

Holy Alliance

SERVING THE DIVINE PHYSICIAN

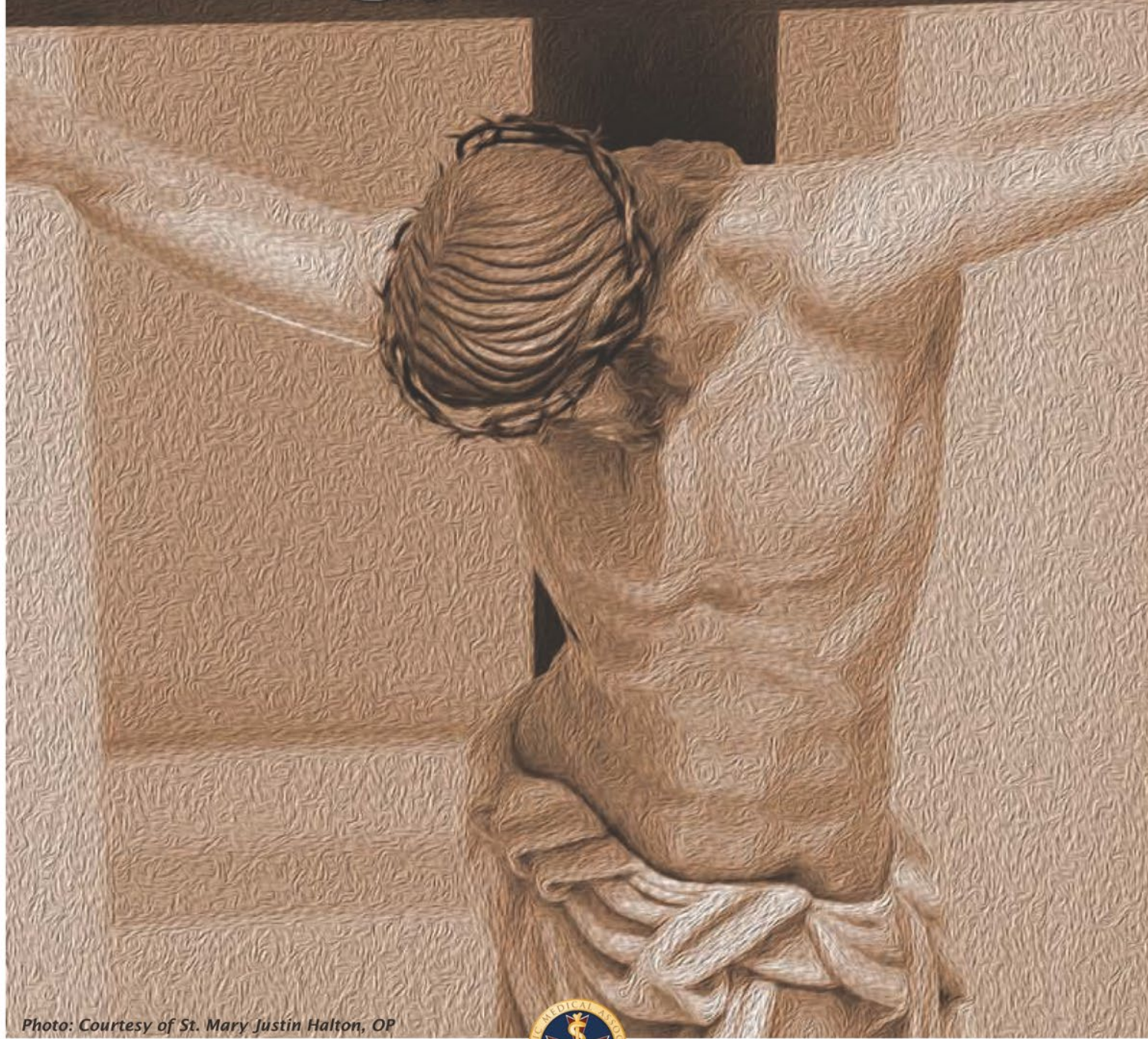


Photo: Courtesy of St. Mary Justin Halton, OP



CATHOLIC MEDICAL ASSOCIATION

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

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HOLY ALLIANCE PROGRAM DESCRIPTION

The Holy Alliance 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.

Nihil obstat
Reverend Monsignor J. Brian Bransfield, S.T.D.
Censor Liborum

Imprimatur
Most Reverend Nelson J. Perez, D.D.
Archbishop of Philadelphia

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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%.

Please see the table on the next page.

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 Two Day 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, M. Schneider and K. Raviele. "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, M. Schneider, K. Raviele, D. Rodriguez, and J. Pruszynski. "Randomized comparison of two Internet-supported fertility-awareness-based methods of family planning," *Contraception*, 88(2013): 24-30.

¹¹ T. Bouchard, M. Schneider and R Fehring. "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." *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 43(2014): 351-358.

Additional Resources for the Laity

Why the Church Is Right About Life and Love

<https://www.ncregister.com/news/why-the-church-is-right-about-life-and-love>

Promoting Humanae Vitae and Natural Family Planning in the Parish by Janet E. Smith

http://www.lifeissues.net/writers/smith/smith_04hvandnfpinparishes.html

NFP Basic Information

<https://www.usccb.org/topics/natural-family-planning/natural-family-planning>

Websites

Billings Ovulation Method

www.boma-usa.org

Couple to Couple League International (CCL)

www.ccli.org

FEMM

<https://femmhealth.org>

Georgetown University Institute for Reproductive Health

<https://irh.org>

(CycleBeads® and TwoDay® Method)

Marquette University College of Nursing, Institute of NFP

<https://nfp.marquette.edu>

iPhone app: Marquette Fertility Tracker

Pope Paul VI Reproductive Institute (FertilityCare™)

<https://www.popepaulvi.com>

Symptopro™ Fertility Education

<https://www.symptopro.org/>

WHEN DOES HUMAN LIFE BEGIN?

The Bioethics Defense Fund has given us permission to link to their website for a White Paper on that subject by Maureen L. Condit, Ph.D., Associate Professor, Neurobiology and Anatomy at the University of Utah School of Medicine. Visit: <https://bdfund.org/stories/whitepapers/>

The BDFund's website provides this summary of the White Paper:

“Resolving the question of when human life begins is critical for advancing a reasoned public policy debate over abortion and human embryo research. This article considers the current scientific evidence in human embryology and addresses two central questions concerning the beginning of life: 1) in the course of sperm-egg interaction, when is a new cell formed that is distinct from either sperm or egg? and 2) is this new cell a new human organism—i.e., a new human being? Based on universally accepted scientific criteria, a new cell, the human zygote, comes into existence at the moment of sperm-egg fusion, an event that occurs in less than a second. Upon formation, the zygote immediately initiates a complex sequence of events that establish the molecular conditions required for continued embryonic development. The behavior of the zygote is radically unlike that of either sperm or egg separately and is characteristic of a human organism. Thus, the scientific evidence supports the conclusion that a zygote is a human organism and that the life of a new human being commences at a scientifically well defined “moment of conception.” This conclusion is objective, consistent with the factual evidence, and independent of any specific ethical, moral, political, or religious view of human life or of human embryos.”

You can download through the above link user-friendly resources on embryology, embryonic stem cell research and cloning, gestational surrogacy, three-parent embryos and more. The BDFund's website also has links to the excellent reports of the 2002-2008 President's Council on Bioethics (Kass Commission) under President George W. Bush. These are ideal resources for physicians, ethicists, other healthcare professionals, legislators, educators, reporters, students, policy makers, or anyone wishing to gain a deeper understanding of bioethical issues.

FETAL PAIN - DOES IT EXIST?

Treating pain in extremely premature babies is the medical standard of care, a standard that has evolved due to the research, particularly for our most premature babies. For those who care for this population, both neonatologists in neonatal intensive care units (NICUs) and anesthesiologists during fetal surgery, the idea that their patient population is pain-capable is not controversial. With excellent neonatal care, a baby as early as 22-23 weeks' gestation at birth, can survive.

In 1987, the landmark paper by Drs. Anand, Phil, and Hickey published in the *New England Journal of Medicine* demonstrated evidence that marked signs of pain perception in these infants clearly constitutes a physiological and perhaps even a psychologic form of stress in premature or full-term neonates.¹ They recommended the use of topical, local or general anesthesia for invasive procedures, such as circumcision, in these infants. In a study they published in 1992, when pain was treated the outcomes were unequivocally better, including statistically significant differences in intra-operative and post-operative markers of stress and fewer post-operative complications.²

The consequences of experiencing pain include: "physiologic instability, altered brain development, and abnormal neurodevelopment, somatosensory, and stress response systems, which can persist into childhood." Premature babies who had previously been exposed to painful stimulation showed evidence of being more stressed when the same procedure was repeated than those of the same gestational age who had not yet been exposed.³ Despite the four-page bibliography used to form the 2016 American Academy of Pediatrics' policy update for avoiding, diminishing, and treating procedural pain, plus the bedside evidence that decreasing noxious stimuli in a premature baby's environment improves medical outcomes, the debate over fetal pain continues.

Exactly how early in gestation can the human fetus feel pain? Research is ongoing, but there is good evidence that peripheral pain receptors can be sufficiently connected to the central nervous system, specifically into the thalamus, as early as 12 weeks' gestation. Thus, pain's ability to create measurable changes acutely as well as produce later "procedural memories" is possible even when the human anatomical nervous system is quite immature.⁴

Because of counter efforts (based more on politics than science) to thwart attempts to outlaw late-term abortions, there is a persistent effort to deny the scientific evidence of the experience of pain by the human fetus. But the data is extensive and compelling that the baby in utero experiences pain when receiving a noxious stimulus. The evidence does indicate that pain is present at a very early stage in fetal

¹ K.J.S. Anand, M.B.B.S., Phil.D., and P.R. Hickey, M.D., "Pain and Its Effects in the Human Neonate and Fetus." *New England Journal of Medicine*, Volume 317, No. 21. (November 19, 1987):1321-1329.

² Ibid., "Halothane-Morphine Compared with High-Dose Sufentanil for Anesthesia and Postoperative Analgesia in Neonatal Cardiac Surgery." *New England Journal of Medicine*, Volume 326, No. 1 (January 2, 1992): 1-9. <https://doi.org/10.1056/nejm199201023260101>.

³ C.C. Johnston, and B.J. Stevens, "Experience in a Neonatal Intensive Care Unit Affects Pain Response." *Pediatrics*, Volume 98, No. 5, 1996, pp 925-930.

⁴ Lowery, Curtis L., et al. "Neurodevelopmental Changes of Fetal Pain." *Seminars in Perinatology*, Volume 31, No. 5, 2007, p. 276., doi:10.1053/j.semperi.2007.07.004.

development, and continuing to deny its existence in order to defend abortion is dishonest. We, the physicians of both the mothers and their babies, both born and unborn, must treat both patients humanely. Thus, armed with the knowledge that fetal pain exists, we are called upon to re-evaluate all of the ways we treat both.

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 five percent 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) 0.75mg 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,

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 Raviele, K., 117-129.

⁵ Ibid.

prevent a clinically detectable pregnancy (i.e., it could have a harmful effect on new life). 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.⁶ 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

<https://www.ncregister.com/news/fda-makes-plan-b-contraceptive-available-to-15-year-olds>

Study: Birth Control Pill and Abortion Spike Breast-Cancer Risk

<https://www.ncregister.com/news/study-birth-control-pill-and-abortion-spike-breast-cancer-risk>

New 'Morning After' Pill Sells Abortion as Contraception

<https://www.ncregister.com/blog/new-morning-after-pill-sells-abortion-as-contraception>

⁶ Raviele, K., 118.

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 she 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. Under the Covid-19 pandemic, President Biden first allowed telemedicine visits and mailing the abortion drugs to the woman without an in-person visit as an emergency authorization. In early 2022, this was made a permanent federal policy, in keeping with the administration's desire to expand abortion services.

How is RU-486 reversed?

As soon as possible after the RU-486 has been taken, the woman is given additional amounts of bioidentical progesterone, (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 visit <https://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 if the woman has taken the second drug (Misoprostol) in the RU-486 abortion regimen 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

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

there will be physicians, nurse practitioners, and physician assistants geographically close to any woman who wants the life-saving reversal regimen.

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 at 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

<https://www.abortionpillrescue.com/>

The Day I Performed the First-Ever RU-486 Abortion Reversal

<https://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

<https://www.lifenews.com/2014/03/17/abortion-interrupted-doctor-reverses-abortion-drug-after-mom-changes-mind/>

Can RU-486 Be Reversed?

<https://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 counter, in case the regular contraception does not work to prevent the conception of a child. Studies show that the majority of

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 the *Catechism of the Catholic Church*, n. 2370 (emphasis added).

² Janet Smith, “Contraception: Why Not?”

Visit: <https://www.catholiceducation.org/en/controversy/common-misconceptions/contraception-why-not.html>

³ Most Reverend James D. Conley, S.T.L., “The Language of Love” (Mar. 25, 2014).

Visit: <https://www.catholiceducation.org/controversy/contraception/the-language-of-love.html>

⁴ Pope Paul VI, *Humanae vitae* (July 25, 1968).

Visit: https://www.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html.

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
- c. Increase in single parenthood

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.

Visit: <https://www.guttmacher.org/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.

Visit: https://www.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).

Visit: https://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.

Visit: <https://www.breastcancer.org/facts-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?”

- 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’

<https://www.ncregister.com/news/bishop-conley-contraception-disrupts-the-language-of-love>

What a Woman Should Know about Contraceptives

<https://www.catholicnewsagency.com/resource/55267/what-a-woman-should-know-about-contraceptives>

The High Cost of Free Contraceptives - Washington Times

<https://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

<https://womenspeakforthemselves.com/the-hhs-mandate-ignores-health-risks-associated-with-contraception-alices-story/>

¹³ Ashley Ahearn, “[Feminized Fish: A Side Effect of Emerging Contaminants](#)” (September 12, 2012). Vanguard News Network Forum, “Birth Control Pills Are Polluting Water Streams” (Apr. 18, 2014).

Visit: <https://vnnforum.com/showthread.php?t=181344>

Technology.org, “Oral Contraceptives Are Feminizing Fish Populations - But Some Carry On Regardless” (Feb. 17, 2014).

