nursing, Institute of NFP: http://nfp.marquette.edu

Northwest Family Services: www.nwfs.org

Georgetown Institute of Reproductive Health: www.naturalfp.com or https://www.cyclebeads.com/

Emergency Contraception or "The Morning After Pill"

Case Study: A parishioner calls her parish priest to say that her 19-year-old daughter was sexually assaulted on Saturday night at a party at her college. She went to the emergency room where they gave her, among other things, the "morning after pill," also known as "Plan B." Although she would not want her daughter to get pregnant as a result of a rape, this mother wonders if this drug might have caused the destruction of human life.

The Ethical and Religious Directives for Catholic Health Care Services in directive 36 shows the concern Catholic hospitals should take in protecting a victim of rape from possible consequences of the assault, including pregnancy, as long as the agent used is **contraceptive** (as opposed to being abortifacient or harming new life)**:**

> Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization, *all of which would be contraceptive actions*. *It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.*[1]

Approximately 5% of women of childbearing age who are fertile and not using contraception at the time of a sexual attack will become pregnant as a result of the assault.[2]

The standard "emergency contraceptive" used in hospitals is Plan B or levonorgestrel (LNG-EC) 0.75 mg given within 120 hours (five days) of the sexual assault, and then repeated twelve hours later; or, alternatively, 1.5 mg given in a single dose.[3] There are other possible regimens, utilizing other similar drugs; however, levonorgestrel/Plan B is the regimen most often used, so for the sake of this discussion, we will be referring to that drug and its known mechanisms of action.

The medical literature claims that the drug works primarily by preventing ovulation.[4] Studies published over the past ten years have shown that it prevents ovulation consistently *only* if given at the start of the six-day fertile window within the woman's monthly cycle.[5] Such studies also show that the drug does not affect sperm motility or the ability to fertilize an egg; however, it can, depending on when it is given, prevent a clinically detectable pregnancy (i.e., it could have a

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[1] United States Conference of Catholic Bishops, *Ethical and Religious Directives*, Fifth Edition (Washington, DC: USCCB, 2009), n. 36 (emphasis added), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.
[2] C.R. Beckmann and L.L. Groetzinger, "Treating Sexual Assault Victims: A Protocol for Health Professionals," *Female Patient* 14 (1989):78–83.
[3] Kathleen Mary Raviele, "Levonorgestrel in Cases of Rape: How Does It Work?" *Linacre Quarterly* 81.2 (2014): 117–118.
[4] Ibid., 117–129.
[5] Ibid.

harmful effect on new life).[6] The drug also can cause a surge of progesterone at the wrong time in the woman's cycle, which can set off other events that could interfere with the survival of a new life or its successful implantation.

The St. Francis Medical Center's "Peoria Protocol" for the administration of "emergency contraception" in emergency rooms in Catholic hospitals allows the administration of Plan B if the woman's menstrual history and testing indicate she is in her monthly preovulatory phase. This is discerned by a negative urinary LH (luteinizing hormone) test and a serum (blood) progesterone level of less than 1.5 ng/ml.[7] If the LH surge is positive, indicating the woman will ovulate in the next 24 to 36 hours, or the serum progesterone level is between 1.5 ng/ml and 5.9 ng/ml, then she is near ovulation and Plan B should not be given.[8] If she is postovulatory with a serum progesterone level of 6 ng/ml or greater, the drug can be given because she is already postovulatory and there is no harm, in that phase of her cycle, in giving the drug. In this case, the patient is beyond her fertile window and possible conception, anyway.

Plan B has been found in research studies to actually not prevent ovulation or fertilization in most cases (i.e., it doesn't have a reliable "contraceptive" effect).[9] Likewise, it has been found to have a probable effect *after* fertilization, thereby preventing the survival of a new life.[10] Therefore, this Peoria Protocol in actuality does not fit the criteria of the *Ethical and Religious Directives'* n. 36.

Any other drug or device alternatively used as an "emergency contraceptive" that affects the hormonal events surrounding conception, such as *Ella* (which is similar to the medical abortion pill RU-486), or a double-dosage of birth control pills, have similar post-conception effects. Likewise, the insertion of an IUD as an "emergency contraceptive" would also prevent successful implantation. At the present time, there is no drug taken after a sexual assault that will not impact a developing human life.

Additional Resources for the Laity

FDA Makes Plan B Contraceptive Available to 15-Year-Olds
http://www.ncregister.com/daily-news/fda-makes-plan-b-contraceptive-available-to-15-year-olds/

Study: Birth-Control Pill and Abortion Spike Breast-Cancer Risk
http://www.ncregister.com/daily-news/study-birth-control-pill-and-abortion-spike-breast-cancer-risk/

New 'Morning After' Pill Sells Abortion as Contraception
http://www.ncregister.com/blog/danielle-bean/new_morning_after_pill_sells_abortion_as_contraception

[6] Ibid.
[7] Ibid., 119.
[8] Ibid.
[9] Ibid., 117–129.
[10] Ibid.

Reversal of Abortion Pill RU-486

Case Study: A few weeks ago, a local prolife doctor was called to aid a woman who had just taken RU-486 in order to have a medical abortion.[1] Soon after taking the pill in the Planned Parenthood facility, she began to have second thoughts. She went online and found that the drug's abortive action could still be stopped. She called the listed hotline for reversal of the drug, and was given potentially life-saving medicine to help her keep the pregnancy.

This scenario is going to be more common due to two facts: the increased availability of the drug RU-486, and the increasing scrutiny of surgical abortions and those who perform them.

What is RU-486?
The so-called French abortion pill, technically called Mifepristone, is a synthetic compound that acts as an anti-progesterone agent. Progesterone is a beneficial hormone during pregnancy, and enables and advances the pregnancy in the womb of the mother. If allowed to proceed unchecked, RU-486 will choke off the nutrients to the early placenta and thus kill the baby. It is usually given in an abortion facility, and then the woman is told to go home and, forty-eight hours later, to take a second drug called Misoprostol, for the purpose of starting contractions. These will then cause her body to expel the placenta and the now-dead baby.

How is RU-486 reversed?
As soon as possible after the RU-486 has been taken, the woman is given additional amounts of progesterone which is bioidentical (i.e., identical to her own naturally-occurring hormone), via injection, suppository, or oral pills. This will then flood her system with this good hormone, and drive out the effects of the poisonous compound. The amount of progesterone given is most concentrated at the outset, and must continue throughout the entire first trimester.

What if a woman regrets taking the RU-486?
She should immediately call 1-877-558-0333 or go to the website www.AbortionPillReversal.com, where she will be directed to the hotline. A pro-life doctor who is trained in the method of reversing the effects of the abortion pill will then be contacted and he/she will be in touch with the woman to guide her through the necessary steps to save her baby. To date, the success rate is approximately 60%. Higher rates can be expected with earlier administration of the reversal medicine. However, even if significant time has passed since ingesting the RU-486, it is still helpful to try the reversal. It should be noted that taking the second drug (Misoprostol) in the RU-486 abortion regimen can complicate matters, as this drug can cause fetal abnormalities.

When should a woman expect to be contacted by the doctor?
The network of pro-life doctors will get in touch with her as soon as possible, since administering the progesterone is of paramount importance. This network of professionals is growing, and it is hoped that there will be physicians, nurse practitioners, and physician assistants geographically close to any woman who wants the life-saving reversal regimen.

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[1] In 2016, the FDA expanded RU-486's use, from 7 weeks, to up to 10 weeks of pregnancy. See Catholic News Agency, "FDA Expands Abortion Pill to Allow Up to 10 Weeks" (Apr. 1, 2016), http://www.washingtontimes.com/news/2016/apr/1/fdas-abortion-pill-expansion-targets-babies-up-to-/

What if the treatment is successful?
Early on, an ultrasound will be ordered to confirm that the baby is still alive. This reassures both doctor and patient that the treatment is having its beneficial effect. Continuation of the treatment lasts throughout the first trimester, to fourteen weeks. Periodic ultrasounds are useful throughout this process. It is known that taking RU-486 (the mifepristone part of the regimen) does not cause any birth defects for the baby that survives—nor does the taking of the larger doses of bioidentical progesterone for the reversal.

What if the treatment is not successful?
The purpose of the ultrasound is to affirm that the baby still has a heartbeat, but if this is not present, then it is likely that cramping and bleeding will occur within the following two weeks. The woman should watch for excessive bleeding, fever, or continuing pain. In that case, she should go to the emergency room for evaluation and treatment. If her blood type is Rh negative, then an injection called RhoGAM will be needed, regardless of whether she has complications. Longer-term psychological and spiritual effects in the woman due to abortion should also be treated, through post-abortion treatment programs such as Project Rachel or Rachel's Vineyard.