Visit: <https://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 FertilityCare™ 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 CO2 laser
- Laparoscopic ovarian wedge resection for women with infertility due to PCOS when medical treatments have failed
- 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 FertilityCare System and NaProTECHNOLOGY:

- FertilityCare Practitioners: trained instructors who teach women and couples how to chart their cycles using the Creighton Model FertilityCare System to achieve or avoid pregnancy
- FertilityCare 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 the following websites:


<https://www.naprotechnology.com>
<https://www.popepaulvi.com>
<https://www.creightonmodel.com>
<https://www.unleashingthepower.info>
<https://www.drhilgers.com>

Additional Resources for the Laity

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

Understanding Infertility: A Catholic Perspective
<https://www.catholicdigest.com/amp/family/201302-25understanding-infertility-a-catholic-perspective/>

Hope for infertility: 'Infertile' couple gives birth thanks to cutting edge natural treatment
<https://www.lifesitenews.com/news/hope-for-infertile-couples>



Living With Your Fertility Through Natural Family Planning

Ninth Edition

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*A separate PowerPoint version of this article is available upon request from the CMA National Office.
Please send an email to info@cathmed.org.*

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Certified NFP teacher of four methods NFP

What do you think of when you hear the term
Natural Family Planning?



What do you hope for in your marriage?



Challenges of Living With Your Fertility



Objectives of Presentation

- Define Natural Family Planning (NFP)
- Describe how NFP works
- Discuss effectiveness of NFP methods
- Explain marital and spiritual benefits of using NFP

Definition of NFP

- Methods of **monitoring and interpreting a woman's natural biological markers** of fertility
- To help determine the **fertile and infertile times** of a woman's menstrual cycle
- Information can be used **to achieve or avoid pregnancy**

NFP Also Means...

- **Abstaining from intercourse** and genital activity during fertile time of cycle if avoiding pregnancy
- **Developing non-genital ways** of expressing intimacy during the fertile times
- **Not using any artificial means** to interfere with fertility
- **Openness to life**

Methods of NFP

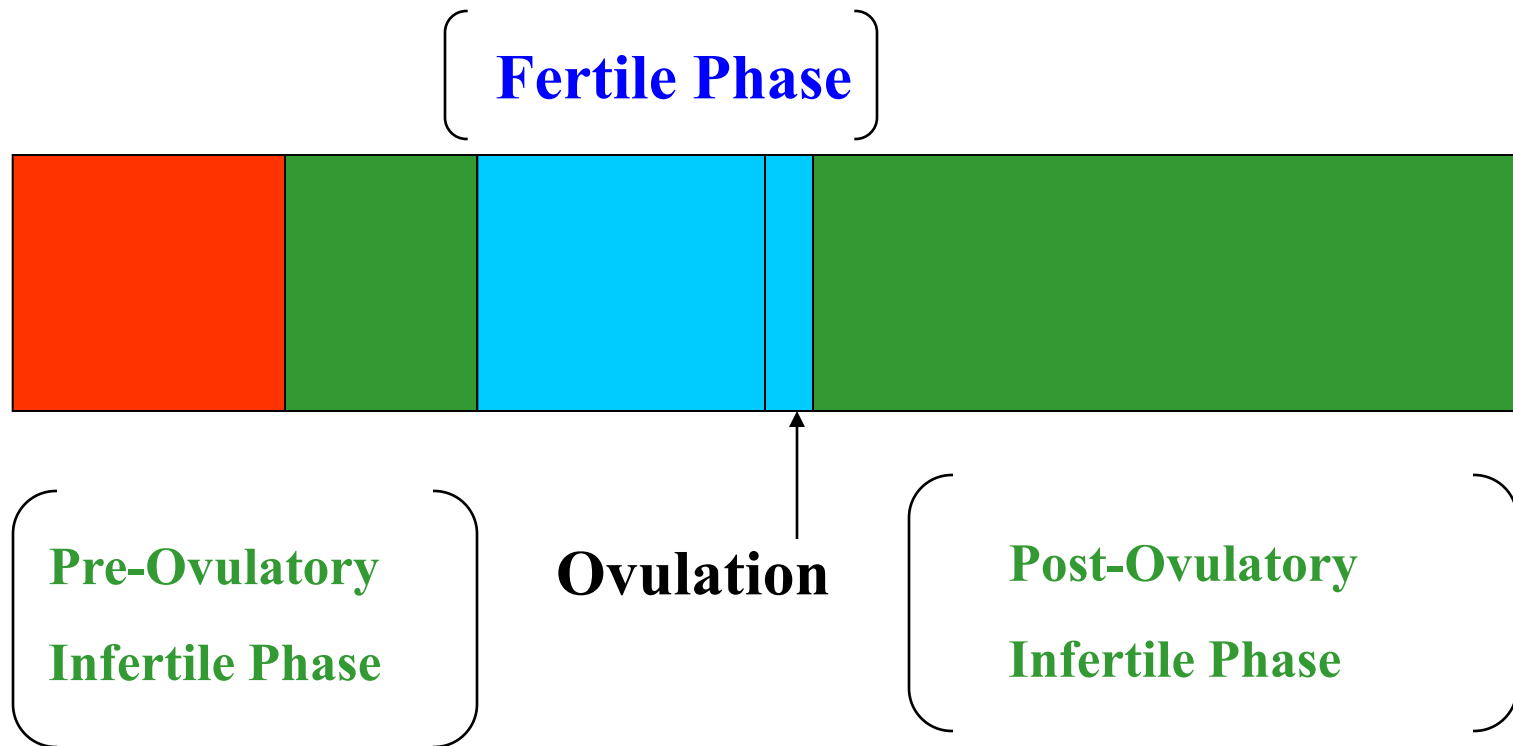
1. CALENDAR/RHYTHM
2. BASAL BODY TEMPERATURE
3. OVULATION METHOD
4. SYMPTO-THERMAL METHODS
5. HORMONAL MONITORING

How Does NFP Work?

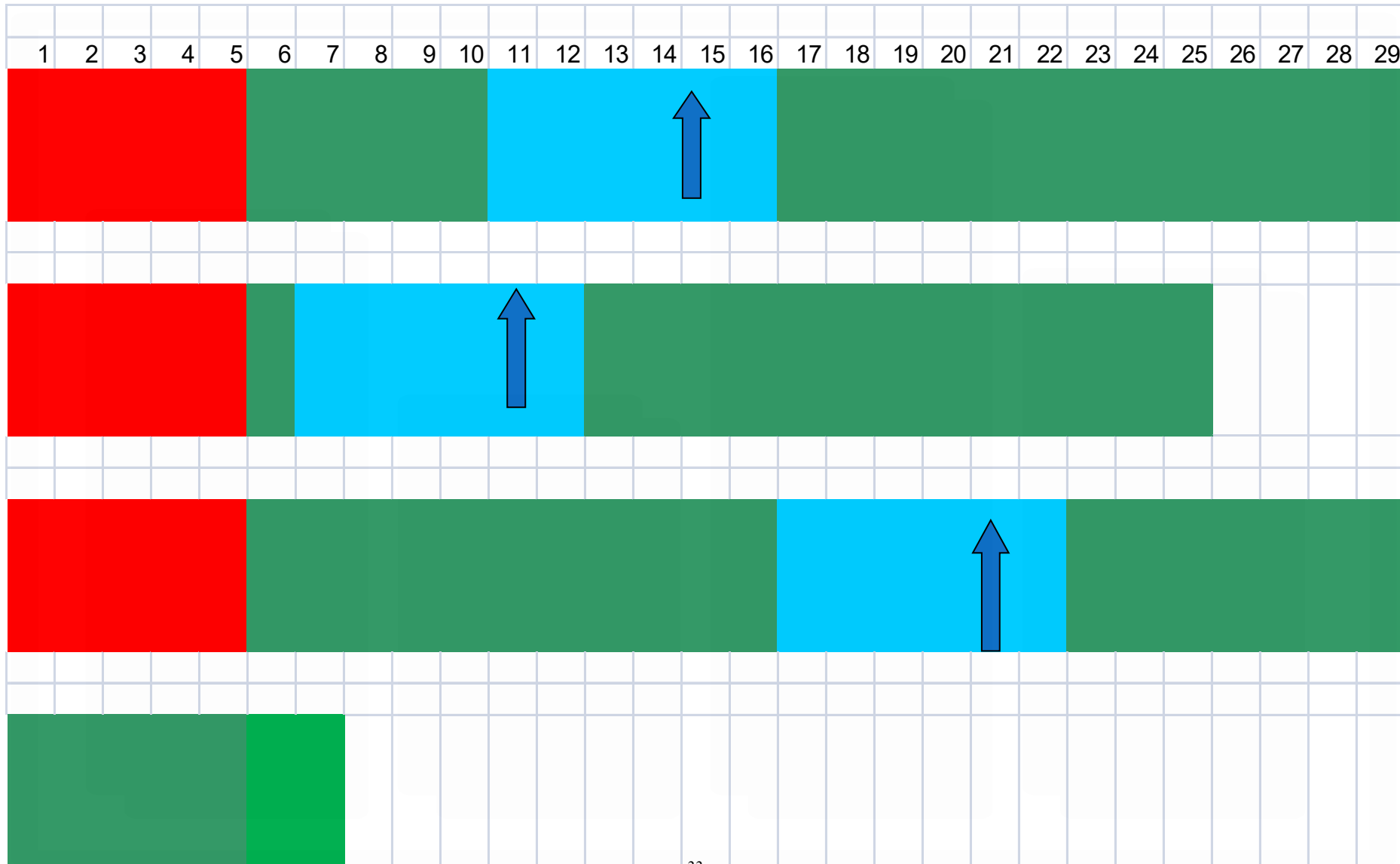
Six Day Fertile Window

- A man and woman together are fertile for only 6 days per month:
- The **day of ovulation** when an egg is released, AND the **5 days before ovulation!**

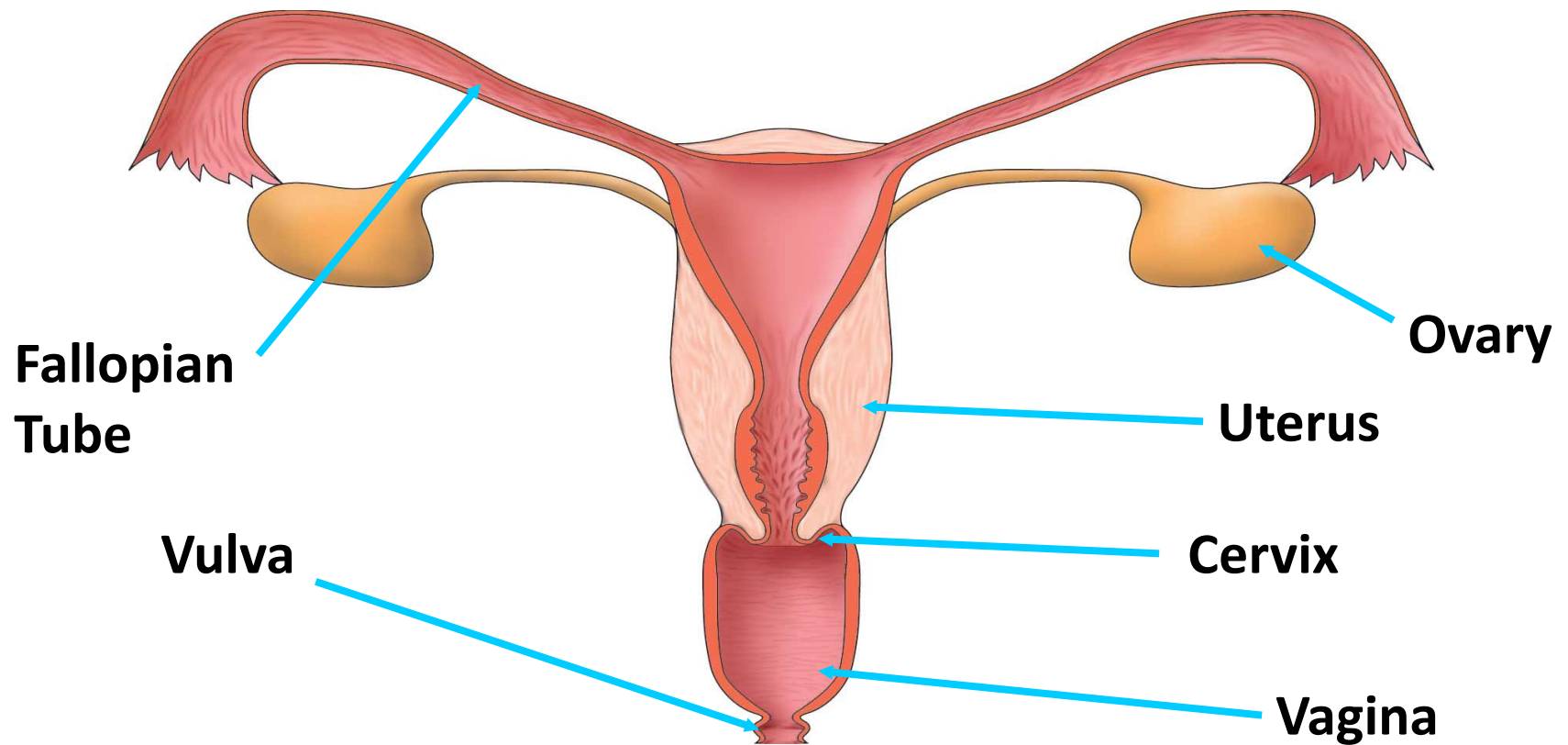
Phases of the Menstrual Cycle



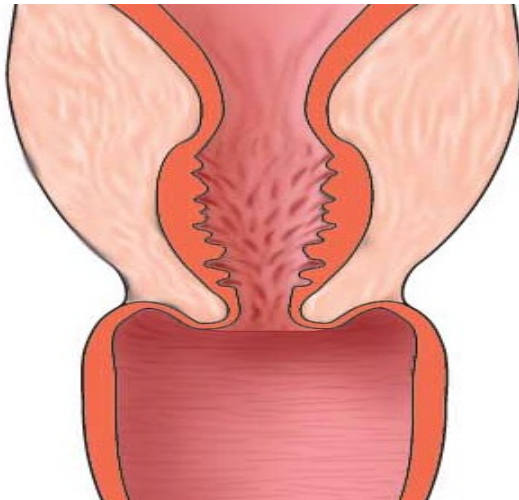
Variability of the Cycle



Female Anatomy: Front View



Female Cervix

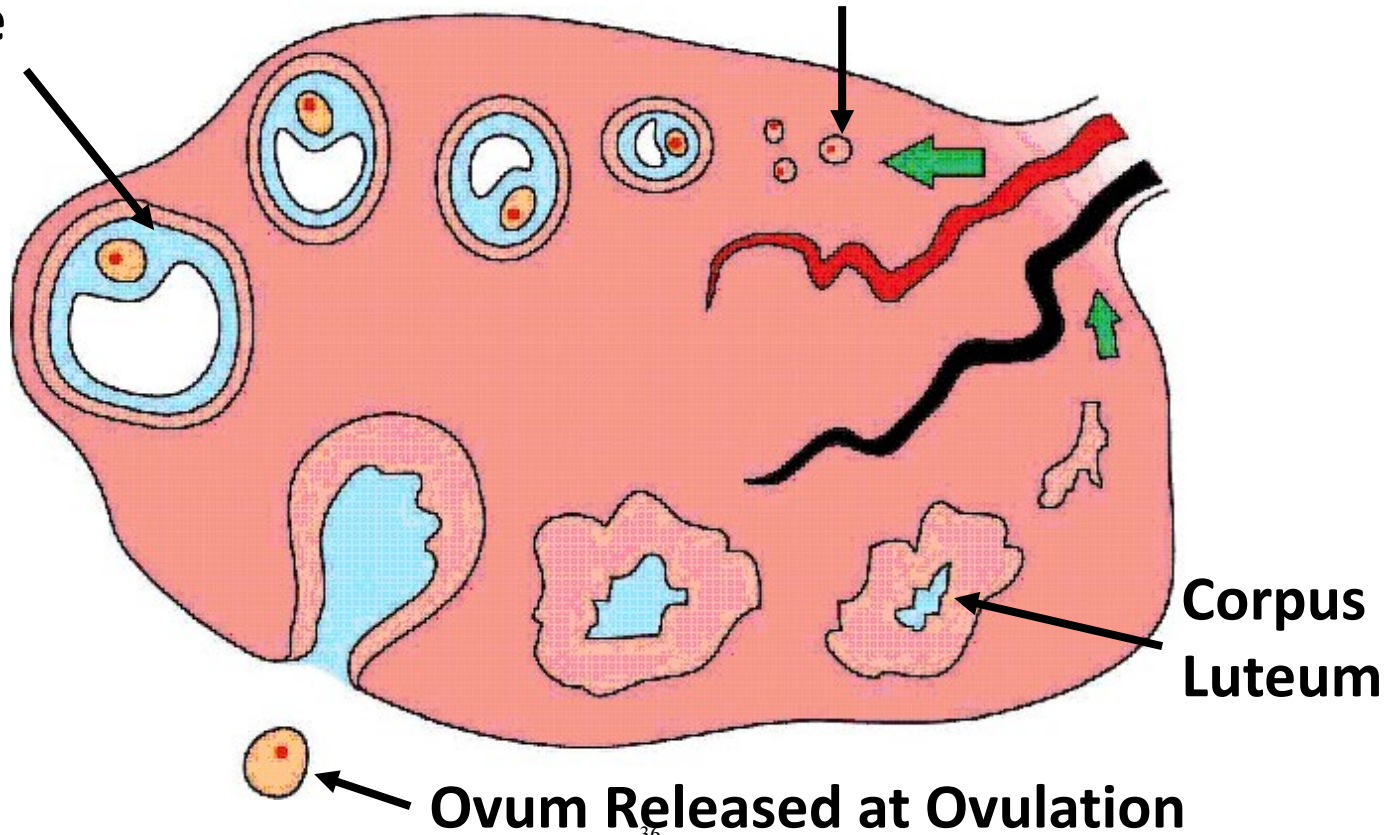


- Produces thin watery fertile mucus when stimulated by estrogen
- Sperm live in good mucus 3-5 days
- Produces thick mucus plug when stimulated by progesterone

Female Ovary

**Ovum (Egg) In Ripe
Follicle**

Developing Follicle



NFP measures:

- **Estrogen** - secreted by follicle
 - Stimulates cervical mucus production
- **LH** - secreted by pituitary
 - Stimulates ovulation
- **Progesterone** - secreted by corpus luteum
 - Raises basal body temperature
 - Dries cervical mucus

Natural Biological Signs of Fertility

- Calendar **Formulas**
- Changes in **Resting Body Temp**
- Changes in **Cervical Mucus**
- Changes in **Female Hormones**

Markers for the Beginning of Fertile Phase

- Presence of cervical mucus
- Rising levels of the hormone estrogen
- Shortest cycle minus 20 days; or day “8”

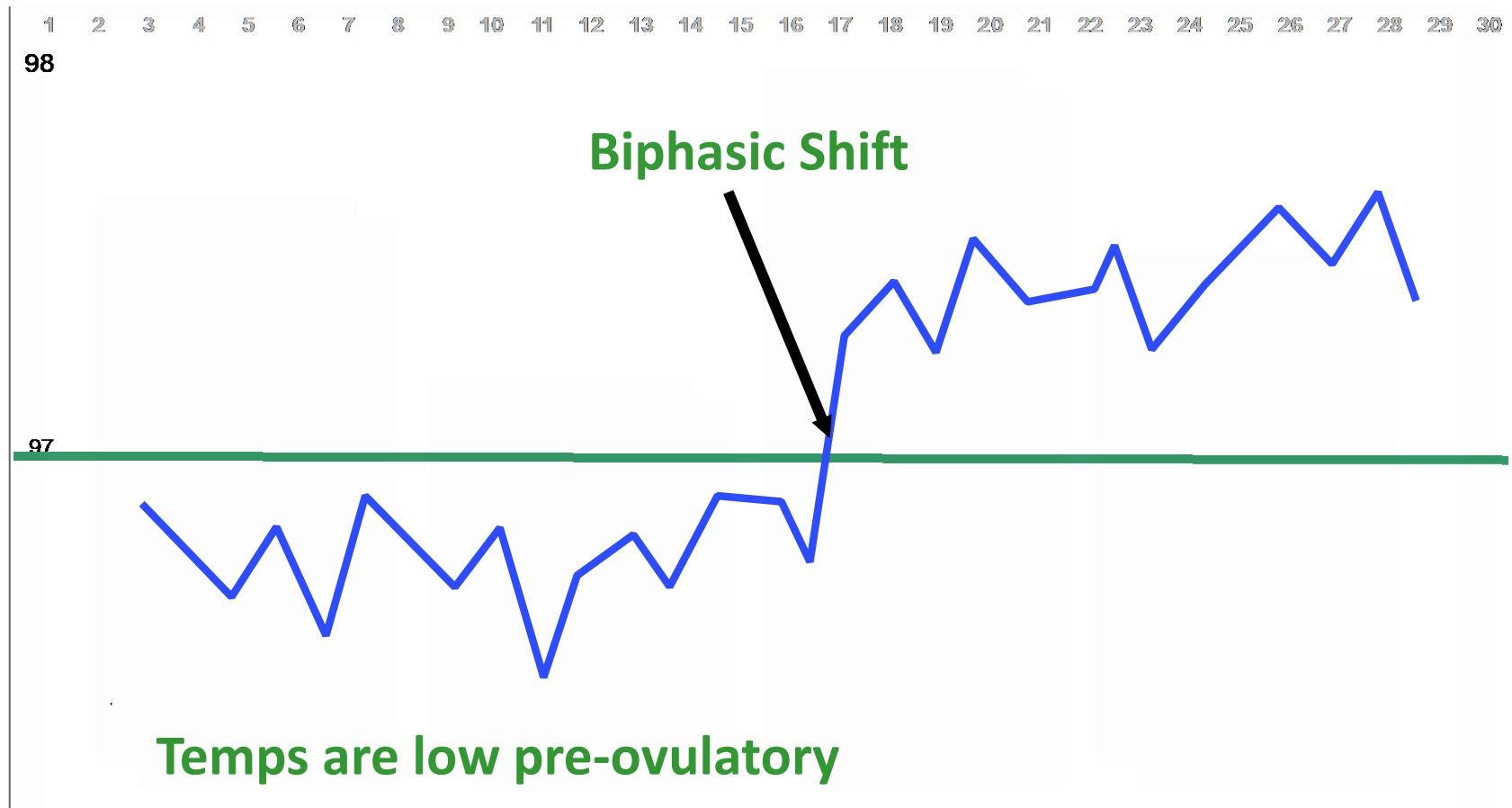
Markers of Peak Fertility

- Cervical mucus – clear, stretchy, slippery
- Rise in basal body temperature
- LH hormone peaks

Markers for the End of the Fertile Phase

- Peak in cervical mucus plus count of 3
- Rise in temperature plus count of 3
- Peak in LH plus count of 3
- Longest cycle minus 10 days; or day “19”
- Positive progesterone test past Peak LH or Peak Mucus

The BBT Chart

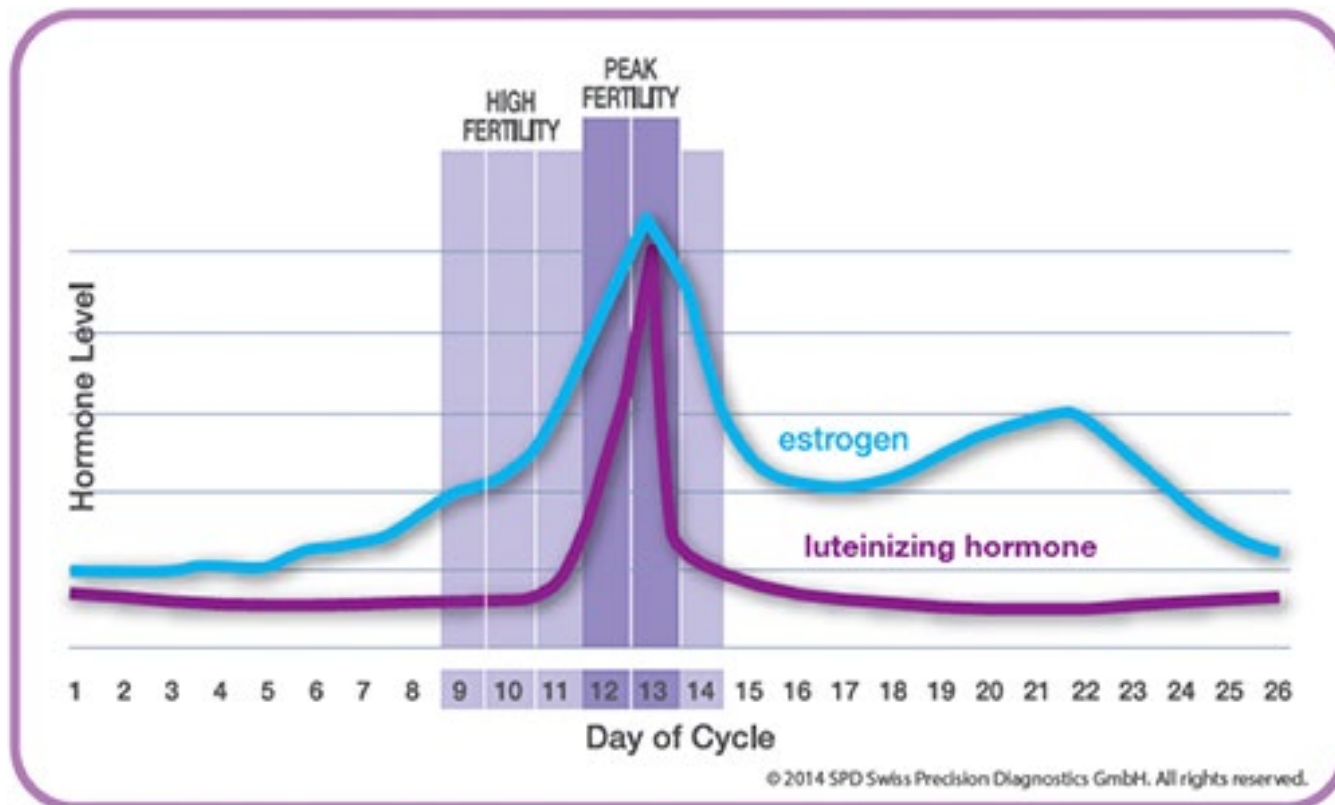


Clearblue Fertility Monitor (CBFM)



- A hand-held digital monitor
- Measures levels of estrogen and LH in the urine
- Provides a reading of “**low**”, “**high**”, or “**peak**” of fertility
- It has been successfully incorporated into NFP with good results
- Cost: \$150 for the monitor and about \$30 on test strips monthly

Clearblue Hormones



Basic Instructions for Achieving and Avoiding Pregnancy

- **Achieve** - Have intercourse during the fertile window!
- **Avoid** – Don't have intercourse during the fertile window!

NFP Efficacy Studies

Terms

- ◎ The **perfect use** unintended pregnancy rate refers to those pregnancies that occur when the method is used consistently and according to instructions.
- ◎ The **typical use** unintended pregnancy rate includes the pregnancies that occur when users of the method take chances or misunderstand an instruction.

Classic and Recent NFP Efficacy Studies: Correct Use and Typical Efficacy Cumulative Pregnancy Rates* per 100 Women Over 12 Months of Use

Study/Year	Indicators	Length**	Perfect	Typical
WHO (1981)	BOM/Mucus	(25-32)	97	78
Howard, et al.(1999)	CrM/Mucus	(25-32)	100	86
Arevalo, et al.(2002)	Fixed Calendar	(26-32)	95	88
Arevalo, et al. (2004)	Mucus 2 Day	(13-42)	96	86
Frank-Hermann, et.al.(2007)	Mucus & Temp	(25-35)	99	93
Fehring, et al.(2007)	Mucus/EHFM***	(21-42)	98	87
Fehring, et al. (2008, 2009)	EHFM vs CrM	(21-42)	99	88/77
Fehring, et al. (2013)	MMII EHFM vs Mucus	(21-42)	100/98	93/81
Bouchard, et al.(2013)	MM Postpartum	Variable	98	88
Fehring, et al. (2014)	MM Perimenopaus	Variable	98	95
Fehring, et al. (2017)	MMI EHFM/PlusMucus	Variable	98	98/94

* Rate = percentage of women per 100 that did not have an unintended pregnancy.