What if there are further questions?
Call the Abortion Pill Reversal (APR) Hotline: 1-877-558-0333 for more information on RU-486 reversal, or other issues concerning the medical handling of abortion. The nurses that staff the 24-hour hotline are an invaluable resource.

Additional Resources for the Laity

Abortion Pill Reversal
http://www.abortionpillreversal.com/

The Day I Performed the First-Ever RU-486 Abortion Reversal
http://www.lifesitenews.com/news/the-day-i-performed-the-first-ever-ru-486-abortion-reversal

Abortion Interrupted: Doctor Reverses Abortion Drug after Mom Changes Mind
http://www.lifenews.com/2014/03/17/abortion-interrupted-doctor-reverses-abortion-drug-after-mom-changes-mind/

Can RU-486 be Reversed?
http://www.heartbeatinternational.org/can-ru-486-be-reversed

Harms of Contraception

Case Study: A young woman with polycystic ovary syndrome consults her gynecologist about her irregular cycles, as she sometimes only has four periods a year. She asks about starting birth control pills to regulate her cycle. Her gyn is Catholic, does not prescribe contraceptives, and recommends instead that she be cycled on progesterone, which can help with her cycles. In addition, she has pre-diabetes, for which the doctor recommends metformin, due to the increased risk to her of "the Pill." She wants to think about it and returns a year later, telling her physician she saw another gyn, was placed on oral contraceptives, and three months later suffered a blood clot in her lung from the birth control pill. Now she is ready to start a different treatment, perhaps the one originally suggested.

Fertility is a great good. One of the first biblical commands is to "be fruitful and multiply," signifying that children are a prized and welcome blessing to marriages and society. Contraceptive pills, devices, and surgical procedures can attack the normally functioning reproductive system of the body, and can harm the virtues of chastity and temperance. The Church has consistently maintained that contraception is intrinsically evil, despite the high use of contraception in our society, often even by the members of the Church.[1]

Why is there such discordance between Church teaching and modern Catholic reproductive choices? One possibility is that Catholics just do not know that contraception can be harmful to themselves, their marriages, and to society at large. One of the best comprehensive resources on this matter is Janet Smith's article/talk, "Contraception: Why Not?"[2] Also, a pastoral letter discussing the destructive nature of contraception was written by Bishop James Conley entitled, "The Language of Love."[3] Of course, the encyclical *Humanae vitae* is short, easy to read, and remains prophetic in its dire predictions about the widespread use of contraception.[4]

In modern times, our culture looks at fertility as something bad – something to be suppressed, mutilated, or destroyed. The child is considered an unwelcome intruder to be avoided at all costs. One example of this is that "emergency" contraception is now regularly available over the

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[1] "Periodic continence, that is, the methods of birth regulation based on self-observation and the use of infertile periods, is in conformity with the objective criteria of morality. These methods respect the bodies of the spouses, encourage tenderness between them, and favor the education of an authentic freedom. In contrast, '*every action which, whether in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible*' [*Humanae vitae.*, n. 14] *is intrinsically evil*: 'Thus the innate language that expresses the total reciprocal self-giving of husband and wife is overlaid, through contraception, by an objectively contradictory language, namely, that of not giving oneself totally to the other. This leads not only to a positive refusal to be open to life but also to a falsification of the inner truth of conjugal love, which is called upon to give itself in personal totality. …The difference, both anthropological and moral, between contraception and recourse to the rhythm of the cycle … involves in the final analysis two irreconcilable concepts of the human person and of human sexuality.' [*Familiaris consortio*, n. 32] " From *Catechism of the Catholic Church*, n. 2370 (emphasis added), http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm.

[2] Janet Smith, "Contraception: Why Not?," http://www.catholiceducation.org/en/controversy/common-misconceptions/contraception-why-not.html.

[3] James Conley, STL, "The Language of Love" (Mar. 25, 2014), http://www.catholiceducation.org/en/controversy/contraception/the-language-of-love.html.

[4] Pope Paul VI, *Humanae vitae* (July 25, 1968), http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html.

counter in pharmacies, in case the use of regular contraception does not work to prevent the conception of a child. Studies show that the majority of women seeking abortions were also using some form of contraception in the months prior to becoming pregnant.[5] St. John Paul II noted the relationship between contraception and abortion in his encyclical *Evangelium vitae*, and called them "fruits of the same tree."[6]

Medical risks of contraception are frequently compared to the risks associated with pregnancy, making the risks of pregnancy appear high, and the contraceptive risks appear relatively lower than they actually may be. However, the two should not really be compared, because pregnancy leads to the gift of a child, with his or her own inherent dignity and value; however, contraception has no associated moral good. Therefore, a more equitable comparison of risks would be between the use of contraception and NFP (Natural Family Planning), the latter which has no risks associated with its use.

What are the harms of contraception?

(1) Medical risks and harms of oral contraceptives (OCPs):

a. **Increased incidence of adverse side effects,** including: decreased libido, depression, lipid changes, osteoporosis, benign liver tumors, joint complaints, migraines, and others too numerous to list.[7]
b. **Increased risk of breast cancer**: while some studies deny the persistent increased risk of breast cancer, other studies note a relative risk increase.[8] Even small increased risks of cancer are important, as breast cancer is the most common female cancer, and about 1 in 8 women are expected to suffer from invasive breast cancer in her lifetime.[9]
c. **Increased risks of cardiovascular disease** (i.e. high blood pressure, deep vein thrombosis, pulmonary embolus, myocardial infarction, stroke and death)[10]
d. **Increased risks of HPV (Human Papilloma Virus)** which is a sexually transmitted disease that is the most common cause of cervical cancer[11]

(2) Sociological Effects:[12]

a. Increase in casual, recreational sex
b. Increase in "accidental pregnancy" and abortion

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[5] Rachel K. Jones, Jacqueline E. Darroch, and Stanley K. Henshaw, "Contraceptive Use Among U.S. Women Having Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health*, 34.6 (Nov./Dec. 2002): 294–303, https://www.guttmacher.org/about/journals/psrh/2002/11/contraceptive-use-among-us-women-having-abortions-2000-2001.

[6] Pope John Paul II, *Evangelium vitae* (Mar. 25, 1995), n. 13, http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.

[7] Bayer Health Pharmaceuticals, "Highlights of Prescribing Information: Yaz" (April 2012), http://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021676s012lbl.pdf.

[8] T. Anothaisintawee et al., "Risk Factors of Breast Cancer: A Systematic Review and Meta-Analysis", *Asia Pacific Journal of Public Health* 25.5 (Sept. 2013): 368–387.

[9] Breastcancer.org, "U.S. Breast Cancer Statistics," http://www.breastcancer.org/symptoms/understand_bc/statistics.

[10] P. Kaminski, M. Szpotanska-Sikorska, and M. Wielgos, "Cardiovascular Risk and the Use of Oral Contraceptives," *Neuroendocrinology Letters* 34.7 (2013): 587–589.

[11] R. Faridi et al., "Oncogenic Potential of HPV and Its Relation with Cervical Cancer," *Virology Journal* 8 (June 3, 2011): 269.

[12] Smith, "Contraception: Why Not?"

c. Increase in single parenthood
d. Increase in sexually transmitted diseases
e. Increased cohabitation
f. Increased divorce rates since the introduction of "the pill"

(3) Environmental Effects:[13]

a. Steroidal sex hormones which are used in oral contraceptive pills (OCPs) may enter the aquatic environment via wastewater effluents and feminize male fish.
b. The accumulation and elimination of OCPs have environmental impact.

Additional Resources for the Laity

Bishop Conley: Contraception Disrupts the 'Language of Love'
http://www.ncregister.com/daily-news/bishop-conley-contraception-disrupts-the-language-of-love

What a Woman Should Know about Contraceptives
http://m.catholicnewsagency.com/resource.php?n=268

The High Cost of Free Contraceptives - Washington Times
http://www.washingtontimes.com/news/2013/mar/20/the-high-cost-of-free-contraceptives/

The HHS Mandate Ignores Health Risks Associated with Contraception: Alice's Story
http://womenspeakforthemselves.com/the-hhs-mandate-ignores-health-risks-associated-with-contraception-alices-story/

[13]Ashley Ahearn, "Feminized Fish: A Side Effect of Emerging Contaminants" (Sept. 12, 2012), http://earthfix.opb.org/water/article/clean-water-the-next-act-emerging-contaminants-fem/; Vanguard News Network Forum, "Birth Control Pills Are Polluting Water Streams" (Apr. 18, 2014), http://vnnforum.com/showthread.php?t=181344; Technology.org, "Oral Contraceptives Are Feminizing Fish Populations – But Some Carry On Regardless" (Feb. 17, 2014), http://www.technology.org/2014/02/17/oral-contraceptives-feminizing-fish-populations-carry-regardless/.