** Range of length of menstrual cycles in study.

*** EHFM = electric hormonal fertility monitoring

Pregnancy rate per 100 users over one year by family planning method

	Perfect Use	Typical Use
<input type="checkbox"/> CHANCE	85	85
<input type="checkbox"/> SPERMICIDES	18	29
<input type="checkbox"/> WITHDRAWAL	4	27
<input type="checkbox"/> OVULATION METHOD	3	19(25)*
<input type="checkbox"/> CONDOMS	2	15
<input type="checkbox"/> SDM	5	12
<input type="checkbox"/> SYMPTOTHERMAL	0.4-2	2 - 11
<input type="checkbox"/> Marquette Method II	0.6-2	2 - 10
<input type="checkbox"/> PILL	0.3	8
<input type="checkbox"/> IUD	0.1	0.6

***Adapted from: Trussell J. Contraceptive failure in the United States. *Contraception*. 2010;70:89-96.**

Effectiveness of NFP

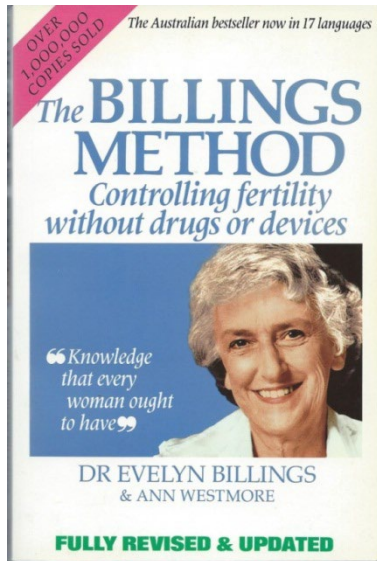
- With accurate charting
- Accurate observations
- Consistent use
- Mutual motivation and loving cooperation
- NFP is close to 98% effective!

Optimizing Fertility Through Use of NFP

- **Age:** A woman is most fertile in her early 20s. A woman in her 30s is 50% less fertile than in the 20s. Achieving pregnancy after the age of 43 is extremely difficult.
- **Fertile Window (FW):** The biological FW of the menstrual cycle is 6 days, the day of ovulation and the 5 preceding days. The most fertile days of the biological fertile window are the 2 days before the day of ovulation.
- **Focused Intercourse:** Electronic hormonal monitoring is the most accurate measure of the FW and has the best evidence for helping couples achieve a pregnancy with focused intercourse on the High and Peak days of fertility.
- Sarah Johnson, and Joseph B. Stanford, et al., (2020). Increased Likelihood of Pregnancy Using an App-Connected Ovulation Test System: A Randomized Controlled Trial. J Womens Health . January 2020; 29(1): 84–90.

Classic Methods of NFP

Billings Ovulation Method



- Cervical Mucus
- Perfect Use = 99 - 100%
- Typical Use = 89 - 99%

Representative Studies of the BOM

S Thapa, MV Wonga, PG Lampe, H Pitojo, A Soejoenoes. Efficacy of three variations of periodic abstinence for family planning in Indonesia. Studies in Family Planning, 21: 327-34, 1990.

JX Xu, JH Yan, DZ Fan, DW Zhang. Billings natural family planning in Shanghai, China.

Advances in Contraception, 10: 195-204, 1994.

Indian Council of Medical Research Task Force on NFP. Field Trial of the Billings Ovulation Method of a Natural Family Planning. Contraception 53: 69-74, 1996.

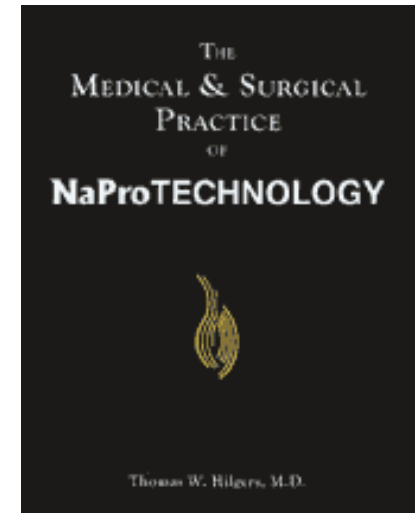
FEMM Medical Management



- Management of women's gyn health issues based on Billings Ovulation Method.
- Fertility awareness to achieve or avoid a pregnancy.

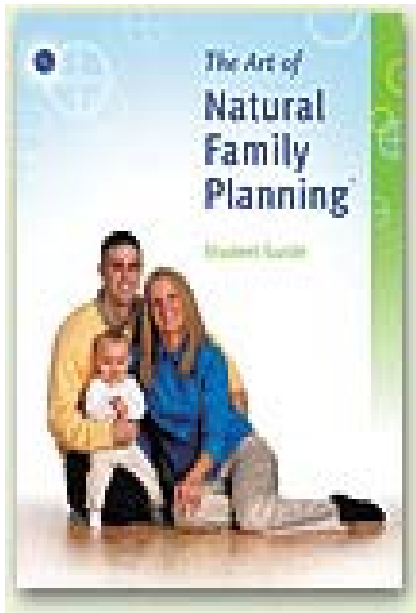
Creighton Model System (CrM)

- Standardized form of the Ovulation Method
- Basis for what is called NaProTechnology
- Correct Use = 99.9%
- Typical Use = 96.8%



Hilgers TW and Stanford JB: Creighton Model NaProEducation Technology for Avoiding Pregnancy: Use Effectiveness. J. Repro. Med. 43: 495-502, June, 1998.

Sympto-Thermal Methods: STM



Includes BBT, cervical mucus, and calendar formulas

- Provided by Couple to Couple League and Northwest Family Systems
- Correct Use = **99%**
- Typical Use = **85 – 94%**

Rice, FJ & Lanctot, C.A., Results of a Recent Study of the Sympto-Thermal Method of Natural Family Planning, Linacre Quarterly 45:4 (November, 1978), 388-391.

New Methods of NFP

Standard Days Method (SDM)



- Days 8 – 19 fertile
- Cycle length 26 – 32
- Correct Use = 95%
- Typical Use = 88%

Arevalo M, Jennings V, Sinai I. *Efficacy of a new method of family planning the Standard Days Method*. Contraception 2002;65:333-338. Search bar
www.naturalfp.com

Efficacy of the TwoDay Method

- Did I note any secretions today?
- Did I note any secretions yesterday?
- Correct = **96.5%**
- Typical = **86.3%**



Arevalo, M. et al., **Efficacy of a the new TwoDay method of family planning.** 2004 *Fertility and Sterility* 82(4): 885-92.

European Double Check



- Use of two indicators of fertility
- Basal body temperature and cervical mucus
- Correct = **99.4%**
- Typical = **98.2%**

Frank-Herrmann, P. et al., (2007). The effectiveness of a fertility awareness based method to avoid pregnancy in relation to a couple's sexual behaviour during the fertile time: a prospective longitudinal study. Human Reprod. 22(5):1310-9.

Marquette Method II and Lite

Not Pregnant Rates – Including Postpartum & Perimenopause



- Hormonal Monitoring
- Cervical mucus monitoring (CMM)
- Fertility Formula
- Correct use = 98 - 100%
- Typical use = 88 - 98%

Recent Effectiveness studies:

Fehring, Schneider, Bouchard, Postpartum Breastfeeding Effectiveness, *JOGNN*, 2017

Fehring, Schneider, Extended Use Effectiveness, *MCN*, 2017

Fehring, R., and Mu, Q. Efficacy among Perimenopause Age Women. *JOGNN*, 2014

Fehring, Schneider, Raviele, Randomized Comparison, *Contraception*, 2013.

Fehring, Schneider, Raviele, Internet Pilot Evaluation of MM, *JOGNN*, 2011.

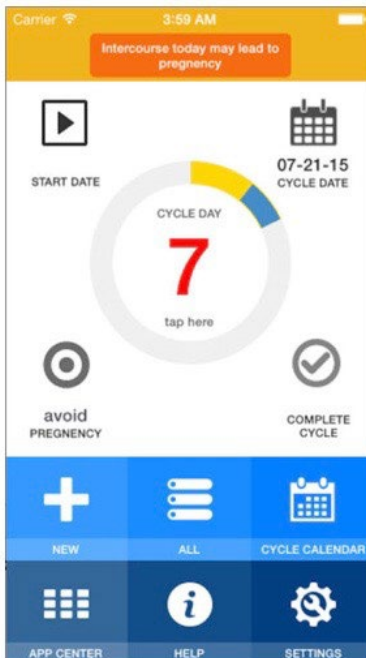
Couple to Couple League app





Marquette Fertility
Richard Fehring

OPEN



Carrier 4:10 AM

Back Create Cycle

May	19	2013
June	20	2014
July	21	2015
August	22	2016
September	23	2017

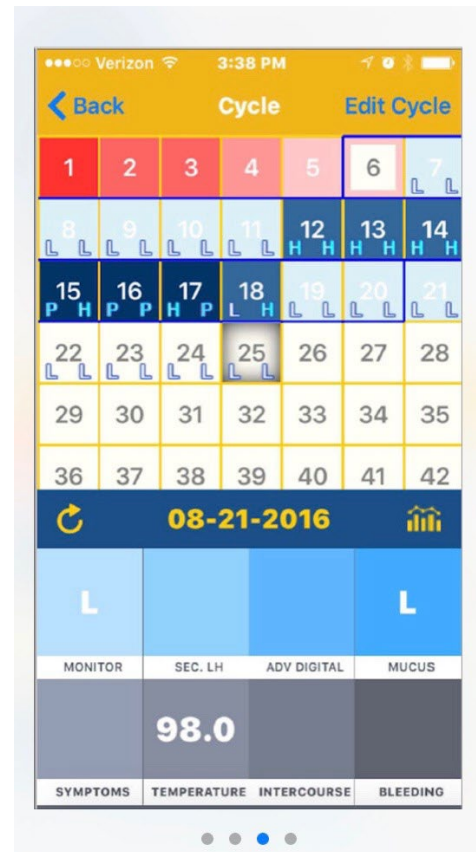
Couple Intension Recording

Avoid Achieve

Did you become Pregnant Before

Yes No

Create Cycle





Space Age NFP

The Next Advance in NFP is Quantitative Hormonal Monitoring

- Space Age NFP – 2020 Quantitative Measure
- Cell phone is measuring device and charting system in one.
- PROOV urine progesterone test
- MIRA monitors estrogen and LH levels
- PREMOM app graphing LH levels
- OOVA test strip for LH and progesterone levels

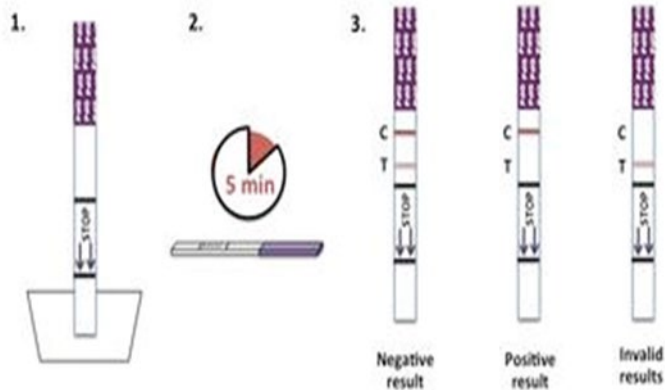
Hormonal Fertility Monitoring

PROOV

TEST PROCEDURE



Dip strip in urine sample for 5 seconds. Urine should not go past the STOP line. Remove from the urine and lay on flat surface. Read results in 5 minutes.



MIRA Fertility Monitor



Quantitative Fertility Monitors

OOVA Monitor



PREMOM Fertility Monitor System



NFP: Marriage and Family

Marriage is a Sacrament

- A sign of God's presence in the world
- A source of grace for the couple



God's Plan for Marriage

- Permanent, faithful, exclusive relationship between husband and wife
- Directed towards mutual sanctification, unity, parenthood, and harmony of life

Supported by secular studies: “ Why Marriage Matters, Third Edition” National Marriage Project, 2011.

Marital Act - Conjugal Act

- Fully Human
- Total
- Faithful
- Fruitful



Why NFP?

- Works with nature rather than against it
- Helps couples to live with their fertility
- Fertility is not a disease, infertility is
- Enables couple to be holistic, healthy and holy

Natural Family Planning



- Allows couples to respect the laws of nature
- Allows them to respect the law of God written on their hearts

Benefits of using NFP

- Understanding fertility
- Safe and healthy
- Communication
- Increased intimacy
- Increased self-mastery
- Sharing and generosity to life
- Fits with moral, ethical and spiritual beliefs

Fertility is a holy time

- NFP couples realize **AWESOMENESS** of the fertile time
- Possibility to be co-creators with **GOD**
- Possibility to create new **IMAGES OF GOD**



Deepening Conjugal Love



Couples who regulate their fertility by living NFP grow in personal dignity and enjoy a deepening of their conjugal love.

Natural Family Planning



“NFP strengthens conjugal love and helps to establish families in peace and security.”

Drs. John and Evelyn Billings



- **Grow in God's Love!**

Web Sites of NFP Programs

- Archdiocesan/Diocesan NFP Office
- Billings Ovulation Method <http://www.boma-usa.org>
- Couple to Couple League International (CCL) www.ccli.org
- FEMM <https://femmhealth.org>
- Georgetown University Institute for Reproductive Health
- <http://irh.org> (CycleBeads® and TwoDay® Method)
- Marquette University College of Nursing, Institute of NFP
- <http://nfp.marquette.edu> iPhone app: Marquette Fertility Tracker
- Pope Paul VI Reproductive Institute (FertilityCare™)
<http://www.popepaulvi.com>
- Symptopro™ Fertility Education <https://www.symptopro.org/>

NFP ACHIEVING PREGNANCY

Natural Family Planning methods can also be useful in helping couples achieve pregnancy, especially for those who are having difficulty doing so.¹ NFP helps couples to focus intercourse on the most fertile days of the menstrual cycle. NFP charting can also be useful in detecting fertility health problems. Recent studies have shown that the use of electronic hormonal fertility monitoring is more effective than random intercourse in achieving pregnancy.^{2,3}

NFP Teacher Training Programs

Following is the link to the listing of NFP teacher training programs that meet the Standards of Diocesan NFP Ministry as developed and approved by the United States Conference of Catholic Bishops.

<https://www.usccb.org/topics/natural-family-planning/nfp-national-providers>

Other Helpful Links

Why the Church Is Right About Life and Love

<https://www.ncregister.com/news/why-the-church-is-right-about-life-and-love>

Promoting Humanae Vitae and Natural Family Planning in the Parish by Janet E. Smith

https://www.lifeissues.net/writers/smith/smith_04hvandnfpinparishes.html

NFP Basic Information

<https://www.usccb.org/topics/natural-family-planning/nfp-basic-information>

Websites of Major NFP Programs

Following is list of websites of major NFP Programs.

Your Archdiocesan/Diocesan NFP Office

(For a listing of Archdiocesan/Diocesan websites, please follow the link below.)