What is NaProTECHNOLOGY?

NaProTECHNOLOGY (also known as "Natural Procreative Technology") is an authentically Catholic approach to reproductive and gynecologic healthcare. Based on over thirty years of scientific research, NaProTECHNOLOGY is a medical system that monitors and maintains a woman's gynecologic and reproductive health in a way that cooperates completely with her normal reproductive cycle. NaProTECHNOLOGY utilizes the Creighton Model Fertility*Care*™ System as the basis for monitoring a woman's menstrual and fertility cycles. The Creighton Model is a standardized method by which a woman can observe and record on a chart daily changes in certain objective biomarkers of her cycle, such as external cervical mucus observations and bleeding patterns. In this way, a woman using the Creighton Model charting system can develop an understanding of the normal or abnormal functioning of her menstrual and fertility cycles. This chart then becomes the basis for a diagnostic evaluation whenever abnormalities arise.

NaProTECHNOLOGY treatments are aimed at three important areas of a woman's health: gynecologic problems, infertility, and high-risk pregnancy. For each of these, NaProTECHNOLOGY provides healthy and effective treatments that do not rely on hormonal contraceptive pills or assisted reproductive technologies (such as *in vitro* fertilization) to artificially suppress or bypass gynecologic or reproductive problems. Instead, the Creighton Model and NaProTECHNOLOGY respect the dignity of each woman, and treatments are focused on addressing underlying issues, and restoring the normal physiologic functioning of a woman's cycle. This leads to better gynecologic health and improved reproductive potential.

NaProTECHNOLOGY is used to successfully treat or cure:

- Infertility
- Endometriosis
- Dysmenorrhea (painful periods)
- Abnormal uterine bleeding
- Polycystic ovarian syndrome (PCOS)
- Recurrent miscarriage
- Premenstrual syndrome (PMS)
- Postpartum depression

The Hallmarks of Surgical NaProTECHNOLOGY include:

- Near-contact laparoscopy
- Complete excision of endometriosis with the CO_2 laser
- Laparoscopic ovarian wedge resection for women with infertility due to PCOS
- Laparoscopic tubal re-anastomosis (tubal ligation reversal)
- Specialized adhesion prevention techniques

How Does NaProTECHNOLOGY Evaluate and Treat Infertility?

As infertility is a *symptom* of an underlying disease — and not a disease in and of itself — NaProTECHNOLOGY seeks to diagnose and correct the underlying cause of a couple's inability to conceive. With the abundant information provided by the Creighton Model charting system, a

physician trained in NaProTECHNOLOGY can begin a thorough evaluation to diagnose the cause of infertility. Such an evaluation also may include hormone profile tests, diagnostic hysteroscopy and laparoscopy, endometrial and endocervical tissue sampling and cultures, and selective hysterosalpingogram (studying the functional integrity of the fallopian tubes).

NaProTECHNOLOGY treatments are then directed toward restoring the normal functioning of the menstrual and fertility cycles, both with medications and, when necessary, with surgery. With certain conditions such as endometriosis, pelvic adhesive disease, and PCOS, NaProTECHNOLOGY offers a unique set of surgical interventions to effectively treat or correct a variety of medical conditions leading to infertility. One of the most exciting aspects of medical and surgical NaProTECHNOLOGY is that the specialized treatments offered prove beneficial to the woman beyond the goal of achieving pregnancy — they correct underlying conditions, providing long-term health benefits.

There are health care professionals and teachers throughout the country who provide different levels of care utilizing the Creighton Model Fertility*Care* System and NaProTECHNOLOGY:

- Fertility*Care* Practitioners: trained instructors who teach women and couples how to chart their cycles using the Creighton Model Fertility*Care* System to achieve or avoid pregnancy
- Fertility*Care* Medical Consultants: physicians, nurse practitioners, physician assistants, or nurse midwives who are trained to evaluate and treat women using the medical aspects of NaProTECHNOLOGY (such as hormone replacement timed according to the Creighton Model chart)
- NaProTECHNOLOGY surgeons: obstetricians/gynecologists who have completed a 1-year fellowship training program in medical and surgical NaProTECHNOLOGY. This select group of physicians (less than 20 worldwide currently) provides both medical *and surgical* treatments for the many conditions, which cause infertility, high-risk pregnancy or other gynecologic problems.

Women can find a medical consultant or NaPro surgeon near them by visiting www.fertilitycare.org. Further information on NaProTECHNOLOGY can be found at http://www.naprotechnology.com; http://www.popepaulvi.com/; http://www.creightonmodel.com/; http://www.unleashingthepower.info/; and http://www.drhilgers.com/.

Additional Resources for the Laity

NaPro Technology: Moral and Better than In Vitro - Catholic Culture
http://www.catholicculture.org/culture/library/view.cfm?recnum=7810

Understanding Infertility: A Catholic Perspective
http://www.catholicdigest.com/articles/family/marriage_relationships/2013/02-25/understanding-infertility-a-catholic-perspective

Hope for infertility: ‘Infertile’ couple gives birth thanks to cutting edge natural treatment
http://www.lifesitenews.com/news/hope-for-infertile-couples

In Vitro Fertilization

As with all issues where science and morality meet, the Catholic church provides a clear and consistent message regarding the use of assisted reproductive technologies (such as artificial insemination and *in vitro* fertilization) that are marketed to help infertile couples achieve pregnancy. Such technologies are a direct violation of the sanctity of the marriage bond and the dignity of the human person. The Catechism explains:

> Techniques involving only the married couple (homologous artificial insemination and fertilization) are perhaps less reprehensible [than heterologous artificial insemination and fertilization], yet remain morally unacceptable. They dissociate the sexual act from the procreative act. The act which brings the child into existence is no longer an act by which two persons give themselves to one another, but one that "entrusts the life and identity of the embryo into the power of doctors and biologists and establishes the domination of technology over the origin and destiny of the human person. Such a relationship of domination is in itself contrary to the dignity and equality that must be common to parents and children. "Under the moral aspect, procreation is deprived of its proper perfection when it is not willed as the fruit of the conjugal act, that is to say, of the specific act of the spouses' union…. Only respect for the link between the meanings of the conjugal act and respect for the unity of the human being make possible procreation in conformity with the dignity of the person."[1]

In vitro fertilization (IVF) stands out as being the most egregious violation of the sanctity of the marriage bond and the dignity of the human person. With IVF, a woman is given medications which hyper-stimulate her ovaries to produce multiple follicles with mature oocytes (eggs). In a standard cycle of IVF, ten to twenty oocytes are harvested through a surgical procedure. Each oocyte is then fertilized with a man's sperm in a Petri dish or through a process called ICSI (intra-cytoplasmic sperm injection), in which a sperm is injected directly into the oocyte. Within hours, fertilization is complete when the DNA from the oocyte and the sperm combine to create a genetically distinct cell called the zygote. Scientists agree that the zygote is a single-celled embryo. Biologically speaking, this embryo is a new human being with a set of forty-six genetically unique chromosomes. After fertilization, the individual cells of the embryo divide every twelve to fourteen hours, and the embryo reaches eight cells after three days. One to three embryos are then transferred to the woman's uterus several days after the oocytes were harvested.

Despite the intricate technology involved in IVF, each cycle of IVF only has a 25-35% chance of achieving successful pregnancy. Additionally, as reported by the Centers for Disease Control and Prevention (CDC), pregnancies resulting from IVF are thirteen times more likely to result in twins, triplets, and higher-order multiples, leading to high-risk pregnancies which are more likely to result in preterm birth and other complications. A study from the New England Journal of Medicine also found that babies conceived with ICSI or IVF have twice the risk of major birth defects compared to babies conceived naturally.[2]

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[1]Catechism of the Catholic Church, n. 2377; internal quotation is from Congregation for the Doctrine of the Faith, *Donum vitae,* n. II, 4.

[2]Michèle Hansen, Jennifer Kurinczuk, Carol Bower, and Sandra Webb, "The Risk of Major Birth Defects after Intracytoplasmic Sperm Injection and in Vitro Fertilization," *New England Journal of Medicine* 346.10 (Mar. 7, 2002): 725-730.

Also extremely unsettling is that IVF treatments require the creation of ten to twenty embryos for each infertile couple, despite the fact that only one to three embryos are used per IVF cycle. The majority of the embryos will either be placed in cryopreservation indefinitely, or simply discarded, leading to a tremendous loss of human life.

Because assisted reproductive technologies are the treatments most uniformly offered to infertile couples, it is important for Catholic couples to understand that the Church's prohibition of such technologies does not mean that the Church has abandoned them in their struggle with infertility. On the contrary, there are many excellent treatments (such as those provided by NaProTECHNOLOGY), which are morally licit and not contrary to the dignity of the human person or the dignity of marriage. Fortunately, such treatments (which happen to be more effective and far less expensive than IVF) provide a cure to the underlying conditions causing infertility, and also often promote overall long-term health.

Additional Resources for the Laity

10 Things You Really Need to Know About IVF before Using It – Aleteia
http://www.aleteia.org/en/health/article/10-things-you-really-need-to-know-about-ivf-5272725291532288

New Tests for Five-Day-Old Embryos Raise Pro-Life Concerns – Aleteia
http://aleteia.org/2014/07/15/new-tests-for-five-day-old-embryos-raise-pro-life-concerns/

IVF's Tarnished Halo
http://www.all.org/-ivfs-tarnished-halo/

Further information on NaProTECHNOLOGY can be found at http://www.naprotechnology.com; http://www.popepaulvi.com/; http://www.creightonmodel.com/; http://www.unleashingthepower.info/; and http://www.drhilgers.com/.

Women can find a NaProTECHNOLOGY medical consultant or surgeon near them by visiting www.fertilitycare.org.

Ectopic Pregnancy

Case Study: E.P. and her husband call their parish priest, as they have just learned she has a pregnancy in her fallopian tube, instead of in the uterus, at six weeks past her last period. They would like to get advice on how to treat her in a morally good manner. Her gynecologist is offering her a drug treatment for the ectopic pregnancy, to make the pregnancy "dissolve," rather than having a surgery. However, they have seen the heartbeat of the baby by ultrasound, and they are not sure what to do.

Ectopic pregnancy is defined as a pregnancy wherein the baby has implanted outside the normal location of the uterus, usually in the fallopian tube. These pregnancies are rarely viable (able to grow outside the womb). They can cause significant harm to the woman as the pregnancy can rupture, which can lead to severe internal bleeding, and even death, if undetected. They account for 2% of all pregnancies and 6% of maternal deaths. They are the leading cause of maternal death in early pregnancy.[1] However, with the advent of vaginal probe ultrasounds and quantitative blood β-hCG (pregnancy hormone) testing, many of these pregnancies are diagnosed prior to rupture. Even at approximately six weeks of age, some of the embryos are alive with a heart beat within the fallopian tube.

There are four possible managements of ectopic pregnancy:

(1) "Expectant" therapy; i.e., nothing is done, and the doctor and patient wait for the tubal pregnancy to resolve itself by miscarriage. If the woman is asymptomatic and has falling β-hCG levels that start out at less than 200 mIU/ml, then 88% of these patients will resolve without treatment.[2] This treatment is morally legitimate.
(2) Surgical treatment: Removal of part (partial salpingectomy) or all (salpingectomy) of the fallopian tube, and, with it, the embryo. Morally permissible due to principle of double effect (see below).
(3) Surgical Treatment: Direct removal/separation of the embryo from the affected bodily site (salpingostomy), while keeping that bodily site intact (usually, the fallopian tube). Not morally legitimate if the embryo is alive; direct killing of embryo.
(4) Drug therapy with methotrexate. Not morally legitimate if embryo is alive; direct killing of embryo.

Note that, if there is evidence from testing (hormone testing, ultrasound, etc.) that the embryo is already deceased, then any acceptable medical or surgical treatment can be morally utilized. Therefore, when the patient presents with an ectopic pregnancy, testing should be performed to discern whether the embryo is alive. Sometimes, the case can be dire. Women who have a ruptured ectopic pregnancy (i.e., the fallopian tube or other organ where it's located has burst) classically present in shock with severe abdominal pain, possible shoulder pain, some vaginal bleeding, and signs of acute blood loss secondary to internal bleeding.

[1] Jessica Bienstock, et al., *The Johns Hopkins Manual of Gynecology and Obstetrics*, 5th ed., (Philadelphia: Wolters Kluwer, 2015): 379–388.
[2] Ibid.

Removal of the portion of, or all of, the damaged fallopian tube where the ectopic pregnancy resides (i.e., number (2) listed above), even if a living embryo is present, is ethical under the principle of double effect.[3] The action of removing a damaged part of the fallopian tube can be considered a good action, as it prevents further ectopic pregnancies in that tube, and saves the mother from internal bleeding and possible death. The bad effect of ending the embryo's life with an indirect abortion is not intended. The good effect of saving the life of the mother can be considered a proportionately good reason for the act of salpingectomy. See also directive 47 of the Ethical and Religious Directives (ERDs).[4]

Directive 48 of the ERDs also states: "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."[5] A direct abortion is defined in the ERDs' directive 45 as "the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus."[6]

Two newer treatments (numbers (3) and (4) listed above) for a living ectopic pregnancy would attack the embryo or fetus directly. With a salpingostomy, the fallopian tube is surgically slit and the embryo is removed. With drug treatment with methotrexate, the embryo and its surrounding trophoblastic tissue are harmed chemically with the drug. Both are direct attacks on the embryo and would constitute abortions. These two treatments for ectopic pregnancies could only be used when there was certainty by serial blood tests and by ultrasound that the embryo was already deceased.

[3] The principle of double effect "requires the following five components: (1) The action, in itself, must be good or at least not morally evil. (2) The good effect cannot be obtained in some other way without harm or evil. (3) The good effect must not be the result of an evil means, or, to put it another way, the evil act cannot be the means for producing the good effect. (4) The evil effect is not willed but merely permitted. (5) There is a proportionate reason for performing the action." From Marie A. Anderson, Robert L. Fastiggi, David E. Hargroder, Rev. Joseph C. Howard Jr., and C. Ward Kischer, "Ectopic Pregnancy and Catholic Morality: A Response to Recent Arguments in Favor of Salpingostomy and Methotrexate," *The National Catholic Bioethics Quarterly*, Spring 2011: 667–684; http://johnpaulbioethics.org/FinalProofs.pdf. This is also a good assessment of the topic, with numerous helpful resources.

[4] United States Conference of Catholic Bishops, Ethical and Religious Directives, Fifth Edition (Washington, DC: USCCB, 2009), n. 47; http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[5] Ibid., n. 48.

[6] Ibid., n. 45.

The Treatment of Endometriosis

Case Study: A young woman undergoes a laparoscopy by a reproductive endocrinologist after five years of infertility, painful periods, and intestinal symptoms. She is found to have extensive endometriosis, involving the bowel and ovaries; however, her fallopian tubes are open. After removal of some of the endometriosis, she is placed on medication to suppress her periods, and a second more extensive surgery is planned. She is instead sent to a specialist in endometriosis surgery and undergoes a second laparoscopy, with removal of all the endometriosis. Within six months of the second surgery, she conceives and delivers a healthy baby boy at age 37.

Endometriosis is a disorder in which tissue that normally lines the uterus is growing outside the uterus. The main symptoms are often-debilitating pelvic pain (usually during menstruation), and sometimes pain with intercourse. It is also associated with infertility.

The disorder is an underdiagnosed, undertreated problem (it is thought to affect 1 in 10 women worldwide); there are well-documented delays in diagnosis of up to 12 years.[4]

Laparoscopy can be used to help treat endometriosis. This is a surgical procedure in which a small incision is made, usually in the navel, and a viewing tube (laparoscope) is inserted. The viewing tube has a small camera on the eyepiece, which allows the doctor to examine the abdominal and pelvic organs, and to visualize the diseased tissue. Laparoscopic surgery by an expert in the treatment of endometriosis can reduce the risk of adhesions or scar tissue, and has been shown to decrease pain and benefit fertility.[5-7]

Hormonal suppression (with birth control pills, or injections like Lupron that cause a chemical menopause), which is often prescribed as treatment by secular doctors, is temporary symptomatic treatment at best. Improvement of pain with such hormonal suppression does *not* help diagnose endometriosis.[1,8] In fact, it often masks correct diagnosis of the issue. The addition of hormonal suppression to surgery also does not decrease recurrence rates of actual disease.[9] The earlier in life one is given hormonal suppression for pelvic pain may be a marker for more advanced disease later in life.[10-12] Hormonal suppression in truth has no role in treating (present or future) infertility.[13]

Optimally, surgical excision or removal of the disease (especially disease deep within abdominal tissues) is the best way to improve pain and quality of life, and to reduce recurrence rates.[14-16]

Early diagnosis and treatment may be the best way to prevent the development of deep or extensive disease and perhaps to preserve fertility, as endometriosis can progress over time.