<https://www.usccb.org/about/bishops-and-dioceses>

Billings Ovulation Method

<https://www.boma-usa.org/>

¹ R. Fehring & Q. Mu, “Cohort Efficacy Study of Natural Family Planning among Perimenopause Age Women.” *Journal of Obstetric, Gynecologic & Neonatal Nursing* 43(2014): 351-358.

² T.P. Bouchard, R. Fehring, and M. Schneider, M. “Achieving Pregnancy Using Primary Care Interventions to Identify the Fertile Window.” Vol. 4; January 18 (2018): 1-7.

³ S. Johnson and J. B. Stanford, et al., “Increased Likelihood of Pregnancy Using an App-Connected Ovulation Test System: A Randomized Controlled Trial.” *Journal of Womens Health* .January 2020; 29(1): 84–90.

Couple to Couple League International (CCL)

<https://ccli.org/>

FEMM™

<https://femmhealth.org>

**Georgetown University Institute for Reproductive Health
(CycleBeads® and TwoDay® Method)**

<https://irh.org>

Marquette University College of Nursing, Institute of NFP
<https://www.marquette.edu/nursing/natural-family-planning.php>

Pope Paul VI Reproductive Institute (FertilityCare™)

<https://popepaulvi.com/>

Symptopro™ Fertility Education

<https://symptopro.org/>



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DO YOU KNOW ROE?

Roe v. Doe legalized abortion through all nine months of pregnancy

Many people don't realize that *Roe v. Wade* legalized abortion through all nine months of pregnancy. *Roe* says abortions may not be restricted at all during the first three months and in the second three months may be regulated only for the mother's health.¹ After "viability"² *Roe* allows abortion to be prohibited but must make an exception for the woman's life or health.³

But in *Roe*'s companion case, *Doe v. Bolton*, the Court defined "health" to include "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being" of the mother.⁴ In most states, that is broad enough to permit virtually any abortion in the seventh, eighth, or ninth months of pregnancy⁵ if any of these reasons is invoked.⁶

If Roe is overturned, the democratic process—not the courts—will determine abortion policy

Before *Roe*, all states permitted abortion if necessary to save the mother's life, and some permitted abortion in additional circumstances.⁷ But *Roe* deemed any prohibition on abortion as unconstitutional.

¹ In the first trimester, "[T]he abortion decision . . . must be left to the medical judgment of the pregnant woman's attending physician." In the second trimester, the State may "regulate the abortion procedure in ways that are reasonably related to maternal health." *Roe v. Wade*, 410 U.S. 113 (1973) at 164.

² "[T]hat is, potentially able to live outside the mother's womb, albeit with artificial aid." *Roe*, at 160.

³ After viability, the State may "proscribe" abortion "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, at 164–65.

⁴ *Doe v. Bolton*, 410 U.S. 179 (1973) at 192. The "*Doe v. Bolton*...opinion and this one, of course, are to be read together." *Roe*, at 165.

⁵ In *Planned Parenthood v. Casey*, the Court abandoned the trimester framework but reaffirmed the legality of abortion "subsequent to viability" for the "preservation of the...health of the mother." 505 U.S. 833 (1992) at 879.

⁶ The Supreme Court, however, has yet to be confronted with a challenge to a post-viability ban that will test *Doe*'s breadth. Indeed, 20 states currently ban late-term abortions subject to a narrow exception for the mother's life or physical health (not for emotional, psychological, familial, or age-related reasons). Most of these laws have gone unchallenged, but they are hard to enforce even if they are constitutionally permissible.

⁷ Paul Benjamin Linton, "Planned Parenthood v. Casey: The Flight from Reason in the Supreme Court," *Saint Louis University Public Law Review* 13, no. 1 (1993): 24–26.

If Roe is overturned, policy decisions about abortion will be made by the citizens of each state through the democratic process, rather than by courts. Some states will place limits on abortion, in others there will likely be few limits.⁸

Not until Roe v. Wade is reversed will the people again be able to govern themselves on the important public policy issue of abortion.

Abortion is not health care

Abortion advocates speak as if abortion is health care, a procedure that is morally and emotionally equivalent to surgically removing one's tonsils or appendix. It is often conveyed as so morally neutral that only a few religious outliers find it objectionable. Yet in reality, the vast majority, over 85%, of OB/GYNs, coming from many faiths or no faith refuse to be associated with or perform an abortion.⁹ In addition, according to the pro-abortion Guttmacher Institute, 86% of hospitals were not involved in abortion.¹⁰ Finally, even Roe acknowledges that abortion is unlike other procedures performed by a health professional and that unborn children deserve some protection.¹¹ Abortion is not health care and we do a disservice to women and health care providers to pretend it is.

Roe's extreme abortion license is not widely supported

Abortion advocates claim that Roe enjoys broad public support and some recent polls seem to provide evidence for this claim. But most polls don't explain Roe's extreme abortion license and some misrepresent it. For example, a 2016 Pew Research Center poll claims 69% of Americans favor Roe v. Wade and 28% oppose it.¹² But the poll wrongly describes Roe as establishing "a woman's constitutional right to an abortion, at least in the first three months of pregnancy." The fact is, Roe made abortion legal through all 9 months of pregnancy and for virtually any reason.¹³

The vast majority of Americans oppose the policy of nearly unlimited abortion dictated by Roe, and most believe abortion should not be legal for the reasons it is most often performed. A May 2018 Gallup poll shows that 65% of Americans said abortion should be illegal in the second trimester and 81% said

⁸ Benjamin Wittes, "Letting Go of Roe," The Atlantic Monthly, January/February 2005, 48.

⁹ Debra B. Stulberg, et al., "Abortion Provision Among Practicing Obstetrician-Gynecologists," Obstetrics and Gynecology, 118, no. 3 (September 2011): 609-614.

Visit: https://journals.lww.com/greenjournal/Fulltext/2011/09000/Abortion_Provision_Among_Practicing.16.aspx.

¹⁰ Stanley K Henshaw, "Abortion Incidence and Services in the United States, 1995–1996," Perspectives on Sexual & Reproductive Health 30, no. 6 (November/December 1998): 263-70.

Visit: <https://www.guttmacher.org/journals/psrh/1998/11/abortion-incidence-and-services-united-states-1995-1996>.

¹¹ "[T]he right of privacy, however based, is broad enough to cover the abortion decision; that the right, nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to protection of health, medical standards, and prenatal life, become dominant....The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus...*The situation therefore is inherently different* from [other situations where the Court has recognized a constitutional right of privacy, such as] marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education." (Emphasis added) Roe, at 155 and 159.

¹² Pew Research Center, "Low Approval of Trump's Transition but Outlook for His Presidency Improves" (December 2016), Q.96F1, p 71. Visit: <file:///C:/Users/Catholic%20Medical/Downloads/12-08-16-December-political-release.pdf>

¹³ See supra notes 1-5.

abortion should be illegal in the last trimester.¹⁴ A 2018 Marist poll shows that 51% of women said abortion should never be permitted (9%) or permitted only in cases of rape, incest, and to save the woman's life (42%).¹⁵

So why do polls show a majority of Americans favoring *Roe v. Wade*? Because they don't really know what *Roe* did.

Roe is bad constitutional law

Even legal experts who support abortion believe *Roe* is not well-reasoned and is a case of extreme judicial overreach.

- The late Yale Law Professor John Hart Ely said, *Roe v. Wade* is “a very bad decision . . . because it is not constitutional law and gives almost no sense of an obligation to try to be.”¹⁶
- Attorney Edward Lazarus, former law clerk to *Roe*'s author, Justice Blackmun, put it this way: “As a matter of constitutional interpretation and judicial method, *Roe* borders on the indefensible . . . [It is] one of the most intellectually suspect constitutional decisions of the modern era.”¹⁷
- Harvard Law Professor Lawrence Tribe criticized *Roe* saying, “behind its own verbal smokescreen, the substantive judgment on which it rests is nowhere to be found.”¹⁸
- Justice Sandra Day O'Connor said, “The Court's abortion decisions have already worked a major distortion in the Court's Constitutional jurisprudence...no legal rule or doctrine is safe from ad hoc nullification by this Court.”¹⁹
- And then-Circuit Judge (now Justice) Ruth Bader Ginsburg said *Roe* “ventured too far in the change it ordered and presented an incomplete justification for its action.”²⁰

¹⁴ Gallup News Service, “Gallup Poll Social Series: Values and Beliefs” (May 1-10, 2018), Q.15.
Visit: <https://news.gallup.com/file/poll/235634/180613AbortionTrimesters.pdf>.

¹⁵ Knights of Columbus/Marist Poll, “Abortion Limits Favored,” (January 2018).
Visit: <http://www.kofc.org/un/en/resources/communications/kofc-marist-poll-national-nature-sample-tables2017.pdf>.

¹⁶ John Hart Ely, “The Wages of Crying Wolf: A Comment on *Roe v. Wade*,” *Yale Law Journal* 82, no. 5 (April 1973): 947,
Visit: <https://pdfs.semanticscholar.org/57de/57a09824f1bdca05e47c898a46e717618d23.pdf>.

¹⁷ Edward Lazarus, “The Lingering Problems with *Roe v. Wade*, and Why the Recent Senate Hearings on Michael McConnell's Nomination Only Underlined Them,” *FindLaw*, October 3, 2002.
Visit: <https://supreme.findlaw.com/legal-commentary/the-lingering-problems-with-roe-v-wade-and-why-the-recent-senate-hearings-on-michael-mcconnells-nomination-only-underlined-them.html>.

¹⁸ Lawrence H. Tribe, “Foreword: Toward a Model of Roles in the Due Process of Life and Law,” *Harvard Law Review*, 87, no. 1, (Nov. 1973): 7.

¹⁹ *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986) (O'Connor dissenting), at 814.

²⁰ Ruth Bader Ginsburg, “Some Thoughts on Autonomy and Equality in Relation to *Roe v. Wade*,” 63 *North Carolina Law Review* 63, no. 2 (January 1985): 376, <http://scholarship.law.unc.edu/cgi/viewcontent.cgi?article=2961&context=nclr>.

When experts on both sides of the abortion debate agree that Roe is bad law, reversing it makes good legal sense and would return abortion policy back to the people to be decided through the democratic process.

Pro-life laws can and do reduce the abortion rate

Most people on both sides of the abortion debate agree that reducing the number of abortions is a desirable outcome. While some argue that contraception is the key to reducing the abortion rate, real-world evidence does not back that up. Instead, research shows that even when women were provided with free “emergency contraception” ahead of time, the pregnancy and abortion rate remained statistically equivalent with those who were not provided with it.²¹ In fact, the availability of contraception and abortion can increase the rate of unintended pregnancies (as well as sexually transmitted infections) as studies show that people engage in more frequent and riskier behavior if they believe their risk has been lowered.²² On the other hand, evidence suggests that laws restricting the funding of abortion (like the Hyde amendment preventing Medicaid funds from going to abortion) or limiting its availability, involving parents, and providing women with more information lower the rate of abortion.²³ Unfortunately, Roe, its companion case Doe, and some subsequent rulings have been used to invalidate many laws meant to lower the rate of abortion.

Abortion fails women

Abortion is often portrayed as essential for women to achieve freedom and equality with men, yet many report feeling some degree of pressure or aborting to please someone else—often their partner.²⁴ Further, after the abortion, many women report feelings of depression, suicidal or self-harm inclinations, sadness, shame, and regret.²⁵ For example, Cynthia Carney in an amicus brief submitted to the Supreme Court described the aftermath of her abortion saying, “For 23 years, I went into crying spells, depression, suicidal thoughts. Emotionally it devastated me.” Camelia Murphy explained, “I have suffered with low self-esteem, self-hatred, suicidal impulses, constant anxiety (especially about sex and about making decisions).” Donna Razin said that her abortion caused her “[d]eep regret—initially I was suicidal—as

²¹ United States Conference of Catholic Bishops, “Fact Sheet: Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion,” June 5, 2014, (citing authority).

Visit: <https://www.usccb.org/issues-and-action/human-life-and-dignity/contraception/fact-sheets/upload/contrafactsheet.pdf>

²² For more information, see USCCB fact sheets: “Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion,” and “Greater Access to Contraceptives Does Not Reduce Abortions,” March 17, 2011.

Visit: <https://www.usccb.org/resources/fact-sheet-greater-access-contraception-does-not-reduce-abortions>

²³ Michael J New, “Analyzing the Effect of Anti-Abortion US State Legislation in the Post-Casey Era,” *State Politics and Policy Quarterly* 11, no. 1 (March 2011), 42.

Visit: <https://journals.sagepub.com/doi/abs/10.1177/1532440010387397>

²⁴ Priscilla Coleman, et al., “Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences” *Journal of American Physicians and Surgeons* 22, no. 4 (Winter 2017), 115.

Visit: <https://www.jpands.org/vol22no4/coleman.pdf>

²⁵ Brief of Sandra Cano, the former “Mary Doe” of Doe v. Bolton, and 180 women injured by abortion as Amici Curiae in support of Petitioner. *Gonzales v. Carhart*, 550 U.S. 124 (2007) (Nos. 05-380, 05-1382).

Visit: <https://thejusticefoundation.org/wp-content/uploads/2011/10/Gonzales-v.-Carhart-Amicus-Brief-Excerpts.pdf>

the years have progressed I have developed a heightened level of bitterness and anger and self-hate.”²⁶ Women would be better served if society tried to creatively answer the needs of single mothers, mothers trying to get through school, mothers needing higher or more stable finances, etc. rather than telling them that the death of their children is the best answer. We can and should do better for all women.

Abortion stops a beating heart

Abortion advocates usually refer to the human being growing in her/his mother’s womb in dehumanizing terms like “product of conception” and suggest that most abortions are done before fetal organs are functioning.

Actually, the vast majority are done after the fetal heart has begun beating. A baby’s heart begins to beat at about 21 or 22 days after fertilization.²⁷ That’s at about 3 weeks of development. The vast majority of abortions in the United States are done well after this point.²⁸

Chief strategist for legalizing abortion lied about deaths from illegal abortions

Claims that thousands of women were dying from illegal abortions at the time of Roe were fabricated for political purposes. The late Dr. Bernard Nathanson, a chief strategist for legalizing

abortion, said he and his associates invented the “nice, round shocking figure” of “5,000 to 10,000 deaths a year” from illegal abortions:

I confess that I knew the figures were totally false, and I suppose the others did too if they stopped to think of it. But in the “morality” of our revolution, it was a useful figure, widely accepted, so why go out of our way to correct it with honest statistics?²⁹

Research confirms that the actual number of maternal deaths resulting from abortion in the 25 years prior to 1973 averaged 250 a year, with a high of 388 in 1948.³⁰ In 1966, before the first state legalized abortion, 120 mothers died from abortion.³¹ While any death is a tragedy, by 1972, when abortion was still illegal in 80 percent of the country, the number dropped to 39 maternal deaths from abortion.³²

²⁶ “Brief of Sandra Cano, the former ‘Mary Doe’ of Doe v. Bolton, and 180 women injured by abortion as Amici Curiae in support of Petitioner,” *Gonzales v. Carhart*, 550 U.S. 124 (2007), 22–24.

Visit: <https://thejusticefoundation.org/wp-content/uploads/2011/10/Gonzales-v.-Carhart-Amicus-Brief-Excerpts.pdf>

²⁷ Keith L. Moore and T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology*, 7th ed. (Philadelphia: W.B. Saunders Co., 2003), 330.

²⁸ 60% are done after the 6th week of “gestational age” counting from the last menstrual period, or the 4th week of development. Tara C. Jatlaoui, et al., “Abortion Surveillance - United States, 2014,” *Morbidity and Mortality Weekly Report, Surveillance Summaries* 66, no. 24 (2017), 1-48.

²⁹ Bernard Nathanson, *Aborting America* (New York: Doubleday, 1979), 193.

³⁰ *Ibid.*, 42.

³¹ From the U.S. Bureau of Vital Statistics Center for Disease Control, as cited in Dr. and Mrs. J. C. Wilke, *Abortion: Questions and Answers*, revised edition (Cincinnati: Hayes Publishing, 1990), 169.

³² *Ibid.*

Furthermore, a groundbreaking 2012 study of abortion in Chile published in a peer-reviewed scientific journal found that Chile's abortion prohibition in 1989 did not cause an increase in the maternal mortality rate (MMR). On the contrary, after abortion was prohibited, the MMR decreased by 69.2% in the following fourteen years.³³

³³ Elard Koch, et al., "Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007," PLoS ONE 7, no. 5 (May 2012).
Visit: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0036613>



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PLANNED PARENTHOOD: SETTING THE RECORD STRAIGHT

In 2015, a series of undercover videos showed officials of the Planned Parenthood Federation of America (PPFA) discussing how they perform abortions and traffic in the tissues and organs of abortion victims. The officials' matter-of-fact comments on destroying unborn human life, and on altering abortion methods to obtain more "intact" organs, have led to a public debate on Planned Parenthood's role as a "women's health" organization receiving large government subsidies. Here are key facts.

1. PPFA is the largest abortion provider in the U.S.

In 2015-2016, the last year reported, Planned Parenthood affiliates performed 328,348 abortions, both surgical and "medical" (using the abortion drug RU-486).¹ PPFA's share of the abortion "market" has expanded steadily over the years: It performed about one in five of all abortions in the United States in 2005, but now performs over a third.²

2. Every Planned Parenthood affiliate must perform abortions.

In 2010, PPFA announced that by 2013 every affiliate must have one or more clinics that perform abortions on-site. A few affiliates left PPFA rather than comply with the new abortion mandate.³ In a fundraising email, PPFA's CEO Cecile Richards said it would be "obscene and insulting" to discontinue its abortion business in order to continue receiving taxpayer funding.⁴

3. Planned Parenthood provides almost 26 times more abortions than birth-oriented services.

While PPFA says abortions make up 3% of its services, this is misleading. PPFA says it served 2.4 million patients (women and men) and performed 328,348 abortions, indicating that nearly 14% of everyone entering a Planned Parenthood clinic receives an abortion. And PPFA provided only 9,419

¹ Planned Parenthood Federation of America, 2015-2016 Annual Report (henceforth 2015-2016 Report), p. 25.

Visit: https://www.plannedparenthood.org/uploads/filer_public/18/40/1840b04b-55d3-4c00-959d-11817023ffc8/20170526_annualreport_p02_singles.pdf. This and all online sources were accessed in July 2017.

² Planned Parenthood Federation of America, 2005-2006 Annual Report (henceforth 2005-2006 Report), p. 4, at <http://liveaction.org/research/wp-content/uploads/2011/06/2005-2006-Planned-Parenthood-Annual-Report.pdf>; R. Jones et al., "Abortion in the United States: Incidence and Access to Services, 2005," 40(1) Perspectives on Sexual and Reproductive Health (March 2008), p. 6, at <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/4000608.pdf>; R. Jones and J. Jerman, "Abortion Incidence and Service Availability in the United States, 2014," 49(1) Perspectives on Sexual and Reproductive Health, March 2017, p. 17, at <https://www.guttmacher.org/journals/psrh/2017/01/abortion-incidence-and-service-availability-united-states-2014> ("In 2014, an estimated 926,200 abortions were performed in the United States.").

³ M. Johnson, "Abortion mandate costs Planned Parenthood a few affiliates," NBC News, Dec. 6, 2012 at <https://usnews.newsvine.com/news/2012/12/06/15702142-abortion-mandate-costs-planned-parenthood-a-few-affiliates>.

⁴ Steven Ertelt, "Cecile Richards: It's 'Obscene and Insulting' to Suggest We Stop Killing Babies in Abortions," LifeNews.com, March 13, 2017. Visit: <https://www.lifenews.com/2017/03/13/cecile-richards-its-obscene-and-insulting-to-suggest-we-stop-killing-babies-in-abortions/>

“prenatal services” (down from 17,610 in 2014) and 2,889 referrals for adoptions at other agencies. So 96% of its services for pregnant women are abortions, outnumbering other options over 26 to 1.⁵

4. Planned Parenthood promotes risky RU-486 abortions that have killed young women.

PPFA strongly supports the dangerous abortion drug RU-486, promoted its expedited approval by the FDA, and volunteered to conduct early U.S. trials. In early trials, young Californians Holly Patterson and Vivian Tran died from infections after RU-486 abortions at Planned Parenthood clinics.⁶ In April 2011, the FDA reported 2,207 adverse events up to that time, including 14 deaths, 339 cases of blood loss requiring transfusions, and (in addition to deaths) 612 hospitalizations.⁷ Actual figures are likely higher, as the FDA doesn't mandate reporting by providers. PPFA clinics flouted FDA protocols by, among other things, using RU-486 “off-label” for abortions up to 63 days after a woman's last menstrual period (two weeks later than the FDA found safe). When Ohio passed a law requiring clinics to follow FDA guidelines, Planned Parenthood sued to tie up the law in court; public data later showed 42 botched RU-486 abortions in Ohio, including 35 women who had to return for a surgical abortion.⁸ Despite these deaths and other adverse events, in 2016 the Obama administration changed the FDA protocol to match what PPFA had been doing without authorization.⁹

5. Planned Parenthood fights even modest laws to reduce or regulate abortions.

PPFA has opposed, and filed suit against, reasonable and widely supported measures on abortion, even those protecting women's health and informed decision making. These include:

- laws to ensure a woman's informed consent, allow her to view an ultrasound before the abortion, or provide a 24-hour waiting period for her to consider her decision
- parental notification or consent before a minor daughter's abortion
- bans on the gruesome partial-birth abortion procedure
- health and safety regulations for abortion facilities
- requiring abortion practitioners to have admitting privileges at a local hospital in case of complications

⁵ 2015-2016 Report, p. 2 (2.4 million patients), p. 23 (claim of 3%), and p. 25 (number of abortions and other services for pregnant women). Cf. 2005-2006 Report, p. 4.

⁶ S. Russell, “Taker of abortion pill died due to infection,” San Francisco Chronicle, Nov. 1, 2003 at <https://www.sfgate.com/health/article/Taker-of-abortion-pill-died-due-to-infection-2551286.php>; J. Muir, “Suit links death to ‘abortion pill’,” The Orange County Register, Oct. 7, 2005, at <https://www.ocregister.com/2005/10/07/suit-links-death-to-abortion-pill/>

⁷ See Food and Drug Administration, “Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011,” at <https://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf>.

⁸ Supreme Court of Ohio Case Summaries, “State Law Restricts Administration of Abortion Drug to FDA-Approved Gestational Limit, Delivery Protocol,” July 1, 2009 at <https://www.sconet.state.oh.us/PIO/summaries/2009/0701/081234.asp>; Ohio Right to Life press release, “Botched RU 486 Abortions Injure 42 Women in Ohio as Planned Parenthood Defies FDA,” August 22, 2013, at www.lifenews.com/2013/08/22/botched-ru-486-abortions-injure-42-women-in-ohio-as-planned-parenthood-defies-fda.

⁹ C. Gacek and A. Grossu, “Issue Brief: The FDA Adopts the Abortion Industry Standards for the Mifeprex® (RU-486) Abortion Regimen,” Family Research Council, April 2016, at <http://downloads.frc.org/EF/EF16D38.pdf>.

- safety standards for the abortion drug RU-486.¹⁰

6. Planned Parenthood doesn't believe in a “right to choose” against abortion.

“Freedom of choice” does not apply to those who disagree with PPFA. It opposes laws recognizing conscience rights for doctors, nurses and health facilities with moral or religious objections to abortion, dismissively referring to conscience clauses as “refusal clauses.”¹¹ Planned Parenthood strongly supports U.S. funding of the U.N. Population Fund (UNFPA); in recent years it has announced “a new level of partnership” with that agency internationally, despite its involvement in the Chinese population program using coerced abortion and involuntary sterilization.¹² Such coercion is recognized internationally as a crime against women.¹³ PPFA also opposes conscience rights for pharmacists who object to providing “emergency contraception” drugs due to their abortifacient potential, and thinks even religious orders like the Little Sisters of the Poor should be forced to include these in their health plans.¹⁴

7. Planned Parenthood is not “pro-choice” for women.

In light of the failure of contraceptive programs to reduce unintended pregnancies or abortions, Planned Parenthood has increasingly promoted “LARCs” (long-acting reversible contraceptives)—implantables, injectables, and intrauterine devices—that can sterilize women for months or years at

¹⁰ Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016)(admitting privileges, safety regulations); Planned Parenthood v. Commissioner, 64 F.Supp.3d 1235 (S.D. Ind. 2014) (safety requirements); Planned Parenthood v. Abbott, 748 F.3d 583 (5th Cir. 2014) (admitting privileges, RU-486); Stuart & Planned Parenthood v. Camnitz, 774 F.3d 238 (4th Cir. 2014) (ultrasound); Planned Parenthood v. DeWine, 64 F.Supp.3d 1060 (S.D. Ohio 2014) (RU-486); Planned Parenthood v. Strange, 33 F.Supp.3d 1330 (M.D. Ala. 2014) (admitting privileges); Planned Parenthood v. Humble, 753 F.3d 905 (9th Cir. 2014) (RU-486); Comprehensive Health of Planned Parenthood v. Templeton, 954 F.Supp.2d 1205 (D. Kan. 2013) (informed consent); Planned Parenthood v. Van Hollen, 738 F.3d 786 (7th Cir. 2013) (admitting privileges); Planned Parenthood v. Dugaard, 799 F.Supp.2d 1048 (D. S.D. 2011) (informed consent); Planned Parenthood v. Rounds, 686 F.3d 889 (8th Cir. 2012) (informed consent); Gonzales v. Planned Parenthood, 550 U.S. 124 (2007) (partial-birth abortion); Ayotte v. Planned Parenthood, 546 U.S. 320 (2006) (parental involvement); Planned Parenthood v. Casey, 505 U.S. 833 (1992) (waiting period); Planned Parenthood v. Ashcroft, 462 U.S. 476 (1983) (parental involvement).

¹¹ ACLU (with PPFA as signatory), “Coalition Sign On Letter to Congress Urging Title X National Family Planning Program Support” (undated).

Visit: <https://www.aclu.org/letter/coalition-sign-letter-congress-urging-title-x-national-family-planning-program-support>.

¹² PPFA news release, “Planned Parenthood Condemns Vote to Eliminate Funding for UNFPA in House Foreign Affairs Committee,” January 30, 2014, at <https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-condemns-vote-eliminate-funding-unfpa-house-foreign-affairs-committee>; International Planned Parenthood Federation, “New IPPF/UNFPA Initiative on Family Planning announced,” May 29, 2013.

Visit: <https://www.ippf.org/news/New-IPPFUNFPA-Initiative-Family-Planning-announced>.

¹³ Chris Smith, “China’s One-Child Policy: Massive Crimes against Women, Supported by the Obama Administration,” The Public Discourse, Oct. 20, 2014, at <http://www.thepublicdiscourse.com/2014/10/13942/>.

¹⁴ PPFA, “Emergency Contraception: History and Access,” August 2013.

Visit: https://www.plannedparenthood.org/files/5713/9611/6188/Emergency_Contraception_History_and_Access.pdf, p. 5; K. Scanlon, “Rep. Diane Black Fires Back at Planned Parenthood for Characterizing the Little Sisters of the Poor as ‘Out-of-Touch Bosses’,” The Blaze, March 24, 2016, at <https://www.theblaze.com/news/2016/03/24/rep-diane-black-fires-back-at-planned-parenthood-for-characterizing-the-little-sisters-of-the-poor-as-out-of-touch-bosses/>; USSCB Secretariat of Pro-Life Activities, “Does the HHS Mandate Include Abortifacients?,” April 3, 2014, at <https://www.usccb.org/issues-and-action/human-life-and-dignity/contraception/upload/Does-the-HHS-Mandate-Include-Abortifacients.pdf>.

a time.¹⁵ Most women have rejected these methods in the past due to their inflexibility and side effects. But supporters favor them for “eliminating adherence and user dependence from the effectiveness equation”¹⁶—that is, LARCs disregard a woman's own changing reproductive goals, and cannot be discontinued without medical assistance. PPFA has even abandoned “pro-choice” as a slogan, insisting instead that contraception and abortion are basic “health care” that all women need access to (whether women ask for that or not).¹⁷

8. Planned Parenthood’s role in serving women’s health is compromised at best, and is better taken over by others.

Planned Parenthood’s supporters cite its “cervical and breast cancer screenings”¹⁸—but its heavily promoted contraceptive services, 30% of PPFA’s activities, are associated with an increased risk of breast and cervical cancer.¹⁹ Planned Parenthood’s “screening” for breast cancer is a preliminary screen that a woman can do for herself—it offers no mammograms or biopsies.²⁰ PPFA emphasizes its testing and treatment of sexually transmitted diseases,²¹ but it heavily promotes contraceptive methods that may increase women’s risk of contracting STDs, including AIDS.²² Women’s comprehensive health needs are much better served by community health centers and other federally qualified health centers, which serve over 24 million patients in both urban and rural areas and outnumber Planned Parenthood clinics 15 to 1 (9,754 to “nearly 650”).²³

¹⁵ 2015-2016 Report, p. 8.