Some advocate the development of centers of excellence for the (surgical) treatment of endometriosis.[19,20] Expert recognition and treatment is needed for the best management of this disease.

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Additional Resources for the Laity

Catholic doctor brings endometriosis specialty to St. Louis
http://stlouisreview.com/article/2012-05-03/catholic-doctor

A moral alternative to treating infertility:
https://www.osv.com/OSVNewsweekly/National/Article/TabId/717/ArtMID/13622/ArticleID/521/A-moral-alternative-to-treating-infertility.aspx

Women can find a physician, medical consultant, or NaProTechnology surgeon (i.e., a doctor who specializes in treating endometriosis) near them by visiting www.fertilitycare.org.

Further information on the treatment of endometriosis via NaProTechnology (a medical system that maintains a woman's reproductive health in a way that cooperates completely with her normal reproductive cycle) can be found at http://www.naprotechnology.com; http://www.popepaulvi.com/; http://www.creightonmodel.com/; http://www.unleashingthepower.info/; and http://www.drhilgers.com/

The Psychology and Neurobiology of Pornography

The use of pornography in the world today has been escalating. In large part, this is due to the introduction of the internet, which allows relatively unrestricted private access to pornography for many, including children and adolescents. Recent statistics have shown the presence of millions of pornographic web sites, including child pornography sites, in an ever-growing industry of nearly 100 billion dollars.

Pornography has been the source of much shame, secrecy, infidelity, divorce, and frequent mental health issues for individuals and families. It is known for its 4 A's: Accessibility, Affordability, Anonymity and Aggressiveness.

Despite its gravity, both in terms of sin and psychologic impact, there is a continued "desensitization" which has occurred in our society, to the point where "soft porn" and immodesty are seen often and are thus assumed to be normal. Many persons are struggling with attempts to "cut down" or stop their use of pornography without success. Although not formally identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) yet as an addiction, it has become clear to many clinicians and researchers that the use of pornography can lead to destructive symptoms consistent with those of a severe addiction. One of these findings is that of "tolerance" which means that increasingly greater amounts of a substance, or in this case, pornography in increasing levels of depravity may be necessary to produce the same results. While the various causes of pornography addiction may be unique to each individual (as regards to one's upbringing, vulnerabilities, and often early exposure), the symptoms of the compulsion are similar. "Withdrawal" symptoms of anxiety and agitation have been described as well.

There has been much evidence to suggest that neurobiochemical changes also occur in the brains of those utilizing pornography which are similar to those using illicit substances. Dopamine, oxytocin, and serotonin are three such biochemicals which normally help with bonding, experience of pleasure, and overall mood stability. These appear to be altered in those who view pornography excessively and lead to an actual type of tragic "bonding" or imprinting to the pornographic material. The natural bonding that should occur within the sacred intimacy of marriage is "rewired" and disrupted, both biochemically and psychologically. Such complex interactions and imprinting may lead to a sense of despair for the user and the family, given the significant difficulties that can be encountered when considering recovery.

However, there is much hope. Recovery usually will require an integrated approach to healing, including spiritual, psychologic, and physical dimensions. We as Catholics, are particularly blessed with the gift of our Sacraments, especially the Eucharist, Sacrament of Reconciliation, and Sacrament of the Sick. The United States Conference of Catholic Bishops has taken this epidemic seriously. There are increased resources and therapeutic modalities which have shown effectiveness, a number of which are Catholic in their approach. In addition, due to our Catholic understanding of demonic temptation (which can be especially fierce in this particular addiction), programs which include deliverance prayers, including models such as "Unbound" by Neil Lozano, have led to deep healing for many.

Additional Resources for the Laity

"Reclaim Sexual Health": A science-based, Catholic online recovery program and other resources for those who desire to reclaim God's plan for their lives and the lives of loved ones impacted by pornography or other unhealthy sexual behaviors. Incorporates education, a cognitive behavioral model of exercises and personal/professional support. Has been used by more than 8,000 individuals in over 80 countries. Founded in part by Elizabeth Ministry International and is under the guidance and direction of Bishop Ricken of the Diocese of Green Bay.
https://reclaimsexualhealth.com/

"Integrity Restored": Helps restore the integrity of individuals, spouses, and families that have been affected by pornography and pornography addiction. Provides education, training, encouragement, and resources to break free from pornography, heal relationships, and to assist parents in preventing and responding to pornography exposure.
http://integrityrestored.com/

"Integrity Starts Here" by Dr. Peter Kleponis: Designed to help men and women, their spouses, and their families break free from the bonds of pornography. Provides clear information on pornography use and addiction, pornography's effects on people's lives, and how to get help.
http://peterkleponis.com/

Covenant Eyes: An online website which helps with blocking sites as well as accountability.
http://www.covenanteyes.com/

"Unbound" and "Heart of the Father Ministries" by Neil Lozano: a Biblically-based listening, loving, prayer ministry open to the healing, deliverance, power, and guidance of Jesus Christ and the Holy Spirit. Empowers people to reclaim their true identity in Christ. Provides books, audio, visuals, and training materials for those seeking to learn about Unbound or grow in their ministry.
http://reapasyousew.com/unbound-ministry/ and http://www.heartofthefather.com/

"Help for Men and Women Struggling with Pornography Use or Addiction" at For Your Marriage (USCCB website): This list provides information about ministries, support groups, and resources for men and women who are looking for support to overcome pornography use and addiction, parents who want to help their children avoid pornography, filtering services to block pornography on Internet-enabled devices, a list of recommended books, and more.
http://www.foryourmarriage.org/help-for-men-and-women-struggling-with-pornography-use-or-addiction/

Bishop Paul Loverde (Arlington): "Bought with a Price: Every Man's Duty to Protect Himself and His Family from a Pornographic Culture" 2014 pastoral letter: includes resources for men, women and parents
http://www.arlingtondiocese.org/documents/bought-with-a-price-anti-pornography-letter

Overcoming Pornography Addiction: A Spiritual Solution (book), By Monsignor J. Brian Bransfield: Presents the struggle of internet pornography in the context of the encounter of Jesus with the Woman of Samaria, emphasizing the practical way in which the teaching of the Church can move us from sin to grace, from pain to healing, through an honest appraisal of the pain of internet pornography and the wonderful beauty of grace and virtue.
https://www.amazon.com/Overcoming-Pornography-Addiction-Spiritual-Solution/dp/0809147971

"Create a Clean Heart" by the U.S. Conference of Catholic Bishops (USCCB): At their November 2015 General Assembly, the U.S. bishops approved this formal statement "Create in Me a Clean Heart: A Pastoral Response to Pornography."
Numerous other links, pamphlets, and resources are also available at this link:
http://www.usccb.org/issues-and-action/human-life-and-dignity/pornography/index.cfm

"Institute for Media Education," by Judith Reisman, Ph.D.: As a researcher & author, historian & teacher, Judith Reisman has focused on pornography as a pandemic, addicting men, women and children and upon exposing Dr. Alfred C. Kinsey's fraudulent sex science research and education. Many useful articles and resources are on this site.
http://drjudithreisman.com/

Ordinary and Extraordinary Medical Care

"Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good."
Catechism of the Catholic Church, n. 2288.

> The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute.[1]

The duty to preserve God's gift of human life has lead the Church throughout history to consider what means of care are required to uphold this moral obligation.

> In 1595 the Dominican theologian Domingo Banez made a distinction that has become classic in medical ethics: between ordinary and extraordinary means. … [Banez said,] 'Although a man is held to conserve his own life, he is not bound to extraordinary means but to common food…, to common medicines, to a certain common ordinary pain: not, however, to a certain extraordinary and horrible pain, nor to expenses which are extraordinary.'[2]

Four centuries later in 1957 Pope Pius XII gave magisterial expression to the distinction between ordinary and extraordinary means in an address to Catholic physicians:

> Normally one is held to use ordinary means – according to the circumstances of persons, places times, and culture – that is to say, means that do not involve any grave burden for oneself or another…Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as one does not fail in some more serious duty.[3]

In May 1980, the Sacred Congregation for the Doctrine of the Faith issued its *Declaration on Euthanasia*, and while upholding the well established theological and magisterial teaching on ordinary and extraordinary means, a new set of terms (proportionate and disproportionate means) was introduced, further clarifying the practical application of the moral principles:

> In the past, moralists replied that one is never obliged to use 'extraordinary' means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of 'proportionate' and 'disproportionate' means.[4]

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[1] United States Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care," Fifth Edition, November 2009.
[2] National Certification Program in Health Care Ethics, National Catholic Bioethics Center, Rev. Russell Smith, Module Reading on "Ordinary and Extraordinary Means."
[3] L'Osservatore Romano, November 25-26, 1957. Pope Pius XII, "Address to an International Congress of Anesthesiologists."
[4] Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," May 1980.

Proportionate means are those offering a reasonable hope of benefit, while not imposing too great a burden. Disproportionate means would be those which impose risks or burdens that outweigh the expected benefits.

> The judgment that a particular means is either proportionate or disproportionate must be made in light of the personal (including religious beliefs), familial, economic, and social circumstances of each individual patient. This means that an *a priori* list of treatments that would be classified as always and everywhere proportionate or disproportionate cannot be made.[5]

Finally, in 2009, the National Conference of Catholic Bishops updated its summary of the application of these principles in the Ethical and Religious Directives for Catholic Health Care # 56 – 59.[6]

The cultural environment in the United States at the beginning of the 21st century nearly deifies personal autonomy and "choice." Therefore, it must be emphasized that a well-informed and truly Catholic moral decision regarding ordinary vs. extraordinary care requires the intimate cooperation of patient, family, physician, and Catholic priest.

Additional Resources for the Laity

What is the Church's Teaching on Extraordinary Care for the Sick?
http://www.catholic.com/quickquestions/what-is-the-churchs-teaching-on-extraordinary-care-for-the-sick

Ordinary vs. Extraordinary Care (American Life League)
http://www.all.org/nav/index/heading/OQ/cat/NDA/id/NzM0Mg/

[5] National Catholic Bioethics Center, *Ethics and Medics*, April 1995, Vol. 20, No.4.
[6] United States Conference of Catholic Bishops, "Ethical and Religious Directives," 2009, nn. 56-59.

Assisted Nutrition and Hydration

"What about a feeding tube?" This question raises a hot button issue in medicine and ethics about which the Church has some helpful counsel to offer. Certain medical problems can make it impossible to eat or drink normally. In such cases assisted nutrition and hydration (ANH) can be life-saving and should be considered. In the short-term this can take the form of intravenous feedings. In the long-term it usually involves the use of a feeding tube, the most common type being the percutaneous endoscopic gastrostomy (PEG) tube, which came into common use in the 1980s. ANH is most often used in patients with cancer, advanced dementia, stroke, Parkinson's Disease, Amyotrophic Lateral Sclerosis, and the minimally conscious state (or "Persistent Vegetative State").

Prior to 1980 it was generally unthinkable to deny food and water to anyone. In the last thirty years, many have raised ethical questions about the use of ANH related to ordinary versus extraordinary care, euthanasia, the right to die, concerns about quality of life, and patient autonomy. ANH has been involved in several well-known legal cases including that of Karen Quinlan in 1985, Nancy Cruzan in 1990, and Terri Schiavo in 2005.

There has been a considerable divergence between mainstream secular approaches to ANH and that of the Catholic Church. If asked, most people would say that they never would want a feeding tube. Look at most living wills and you'll find "No" to feeding tubes. Many physicians reject the use of ANH on utilitarian grounds for patients who are considered to have a poor quality of life especially in situations like advanced dementia or other neurologic conditions that impair cognitive function. Patients in need of ANH may be dehumanized and referred to as "gomers" or "vegetables."[1] The medical community considers ANH a medical act that can be refused and hence is never obligatory. Failure to provide ANH is now common practice in hospitals, nursing homes, and hospice programs and leads to the death of the patient due to dehydration. Failure to provide ANH is often coupled with the use of large doses of morphine and constitutes a form of slow euthanasia. Death by dehydration has become common practice.

Yet, Catholic moral teaching sees the issue of ANH from a different perspective, one grounded in the innate dignity of the human person and the belief that God, not man, is the master of life and death. We are but stewards and should use all ordinary means to preserve life. Nutrition and hydration are considered part of basic care to which everyone is entitled, even if it requires use of a feeding tube. ANH was the subject of important statements by Pope John Paul II in 2004[2] and by the Congregation for the Doctrine of the Faith in 2007, the latter stating:

> The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented.[3]

The Ethical and Religious Directives (ERDs) for Healthcare has this to say about ANH:

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[1] Howland, JS and Gummere PJ, "Challenging Common Practice in Advanced Dementia Care: A Fresh Look at Assisted Nutrition and Hydration," *NCBQ* 14.1 (Spring, 2014): 53-63.

[2] John Paul II, "Address of John Paul II to the Participants in the International Congress on 'Life-Sustaining Treatments and the Vegetative State: Scientific and Ethical Dilemmas." March, 2004.

[3] Congregation for the Doctrine of the Faith. "Responses to Certain Questions of the USCCB concerning Artificial Nutrition and Hydration." 2007.

> In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the 'persistent vegetative state') who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be 'excessively burdensome for the patient or (would) cause significant physical discomfort, for example, resulting from complications in the use of the means employed.' For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.[4]

Aren't there some situations when ANH is not a good idea? As the CDF statement and the ERDs indicate, ANH is not appropriate if death is imminent, or if it is excessively burdensome, such as when a person develops complications from the feeding tube. There are also situations such as severe heart failure or multiple organ failure, in which ANH can't "accomplish its proper finality," meaning that it just doesn't work and is not able to nourish or hydrate the patient.

Faced with a need for ANH, patients and family members often need considerable help in understanding the situation and coming to an appropriate decision. Patients will often get conflicting advice and reject ANH for fear of being a burden or because they want to hasten death. Patients and family members often react negatively to the idea of a feeding tube when in reality it is not the tube they fear but a long, lingering illness and death. Priests and chaplains may be asked to provide spiritual counsel in such situations and can be of great help dealing with such life and death issues. A multidisciplinary group has published guidelines for the use of ANH from a Catholic perspective. These guidelines can be of help to priests who are involved in discussing these issues with patients and families.[5]

The medical and ethical issues surrounding ANH can become complex, but there is also a simple way to look at the question.[6] All of us know what it is like to suffer hunger and thirst. Food and water are essential for life. When a child come to us and says, "I'm hungry and I'm thirsty," we instinctively know what to do. Recall the words of Jesus calling us to Christian charity: "For I was hungry and you gave me food, I was thirsty and you gave me drink" (Matt. 25:35).

Additional Resources for the Laity

Catholic Teaching on Assisted Nutrition and Hydration - By Father Thomas Berg
http://www.catholicnewsagency.com/column.php?n=1099

[4] U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009).
[5] The Ad-Hoc PEG Tube Study Group, "When to Recommend a PEG Tube: A Decision Tree for Clinicians from a Catholic Perspective," *Linacre Quarterly,* 79(1) (February 2012): 25-40.
[6] Howland, JS, "A Defense of Assisted Nutrition and Hydration in Patients with Dementia," *National Catholic Bioethics Quarterly*, 9:4 (Winter 2009): 697-710.

Concerning Artificial Nutrition and Hydration
http://www.priestsforlife.org/euthanasia/concerning-artificial-nutrition-and-hydration.htm

Fr. Pavone Welcomes Vatican Statement on Nutrition and Hydration
http://www.christiannewswire.com/news/47444193.html

The Catholic Living Will

The living will is one type of an advanced directive that allows patients to give instructions about medical treatments they desire to be administered or withheld at a future date. This declaration becomes active only when patients become incapacitated and cannot speak for themselves. This can result from a temporary or permanent medical condition. Ideally, a complementary directive called a *healthcare proxy* or *durable power of attorney for healthcare* should accompany the living will. This document assigns and allows surrogates to make decisions for patients when the patients are not able to make decisions for themselves.

A living will, to be consistent with Catholic teaching, needs to address five key principles: (1) the desire for pain relief, (2) assessing treatments as either ordinary or extraordinary, (3) providing nutrition and hydration, (4) prohibiting euthanasia, (5) providing for spiritual care.

Relieving Pain

Church teaching is very supportive of the goal of keeping patients as free of pain as possible so that they may die comfortably and with dignity. The Church also teaches about the redemptive nature and mystery of suffering. Saint John Paul II in his apostolic letter *Salvifici doloris (On the Christian Meaning of Human Suffering)* explains the "why" of suffering by looking at the ultimate source of the meaning of everything that exists, divine love. Times of suffering have a special place in God's saving plan. Some patients may view the end of life as the last opportunity to unite their suffering with the suffering of Christ, and may wish to moderate their use of pain medication. Healthcare personnel should always explore the patient's goals regarding pain management.