¹⁶ The American College of Obstetricians and Gynecologists, “Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy,” ACOG Committee Opinion Number 642, p. 1, at <https://www.acog.org/-/media/Committee-Opinions/Committee-on-GynecologicPractice/co642.pdf?dmc=1&ts=20160111T1232405166>.

¹⁷ J. Calmes, “Advocates Shun ‘Pro-Choice’ to Expand Message,” The New York Times, July 28, 2014. Visit: <https://www.nytimes.com/2014/07/29/us/politics/advocates-shun-pro-choice-to-expand-message.html>

¹⁸ See, for example, Senator Robert Casey, “Casey Statement on Planned Parenthood,” August 4, 2015, at <https://www.casey.senate.gov/newsroom/releases/casey-statement-on-planned-parenthood>.

¹⁹ See summaries at National Cancer Institute, www.cancer.gov/about-cancer/causes-prevention/risk/hormones/oral-contraceptives-fact-sheet#q6 (cervical cancer) and www.cancer.gov/about-cancer/causes-prevention/risk/hormones/oral-contraceptives-fact-sheet#q3 (breast cancer).

²⁰ J. McCormack, “After Lying About Providing Mammograms, Planned Parenthood Outraged That Breast Cancer Charity Cuts Off Grants,” The Weekly Standard, Feb. 2, 2012, at <https://www.weeklystandard.com/after-lying-about-providing-mammograms-planned-parenthood-outraged-breast-cancer-charity-cuts-grants/article/620875>.

²¹ 2015-2016 Report, pp. 22-25.

²² For example, J. Baetan et al., “The Influence of Hormonal Contraceptive Use on HIV-1 Transmission and Disease Progression,” 45(3) Clinical Infectious Diseases (August 2007), pp. 360-9, cid.oxfordjournals.org/content/45/3/360.long. On Depo-Provera see P. Belluck, “Contraceptive Used in Africa May Double Risk of H.I.V.,” The New York Times, Oct. 3, 2011, at https://www.nytimes.com/2011/10/04/health/04hiv.html?_r=0.

²³ National Association of Community Health Centers, “Key Health Center Data by State, 2015: Federally-Funded Health Centers Only,” at https://www.nachc.org/wp-content/uploads/2016/10/Key-Health-Center-Data-by-State_2015.pdf; 2015-2016 Report, p. 2.

9. “Nonprofit” Planned Parenthood reaps enormous revenues, including tax revenues.

PPFA is legally a nonprofit organization but takes in enormous revenues: \$1.35 billion in the year ending June 30, 2016, netting \$77.5 million over expenses.²⁴ \$554.6 million, or 41% of total revenue, is from taxpayers’ dollars.²⁵ This is a sizeable increase from the \$305.3 million in government contracts received in the year ending June 30, 2006.²⁶ And this increase occurred while Planned Parenthood’s U.S. clientele decreased from a reported 3 million to 2.4 million people of both genders.²⁷

10. Even as Planned Parenthood’s government funding has increased, the number of medical services it provides has decreased—but not abortions. From 2004 to 2015, Planned Parenthood has reported a dramatic decrease in the following:²⁸ Pap tests (down 75%), breast exams (65%), total cancer screenings (69%), and even contraception/sterilization by any method (18%). By contrast, abortions have increased by 29% since 2004. There has been a clear shift in the kinds of services Planned Parenthood provides, away from the many other kinds of services it boasts of and toward abortion.

11. Planned Parenthood promotes risky “emergency contraception” to minors.

PPFA promotes over-the-counter sales of high-dose “emergency contraceptive” (EC) pills, even to minors below the age of 15, although lower-dose birth control pills require a prescription due to health risks.²⁹ Planned Parenthood’s claim that programs boosting access to ECs would reduce unintended pregnancies and abortions has been rebutted by numerous studies.³⁰

12. Planned Parenthood has promoted abortions worldwide, even where it is illegal.

PPFA exports its ideology to developing nations, promoting abortion as family planning. As long ago as 1983, the then-current president of PPFA co-authored and signed a notorious International Planned Parenthood Federation (IPPF) declaration urging affiliates to violate their own countries’ laws and perform illegal abortions: “Family Planning Associations and other non-governmental organizations should not use the absence of a law or the existence of an unfavourable law as an excuse for inaction; action outside the law, and even in violation of it, is part of the process of stimulating change.”³¹

²⁴ 2015-2016 Report, pp. 28-29.

²⁵ 2015-2016 Report, pp. 27-28.

²⁶ 2005-2006 Report, p. 14.

²⁷ Ibid., p. 4; 2015-2016 Report, p. 2.

²⁸ 2005-2006 Report, p. 4; 2015-2016 Report, pp. 22, 25.

²⁹ Planned Parenthood Action Fund, “Emergency Contraception” (2017).
Visit: <https://www.plannedparenthoodaction.org/issues/birth-control/emergency-contraception>

³⁰ When experts who support this agenda reviewed 23 major studies on such programs, they admitted that “no study found an effect on pregnancy or abortion rates.” E. Raymond et al., “Population Effect of Increased Access to Emergency Contraceptive Pills,” 109 *Obstetrics & Gynecology* (2007), pp. 181-8, at www.ncbi.nlm.nih.gov/pubmed/17197603. Also see USCCB Secretariat of Pro-Life Activities, “Fact Sheet: Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion,” June 5, 2014 at www.usccb.org/issues-and-action/human-life-and-dignity/contraception/fact-sheets/emergency-contraception-fails-to-reduce-unintended-pregnancy-abortion.cfm

³¹ IPPF, Report of the Working Group on the Promotion of Family Planning as a Basic Human Right, Nov. 1983, pp. 28-9.

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

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.

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 heartbeat 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, usually in pieces. 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.

³The 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. Visit: <https://johnpaulbioethics.org/resources>. 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. Visit: <https://www.usccb.org/resources/ethical-religious-directives-catholic-health-care-services-5th-edition-2009-pdf>.

⁵ *Ibid*, 48.

⁶ *Ibid*, 45.

NAVIGATING THE LIFE ISSUES IN RESIDENCY TRAINING

We are living in difficult times as medical students and physicians in training as we go through programs that teach contraception, abortion, sterilization, artificial reproductive technologies, transgender treatments and physician-assisted suicide as normal medical “care.” All of these are part of the Culture of Death that exists in American Medicine today and these “treatments” are opposed to Catholic teaching. As you are not providing direct care as a medical student you can usually avoid these situations, but once you have a medical degree and enter into residency training, you are providing direct care that may entangle you in direct cooperation with these evils.

To avoid violating your conscience as a Catholic, we recommend taking some important actions as you apply for residency. First, identify programs that have respected Catholic residents in the past. We have listed some below. Second, do not mention your “don’ts” before your interview. At the interview, after most of it has been conducted, pose the question, “How are conscientious objections to certain procedures or treatments handled in your institution?” Once accepted, put in writing what you are not willing to do—scrubbing on sterilizations, participating in an abortion, rotating on reproductive technology services, prescribing contraceptives, inserting IUDs, euthanasia etc. Give a notarized copy of your letter to the Dean of the Medical School, the Diversity officer of the hospitals involved and the chairman of your department and ask it be placed in your file, as well as keep a copy for yourself. Assure them you will be an exemplary resident! Be the first to arrive, the last to leave, know your patients thoroughly and take on other patients “in trade” from fellow residents for patients you cannot provide care. Express the desire to learn everything you can while on service. Thoroughly study all the treatments and procedures which you find objectionable. You can KNOW about something without DOING something.

On each service as you rotate, speak with the attending regarding your conscience preferences with a friendly, careful choice of words. It’s not what you say, but how you say it! Expect the worst and hope for the best. Pray daily for your fellow physicians and patients and do not be afraid. If there is an attempt to violate your conscience, do not be afraid, there are conscience laws on the books protecting you and Alliance Defending Freedom (ADF) is available to defend you if they are not followed by your training program, which is receiving federal funds and grants.

An annually updated resource for students applying for residency is: <https://conscienceinresidency.com/>.

And there are two videos which explain this further:

Short Version: <https://www.youtube.com/watch?v=P2KI3UIWtk>

Long Version: <https://www.youtube.com/watch?v=OFV9v2By-6Y>

As of 2019, Ob-Gyn programs that have been most respectful of Catholic conscience are: The OB/GYN Residency Program at Mercy Hospital, St. Louis, Missouri; Houston Methodist, Houston, Texas and the Obstetrics and Gynecology Residency Program at Sisters of Charity Hospital in Buffalo, New York.

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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.

BIBLIOGRAPHY/REFERENCES

1. Practice bulletin no. 114: Management of endometriosis. *Obstet Gynecol* 2010;116:223-36.
2. ACOG Committee Opinion. Number 310, April 2005. Endometriosis in adolescents. *Obstet Gynecol* 2005;105:921-7.
3. Dunselman GA, Vermeulen N, Becker C, et al. ESHRE guideline: management of women with endometriosis. *Hum Reprod* 2014;29:400-12.
4. Rogers PA, D'Hooghe TM, Fazleabas A, et al. Priorities for endometriosis research: recommendations from an international consensus workshop. *Reprod Sci* 2009;16:335-46.
5. Jacobson TZ, Barlow DH, Koninckx PR, Olive D, Farquhar C. Laparoscopic surgery for subfertility associated with endometriosis. *Cochrane Database of Systematic Reviews* 2002;4.
6. Jacobson TZ, Barlow DH, Garry R, Koninckx P. Laparoscopic surgery for pelvic pain associated with endometriosis. *Cochrane Database of Systematic Reviews* 2001;4.
7. Yeung PP, Jr., Shwayder J, Pasic RP. Laparoscopic management of endometriosis: comprehensive review of best evidence. *J Minim Invasive Gynecol* 2009;16:269-81.
8. Falcone T, Lebovic DI. Clinical management of endometriosis. *Obstet Gynecol* 2011;118:691-705.
9. Doyle JO, Missmer SA, Laufer MR. The effect of combined surgical-medical intervention on the progression of endometriosis in an adolescent and young adult population. *J Pediatr Adolesc Gynecol* 2009;22:257-63.
10. Chapron C, Souza C, Borghese B, et al. Oral contraceptives and endometriosis: the past use of oral contraceptives for treating severe primary dysmenorrhea is associated with endometriosis, especially deep infiltrating endometriosis. *Hum Reprod* 2011;26:2028-35.
11. Chapron C, Lafay-Pillet MC, Monceau E, et al. Questioning patients about their adolescent history can identify markers associated with deep infiltrating endometriosis. *Fertil Steril* 2011;95:877-81.
12. Chapron C, Borghese B, Streuli I, de Ziegler D. Markers of adult endometriosis detectable in adolescence. *J Pediatr Adolesc Gynecol* 2011;24:S7-12.
13. Endometriosis and infertility: a committee opinion. *Fertil Steril* 2012;98:591-8.
14. Yeung P, Jr., Sinervo K, Winer W, Albee RB, Jr. Complete laparoscopic excision of endometriosis in teenagers: is postoperative hormonal suppression necessary? *Fertility and Sterility* 2011.
15. Yeung P, Sinervo K, Winer W, Albee RB. Reply of the Authors. *Fertility and Sterility* 2011;96:e146.
16. Yeung P, Jr., Tu F, Bajzak K, et al. A pilot feasibility multicenter study of patients after excision of endometriosis. *JSL* 2013;17:88-94.

17. Albee RB, Jr., Sinervo K, Fisher DT. Laparoscopic excision of lesions suggestive of endometriosis or otherwise atypical in appearance: relationship between visual findings and final histologic diagnosis. J Minim Invasive Gynecol 2008;15:32-7.
18. Brosens I, Gordts S, Benagiano G. Endometriosis in adolescents is a hidden, progressive and severe disease that deserves attention, not just compassion. Hum Reprod 2013.
19. D’Hooghe T, Hummelshoj L. Multi-disciplinary centres/networks of excellence for endometriosis management and research: a proposal. Hum Reprod 2006;21:2743-8.
20. Saridogan E, Byrne D. The British Society for Gynaecological Endoscopy Endometriosis Centres Project. Gynecol Obstet Invest 2013.

Additional Resources for the Laity

Catholic doctor brings endometriosis specialty to St. Louis

<https://www.archstl.org/st-louis-review/article/2012-05-03/catholic-doctor>

A moral alternative to treating infertility

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:

<https://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:

<https://naprotechnology.com/>
<https://popepaulvi.com/>
<https://creightonmodel.com/>
<https://www.unleashingthepower.info>
<https://www.drhilgers.com/>

REIKI HEALING AND THE NEW AGE

Reiki healing is a form of “energy healing” through what is called “spiritually guided life force energy.” Its origins are Japanese with an individual named Mikao Usui (1865-1926) who claimed to have developed a healing system based on Buddhist teachings written in Sanskrit. He suffered a massive stroke and died while instructing practitioners in Reiki. Those who practice Reiki claim this technique raises our “vibrational frequencies” as well as that of the world. They claim illness is due to an imbalance of one’s flow of “life energy.” Usui claimed a spiritual entity, Avalokiteshvara, gave him this technique and that this spirit is the guiding force behind reiki.

Those who use Reiki are a “channel” for the “universal energy” to flow from the practitioner through the patient via palm healing. There is no scientific evidence that this universal energy exists and no scientific evidence that this pseudoscience is effective in treating any illness as compared to placebo in a systematic scientific review published in 2008.¹

The practitioner of Reiki undergoes an initiation by other Reiki guides to transfer this power from the Reiki Master to the student. During the “attunement process” sacred non-Christian symbols are used and one’s crown, heart and palm “chakras,” which are Hindu in origin, are opened. Other “spirits” are present during this process and the student may have a mystical experience, experience increased psychic sensitivity, increased intuitive awareness and an “opening of the third eye”. Exorcists explain the third eye is the eye of the mind that sees into the spirit world. This facilitates contact with New Age “spirit guides” and “ascended masters”.