Assessing Treatments as either Ordinary or Extraordinary

The Church offers solid counsel in making end-of-life decisions. Patients or their surrogates need to be given adequate information regarding their care. There should be a clear understanding as to whether the proposed treatment will: (1) serve as a bridge to recovery from an acute medical problem, (2) alleviate discomfort and suffering from an on-going condition, or (3) offer little hope of benefit and may actually add burden to the patient's care.

Making end-of-life medical decisions can be very challenging for physicians and the medical team caring for the patient. It can also be the most rewarding, learning their patients' life stories and seeing Christ in them as they are being called home.

Providing Nutrition and Hydration

Making a request for the administration of food and water, even if given by artificial means, is a hallmark of Catholic moral teaching. It is generally not included in a secular living will. Saint John Paul II has clearly stated that the administration of food and water, even when provided by artificial means, always represents a natural means of preserving life, and not a medical act.

The secular medical community does not accept hydration and nutrition as an act of normal care. The scientific/secular approach considers life an instrumental good, a good *for* the person. According to that view, any standard therapeutic recommendation has to show a concrete, tangible improvement in quality or longevity of life. The Church, however, considers life a good *of* the person, focusing on the dignity of the human person made in the image and

likeness of God, and making recommendations based on the sanctity of human life. The benefits to the patient derived from the approach of the Catholic Church would not necessarily be discernible or recognized by the secular medical community.

The Catholic position starts from the presumption *in favor* of hydration and nutrition, until it is no longer useful or becomes burdensome. The secular medical community starts from the presumption *against* hydration and nutrition, unless there are statistical, reproducible, and tangible benefits to support its use. It is not surprising, therefore, that this will be an on-going area of controversy and conflict. It should be made clear, however, that the Church does understand that there are times when hydration and nutrition may no longer be helpful and could be discontinued. For example, if death is imminent, or when artificial hydration and nutrition can't "accomplish its proper finality," meaning that it just doesn't work and is not able to nourish or hydrate the patient, such as when a patient has multiple organ failure.

Prohibiting Euthanasia

The immorality of euthanasia can be understood by natural moral law and predates Christianity. Hippocrates prohibited euthanasia in his original oath when he stated "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan." Saint John Paul II has stated that euthanasia is a false mercy and indeed a perversion of mercy. There are two components of euthanasia, the act itself and the intention, which is to cause death. Both components are necessary for an act to be considered euthanasia. Combating the growing trend of legalized physician-assisted suicide will be an ongoing challenge for the Church.

Providing for Spiritual Care

Our faith in the resurrection and eternal life are strengthened through the sacraments. The sacraments of Baptism, Confirmation, and the Eucharist are the sacraments of Christian initiation. In the same way, the sacraments of Penance and Anointing of the Sick, and the administration of the Eucharist as Viaticum, complete the earthly pilgrimage. Priests have an invaluable role in providing optimal end-of-life care for the faithful.

Conclusion

The Magisterium has put forth valid teachings that are grounded in faith and supported by reason. A Catholic living will that addresses the five principles outlined will avoid the shortcomings of secular living wills that deny patients proper end-of-life care. The Catholic Church will always guide our earthly life, as well as our journey from death to eternal life in Christ.

The above is a synopsis from:
Morrow PT, "The Catholic Living Will and Healthcare Surrogate: A Teaching Document for Evangelization, and a Means of Ensuring Spirituality Throughout Life," *The Linacre Quarterly* 80; (4) 2013: 317-322.

Additional Resources

"A Catholic Guide to End-of-Life Decisions," National Catholic Bioethics Center, 2011, Philadelphia, PA: NCBC.

Advanced Directive: Protective Medical Decisions Document, by Rita Marker, JD, Patients Rights Council:
http://www.patientsrightscouncil.org/site/advance-directive- protective-medical-decisions-document/

Understanding the Catholic Living Will; Health Care Surrogate:
http://flaccb.org/declaration-on-life-and-death

National Right to Life, Will to Live Document:
http://www.nrlc.org/medethics/willtolive/

POLST: Life Sustaining or Life Ending?

What is POLST?

POLST (Physician Orders for Life-Sustaining Treatment): A medical directive form intended to lock in restrictions on life sustaining treatments. The innovation of POLST is not that patients may choose to receive such treatments – sustaining life has long been the standard in medicine. Rather POLST proposes a new option: in advance, patients may limit or reject life-sustaining treatments, with choices locked in as orders to be followed for future medical situations that may occur. When POLST orders are written that withhold life-sustaining treatments, a patient needing such treatment is expected to die as a result of these orders.

Note: In some locations, POLST is identified by other acronyms – POST, MOLST, MOST, etc.

POLST is rigid and inflexible:

– The POLST form contains checkbox choices to indicate whether, at any time in the future, the patient can receive treatments such as cardiopulmonary resuscitation (CPR), antibiotics, tube feedings, hospital admission, or simply "comfort care" (generally excluding all of the above). With such checkbox options, treatments may or may not be unduly burdensome; however, it is entirely possible that without these treatments, the patient may die. POLST contains no explanation for why any limitations were chosen. POLST orders dictate what caregivers are allowed to provide, circumventing further discussions with patient or the family of what a patient would want as new situations evolve. Thus while patients and family may assume the POLST plays an advisory role only for future situations such as terminal illness or persistent unconsciousness, POLST is a current order *now and from this point forward,* and no further discussion may be required or even encouraged.

– POLST forms are immediately recognizable (often printed on brightly colored, thick paper and placed in front of the patient's chart). POLST always accompanies the patient during transfers and the orders are expected to be followed by all health care providers and EMTs (emergency medical technicians), no matter the reason for choices made, or personal beliefs of involved caregivers. Some states require that POLST orders written at one facility be followed even at distant sites where the original physician's signature is unknown.

– In some locations, the form contains statements that discourage health care providers from raising questions. (Example: "FIRST follow these orders, THEN contact the patient's provider**"** - emphasis original, from one Minnesota POLST form).

– POLST orders may override advance directives, and POLST forms may contain statements that discourage reconciling POLST orders with existing advance directives. (Example: "This is a Physician Order Sheet…It summarizes any Advance Directive". Source: one Wisconsin POLST form).

This rigidity of POLST can be expected to force nurses and other healthcare professionals to obey them, who otherwise might wish to provide treatment. In the end, this may create negative attitudes toward worthiness of treatment for the elderly and disabled.

What is the POLST Paradigm?

The "National POLST Paradigm" is

> an approach to end-of-life planning based on *conversations* between patients, loved ones, and *health care professionals* designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and honored."[1]

Frequently within POLST circles, the following statement directs the POLST focus: "It's not about the documents! It's about the conversation."[2] However, some items that need to be considered are:

a) Who are the "health care professionals" hosting conversations? What is their training? Who employs them?
b) Within POLST conversations, how are decisions made regarding life-sustaining treatments?
c) How are POLST forms completed after conversations and subsequently activated?
d) Which patients may be candidates for POLST?

"Health Care Professionals" Initiate POLST Conversations

Every well-established POLST program utilizes non-physicians to provide most of the patient counseling and preparation of POLST forms, and then they submit them to doctors for signature.[3] These non-physicians are titled "facilitators." They may be social workers, nurses, chaplains, ward clerks, nursing home staff, etc. — they need no previous health care training or experience. Facilitator certification is through programs instituted by Respecting Choices, located at the Gundersen Clinic of La Crosse, Wisconsin, and consists of six hours of online and eight hours of classroom training. Of course, fourteen hours pales against years of training normally expected for health care professionals. Facilitators are usually employed by nursing homes and other health care institutions where they facilitate POLST conversations with patients. (At some nursing homes, residents were frequently told, erroneously, that a POLST was mandatory, regardless of their health condition.[4]) Upon receipt of a completed POLST from a facilitator, a physician is expected to verify the choices made and sign off on the orders.[5]

What Are The Criteria for POLST Decision-Making that Facilitators Utilize with Patients?

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[1] *What is POLST? (*Emphasis added.) Available at www.POLST.org.
[2] *The NC MOST Form: What's in it for LTC facilities, patients, families & providers?* NC Health Care Facilities Association Webinar, August 2, 2012 . Available at: http://www.ebookily.org/ppt/health-care-north-carolina. Also see https://www.facebook.com/permalink.php?story_fbid=248665121850396&id=106100128751.
[3] Charles P. Sabatino and Naomi Karp, *Improving Advanced Illness Care: The Evolution of State POLST Programs, 2011*, page 24. Available at http://assets. aarp.org/rgcenter/ppi/cons-prot/POLST- Report-04-11.pdf
[4] CANHR Policy Brief – *Physician Orders for Life Sustaining Treatment ("POLST"): Problems and Recommendations*, California Advocates For Nursing Home Reform, page 1. Available at http://www.canhr.org/reports/2010/POLST_WhitePaper.pdf
[5] Sabatino and Karp, 2011, page 24.

Facilitator manuals and materials appear negatively-biased regarding various life-sustaining treatments, focusing more on potential discomfort and invasiveness of treatments, rather than the possibility of positive outcomes from short-term courses of treatment. [6,7,8] They detail numerous possible problems and side effects of treatment — yet leave out that, with proper care, these problems may be mitigated or avoided. Furthermore, the downsides of refusing treatments are minimized, such as death or medical complications for patients who survive non-treatment.

POLST conversations with patients often begin by discussing the topic of "living well," asking the patient specifically what makes life "worth living" — which might be golf, good books, self-sufficiency, etc.[9] Such "quality of life" discussions may lead the facilitator or patient to conclude that future life-sustaining treatments should be rejected in the event that health takes a serious turn for the worse and the patient may not be able to enjoy those good things.

How Are POLST Forms Completed and Activated?

After hosting the POLST conversation, a facilitator checks off specific orders and sends the POLST form to the doctor for signature, to activate the orders. Some states allow signing by a nurse practitioner or physician assistant. In various states, the patient's signature is not required, but "recommended." Nonetheless, a recent paper showed that where patient's signature was not required, 95% did not have it.[10] Thus whether the patient even knew of their form's existence or the orders written was undocumented by the customary legal standard — a patient's signature.

After a facilitator prepares POLST orders, doctors are expected to sign. In some locations medical institutions track signature compliance through the electronic medical record and doctors are financially rewarded or docked based on their compliance.

The facilitator paradigm conflicts with the usual ethical and legal standard of proper decision-making in medicine — physician-informed consent, in which the doctor provides complete information to the patient, ensuring the patient's decision is well-informed.

While doctors may feel they were compelled to cooperate with this looser standard of critical decision making — call it "facilitator-informed consent" — and thus may feel less responsible, all other parties view POLST as signed doctor's orders and agree that the doctor assumes full responsibility under POLST.[11]

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[6] *The POLST paradigm and form: Facts and analysis*, Brugger, C. et al, The Linacre Quarterly 80 (2) 2013, 103-138, page 117-118. Available at http://cathmed.org/assets/files/POLST_Paradigm_and_Form.pdf

[7] CANHR Policy Brief – *Physician Orders for Life Sustaining Treatment ("POLST"): Problems and Recommendations, page 5.*

[8] Press Release: *Disability Right Organizations Led By Not Dead Yet Issue Open Letter Criticizing Respecting Choices Program for Bias Against Feeding Tubes and Breathing Devices*, December 20, 2013, available at: http://www.notdeadyet.org/2013/12/press-release-disability-rights-organizations-led-by-not-dead-yet-issue-open-letter-criticizing-respecting-choices-program-for-bias-against-feeding-tubes-and-breathing-devices.html

[9] Respecting Choices, *"Advance Care Planning Skills with Adults Likely to Die in the Next 12 Months or Adults Living in Long-Term Care,"* in *Advance Care Planning: Facilitator's Manual*, 3rd ed. (La Crosse, WI: Gundersen Lutheran Medical Foundation, 2007), chapter 5.4.

[10] *Use of the Physician Orders for Life-Sustaining Treatment Program for Patients Being Discharged from the Hospital to the Nursing Facility*, Hickman, SE, et al, J Palliat Med, 2014, 17, 1-7.

[11] *Speaker Training Tool for POLST Presenters*, POLST California, page 9. Available at http://med.fsu.edu/userFiles/file/Q&A%20Reference%20Document.pdf

The potential for financial benefits for health care institutions who initiate the POLST Paradigm may pose an obvious conflict of interest. New models of care are increasing incentives to move from physician-informed consent, to the use of POLST-type "facilitator conversations." For example, Accountable Care Organizations (organizations which participate in the Medicare program) are allowed to share in Medicare cost savings that might be realized by implementing the POLST paradigm.

Which Patients May Be Candidates for POLST Orders?

Some assume that POLST is utilized only at the end of life. Over time, POLST has been offered to more populations, increasing the likelihood that POLST may prematurely end lives. It was originally recommended that POLST should be used when a health care provider "would not be surprised if this patient died within the next year," a rather inexact concept. Later, in various locations, this was changed to, "would not be surprised if this patient died within the next five years." Further changes allowed the use of POLST if one "would not be surprised if the patient died *or had a complication*." Some forms allowed the patient to define specific preferences for when to use POLST. In other words, literally anyone for any reason, including a desire to die, could use POLST. In some locations, POLST may be used for children and pregnant women, unlike restrictions governing documents such as living wills.

The Catholic Approach to Health Care Decisions

Catholics are not required to undergo any and all treatments, but must always seek to preserve life, using ordinary, proportionate measures (obvious examples are food, drink, warmth, and cleanliness). We *may* accept, but are *not required* to accept, disproportionate or "extraordinary" care — treatment that is unduly burdensome compared to the expected benefit, treatment that would cause disproportionate suffering with little hope of success. A moral decision may be made to refuse extraordinary treatment, but it is the disproportionate *burdens of treatment* that are rejected. It is *not* the burdens of a "poor quality of life" that are rejected. Rejection of life constitutes euthanasia, a grave sin against God.

The ultimate moral analysis must carefully consider the specific medical condition, treatment options, and surrounding circumstances. Of course, all of these facts are *only apparent at the actual time of illness and cannot be known in advance*. Thus, advance decisions such as POLST orders restricting treatment are morally problematic.

The fallacy of POLST is that *advance* decisions are the best decisions. Practically speaking, such decisions are primarily focused on *burdens* of the treatment and even of life itself. Advance decisions suffer from a *lack of context* of how *beneficial* a treatment might be in unforeseen future situations, when treatment would be reasonably considered.

The Wisconsin Catholic Bishops have found:

> A POLST form presents options for treatments as if they were morally neutral. In fact, they are not. Because we cannot predict the future, it is difficult to determine in advance whether specific medical treatments, from an ethical perspective, are absolutely necessary or optional. These decisions depend upon factors such as the benefits, expected outcomes, and the risks or burdens of the treatment. A POLST oversimplifies these decisions and bears the real risk that an indication may be made on it to withhold a treatment that, in particular circumstances, might be

an act of euthanasia. Despite the possible benefits of these documents, this risk is too grave to be acceptable.[12]

It is perhaps not surprising that POLST is endorsed by pro-euthanasia organizations such as Compassion and Choices.

POLST and the Doctor-Patient Relationship

The use of POLST facilitators isolates patients from their doctors at critical times of informing and decision-making, a form of patient abandonment and a poor substitute for informed consent. Furthermore, preexisting POLST restrictions in care mean that a future need to contact physicians is reduced, again isolating patients from their doctors at times of medical need. There are specific medical situations when the doctor's presence and involvement are essential, to assist in informed decision-making and for compassionate support of the patient and family.

Catholic physicians have the unique opportunity and solemn obligation to defend their patients and profession. We recommend against the use of POLST; we advise against the signing of orders that others have written; and we argue for postponement of decisions until the actual moment of medical need. The safest model for advance medical documentation is the appointing of a person, such as a Healthcare Power of Attorney, to make decisions in-the-moment, when the patient cannot.

Additional Resources for the Laity

Physician's Order for Life-Sustaining Treatment: Helpful or a New Threat?:
http://www.ncregister.com/daily-news/physicians-order-for-life-sustaining-treatment-helpful-or-a-new-threat

Legalizing Euthanasia by Omission:
http://www.zenit.org/en/articles/legalizing-euthanasia-by-omission

POLST Forms Seen as Threatening Dignity of Patients (Diocese of Green Bay):
http://www.thecompassnews.org/2012/08/catholics-urged-to-obtain-power-of-attorney-for-health-care/

POLST and MOLST: Are You Signing Your Life Away? [Video]:
https://www.youtube.com/watch?v=1uv7vjY7APk or http://www.cathmed.org/programs-resources/health-care-policy/polst/

[12] *Upholding the Dignity of Human Life: A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST) from the Catholic Bishops of Wisconsin.* Available at http://www.wisconsincatholic.org/WCC%20Upholding%20Dignity%20POLST%20Statement%20FINAL%207-23.pdf.