All of this is divination and worship of false idols. Magical rites and rituals do not connect us with God but with demons. It is God who heals people by divine grace and by scientific methods. Healing comes from the use of conventional medicine and through the power of the Holy Spirit with the laying on of hands, intercessory prayer, the sacrament of the Anointing of the Sick and the Eucharist. Those who have been involved with Reiki should seek forgiveness in the Sacrament of Reconciliation.

Case: A 70-year-old woman awakens on New Year’s Day with significant shortness of breath. Upon arrival in the emergency room, studies are done which show she has a large blood clot in her right ventricle. Attempts to reach her cardiologist are unsuccessful and in the meantime her pastor is called to the emergency room to see her. He performs the Anointing of the Sick and then goes to the waiting room. Another cardiologist is reached and he arrives in the patient’s room, reviews the ultrasound of her heart and says he will try a medication to break up the clot but he is not hopeful and this means certain death for her. He administers the medication through a vein while watching her heart under ultrasound. The large clot disappears before his eyes! The non-Christian cardiologist cries out this is a miracle because that should not have happened! The woman spends the next year telling everyone she comes in contact with that she experienced a miracle through the Anointing of the Sick.

For further reading on Reiki and other New Age practices, please see the reference below as well as the USCCB’s Guidelines for Evaluating Reiki as an Alternative Therapy, which is reprinted in this binder.

¹ Lee, M.; Pittler, M.; Ernst, E. (2008). “Effects of reiki in clinical practice: A systematic review of randomised clinical trials.” *International Journal of Clinical Practice*. 62: 947-54. DOI: 10.1111/j.1742-1241.2008.01729.x

GUIDELINES FOR EVALUATING REIKI AS AN ALTERNATIVE THERAPY

Committee on Doctrine
United States Conference of Catholic Bishops
25 March 2009

1. From time to time questions have been raised about various alternative therapies that are often available in the United States. Bishops are sometimes asked, “What is the Church’s position on such therapies?” The USCCB Committee on Doctrine has prepared this resource in order to assist bishops in their responses.

Section I: Healing by Divine Grace and Healing by Natural Powers

2. The Church recognizes two kinds of healing: healing by divine grace and healing that utilizes the powers of nature. As for the first, we can point to the ministry of Christ, who performed many physical healings and who commissioned his disciples to carry on that work. In fidelity to this commission, from the time of the Apostles the Church has interceded on behalf of the sick through the invocation of the name of the Lord Jesus, asking for healing through the power of the Holy Spirit, whether in the form of the sacramental laying on of hands and anointing with oil or of simple prayers for healing, which often include an appeal to the saints for their aid. As for the second, the Church has never considered a plea for divine healing, which comes as a gift from God, to exclude recourse to natural means of healing through the practice of medicine.¹ Alongside her sacrament of healing and various prayers for healing, the Church has a long history of caring for the sick through the use of natural means. The most obvious sign of this is the great number of Catholic hospitals that are found throughout our country.

3. The two kinds of healing are not mutually exclusive. Because it is possible to be healed by divine power does not mean that we should not use natural means at our disposal. It is not our decision whether or not God will heal someone by supernatural means. As the Catechism of the Catholic Church points out, the Holy Spirit sometimes gives to certain human beings “a special charism of healing so as to make manifest the power of the grace of the risen Lord.”² This power of healing is not at human disposal, however, for “even the most intense prayers do not always obtain the healing of all illnesses.”³ Recourse to natural means of healing therefore remains entirely appropriate, as these are at human disposal. In fact, Christian charity demands that we not neglect natural means of healing people who are ill.

¹ See Congregation for the Doctrine of the Faith, *Instruction on Prayers for Healing* (14 September 2000), I, 3: “Obviously, recourse to prayer does not exclude, but rather encourages the use of effective natural means for preserving and restoring health, as well as leading the Church’s sons and daughters to care for the sick, to assist them in body and spirit, and to seek to cure disease.”

² *Catechism*, no. 1508.

³ *Catechism*, no. 1508.

Section II: Reiki and Healing

A) The Origins and Basic Characteristics of Reiki

4. Reiki is a technique of healing that was invented in Japan in the late 1800s by Mikao Usui, who was studying Buddhist texts.⁴ According to Reiki teaching, illness is caused by some kind of disruption or imbalance in one's "life energy." A Reiki practitioner effects healing by placing his or her hands in certain positions on the patient's body in order to facilitate the flow of Reiki, the "universal life energy," from the Reiki practitioner to the patient. There are numerous designated hand positions for addressing different problems. Reiki proponents assert that the practitioner is not the source of the healing energy, but merely a channel for it.⁵ To become a Reiki practitioner, one must receive an "initiation" or "attunement" from a Reiki Master. This ceremony makes one "attuned" to the "universal life energy" and enables one to serve as a conduit for it. There are said to be three different levels of attunement (some teach that there are four). At the higher levels, one can allegedly channel Reiki energy and effect healings at a distance, without physical contact.

B) Reiki as a Natural Means of Healing

5. Although Reiki proponents seem to agree that Reiki does not represent a religion of its own, but a technique that may be utilized by people from many religious traditions, it does have several aspects of a religion. Reiki is frequently described as a "spiritual" kind of healing as opposed to the common medical procedures of healing using physical means. Much of the literature on Reiki is filled with references to God, the Goddess, the "divine healing power," and the "divine mind." The life force energy is described as being directed by God, the "Higher Intelligence," or the "divine consciousness." Likewise, the various "attunements," which the Reiki practitioner receives from a Reiki Master are accomplished through "sacred ceremonies" that involve the manifestation and contemplation of certain "sacred symbols" (which have traditionally been kept secret by Reiki Masters). Furthermore, Reiki is frequently described as a "way of living," with a list of five "Reiki Precepts" stipulating proper ethical conduct.

6. Nevertheless, there are some Reiki practitioners, primarily nurses, who attempt to approach Reiki simply as a natural means of healing. Viewed as natural means of healing, however, Reiki becomes subject to the standards of natural science. It is true that there may be means of natural healing that have not yet been understood or recognized by science. The basic criteria for judging whether or not one should entrust oneself to any particular natural means of healing, however, remain those of science.

7. Judged according to these standards, Reiki lacks scientific credibility. It has not been accepted by the scientific and medical communities as an effective therapy. Reputable scientific studies attesting to the efficacy of Reiki are lacking, as is a plausible scientific explanation as to how it could possibly be efficacious. The explanation of the efficacy of Reiki depends entirely on a particular view of the world as permeated by this "universal life energy" (Reiki) that is subject to manipulation by human thought and will. Reiki practitioners claim that their training allows one to channel the "universal life energy"

⁴ It has also been claimed that he merely rediscovered an ancient Tibetan technique, but evidence for this claim is lacking.

⁵ As we shall see below, however, distinctions between self, world, and God tend to collapse in Reiki thought. Some Reiki teachers explain that one eventually reaches the realization that the self and the "universal life energy" are one, "that we are universal life force and that everything is energy, including ourselves" (Libby Barnett and Maggie Chambers with Susan Davidson, *Reiki Energy Medicine: Bringing Healing Touch into Home, Hospital, and Hospice* [Rochester, Vt.: Healing Arts Press, 1996], p. 48; see also p. 102).

that is present in all things. This “universal life energy,” however, is unknown to natural science. As the presence of such energy has not been observed by means of natural science, the justification for these therapies necessarily must come from something other than science.

C) Reiki and the Healing Power of Christ

8. Some people have attempted to identify Reiki with the divine healing known to Christians.⁶ They are mistaken. The radical difference can be immediately seen in the fact that for the Reiki practitioner the healing power is at human disposal. Some teachers want to avoid this implication and argue that it is not the Reiki practitioner personally who effects the healing, but the Reiki energy directed by the divine consciousness. Nevertheless, the fact remains that for Christians the access to divine healing is by prayer to Christ as Lord and Savior, while the essence of Reiki is not a prayer but a technique that is passed down from the “Reiki Master” to the pupil, a technique that once mastered will reliably produce the anticipated results.⁷ Some practitioners attempt to Christianize Reiki by adding a prayer to Christ, but this does not affect the essential nature of Reiki. For these reasons, Reiki and other similar therapeutic techniques cannot be identified with what Christians call healing by divine grace.

9. The difference between what Christians recognize as healing by divine grace and Reiki therapy is also evident in the basic terms used by Reiki proponents to describe what happens in Reiki therapy, particularly that of “universal life energy.” Neither the Scriptures nor the Christian tradition as a whole speak of the natural world as based on “universal life energy” that is subject to manipulation by the natural human power of thought and will. In fact, this world-view has its origins in eastern religions and has a certain monist and pantheistic character, in that distinctions among self, world, and God tend to fall away.⁸ We have already seen that Reiki practitioners are unable to differentiate clearly between divine healing power and power that is at human disposal.

Section III: Conclusion

10. Reiki therapy finds no support either in the findings of natural science or in Christian belief. For a Catholic to believe in Reiki therapy presents insoluble problems. In terms of caring for one’s physical health or the physical health of others, to employ a technique that has no scientific support (or even plausibility) is generally not prudent.

⁶ For example, see “Reiki and Christianity” at http://iarp.org/articles/Reiki_and_Christianity.htm and “Christian Reiki” at <http://areikihealer.tripod.com/christianreiki.html> and the website www.christianreiki.org.

⁷ Reiki Masters offer courses of training with various levels of advancement, services for which the teachers require significant financial remuneration. The pupil has the expectation and the Reiki Master gives the assurance that one’s investment of time and money will allow one to master a technique that will predictably produce results.

⁸ While this seems implicit in Reiki teaching, some proponents state explicitly that there is ultimately no distinction between and the self and Reiki. “Alignment with your Self and being Reiki is an ongoing process. Willingness to continuously engage in this process furthers your evolution and can lead to the sustained recognition and ultimate experience that **you are universal life force**” (The Reiki Healing Connection [Libby Barnett, M.S.W.], <http://reikienergy.com/classes.htm>, accessed 2/6/2008 [emphasis in original]). Diane Stein summarizes the meaning of some of the “sacred symbols” used in Reiki attunements as: “The Goddess in me salutes the Goddess in you”; “Man and God becoming one” (Essential Reiki Teaching Manual: A Companion Guide for Reiki Healers [Berkeley, Cal.: Crossing Press, 2007], pp. 129-31). Anne Charlsh and Angela Robertshaw explain that the highest Reiki attunement “marks a shift from the ego and self to a feeling of oneness with the universal life-force energy” (Secrets of Reiki [New York, N.Y.: DK Publishing, 2001], p. 84).

11. In terms of caring for one's spiritual health, there are important dangers. To use Reiki one would have to accept at least in an implicit way central elements of the worldview that undergirds Reiki theory, elements that belong neither to Christian faith nor to natural science. Without justification either from Christian faith or natural science, however, a Catholic who puts his or her trust in Reiki would be operating in the realm of superstition, the no-man's-land that is neither faith nor science.⁹ Superstition corrupts one's worship of God by turning one's religious feeling and practice in a false direction.¹⁰ While sometimes people fall into superstition through ignorance, it is the responsibility of all who teach in the name of the Church to eliminate such ignorance as much as possible.

12. Since Reiki therapy is not compatible with either Christian teaching or scientific evidence, it would be inappropriate for Catholic institutions, such as Catholic health care facilities and retreat centers, or persons representing the Church, such as Catholic chaplains, to promote or to provide support for Reiki therapy.

Most Rev. William E. Lori (Chairman)
Bishop of Bridgeport

Most Rev. John C. Nienstedt
Archbishop of St. Paul and Minneapolis

Most Rev. Leonard P. Blair
Bishop of Toledo

Most Rev. Arthur J. Serratelli
Bishop of Paterson

Most Rev. José H. Gomez
Archbishop of San Antonio

Most Rev. Allen H. Vigneron
Bishop of Oakland

Most Rev. Robert J. McManus
Bishop of Worcester

Most Rev. Donald W. Wuerl
Archbishop of Washington

⁹ Some forms of Reiki teach of a need to appeal for the assistance of angelic beings or "Reiki spirit guides." This introduces the further danger of exposure to malevolent forces or powers.

¹⁰ See Catechism, no. 2111; St. Thomas Aquinas, *Summa theologiae* II-II, q. 92, a. 1.

SEXUALLY TRANSMITTED DISEASE EPIDEMIC AMONG ADOLESCENTS AND YOUNG ADULTS IN THE UNITED STATES

Case: A Catholic mother brings her 13-year-old daughter to her primary care provider seeking the contraceptive pill. She has a concern that her daughter might be sexually active and does not want to be a grandmother at a young age. She also asks if the pill would help her daughter's mild acne. The physician prescribes the pill and informs the mother and daughter that she should use safe sex and use condoms. The physician sends the teen girl to a social worker who talks to her about safe sex and condom use.

The Problem

Although there has been a significant decrease in the birth rates among adolescents and young adults in recent years, there is currently an epidemic in sexually transmitted diseases (STDs).¹ This epidemic of STDs continues to get worse even with greater use of contraception.² Researchers at the Center for Disease Control (CDC) found that one in four female adolescents have a sexually transmitted disease.³ The latest (2019) data from the CDC showed an increase in STDs from 2015 to 2019 in all four reported categories among young people aged 15-24, i.e., a 19% increase in chlamydia (i.e., 1.8 million cases), a 56% increase in gonorrhea, a 75% increase in syphilis and a 279% increase of syphilis among newborns.⁴

Health Professionals Contributing to the Problem

Healthcare professionals (i.e., physicians, physician assistants, and advanced practice nurses) are the main gateway for prescribing contraception to adolescents and young adults. Furthermore, healthcare professionals often treat common adolescent health problems with oral hormonal contraceptives with the view of also preventing unintended pregnancies.⁵ By doing so, health professionals may be contributing to lowering the barriers to risky sexual behaviors like early sexual debut and multiple sexual partners. Fear of pregnancy and not wanting to catch a sexually transmitted disease are frequent reasons why adolescents and young adults delay sexual intercourse.⁶ From a behavioral model standpoint, taking away these two consequences of sexual intercourse will likely encourage the behavior. Furthermore, the authority of the healthcare professional will send the message that sexual intercourse is expected. (Please see Figure 1 on the next page.)

¹ L. Lindberg, J. Santelli, and S. Desai, "Understanding the Decline in Adolescent Fertility in the United States 2007-2012," *Journal of Adolescent Health* 59/5 (2016): 577-83.

² Ibid.

³ S.E. Forhan, S.L. Gottlieb, and M.R. Sternberg et al., "Prevalence of Sexually Transmitted Diseases among Female Adolescents Aged 14 to 19 in the United States," *Pediatrics* 124 (2009): 1505-12.

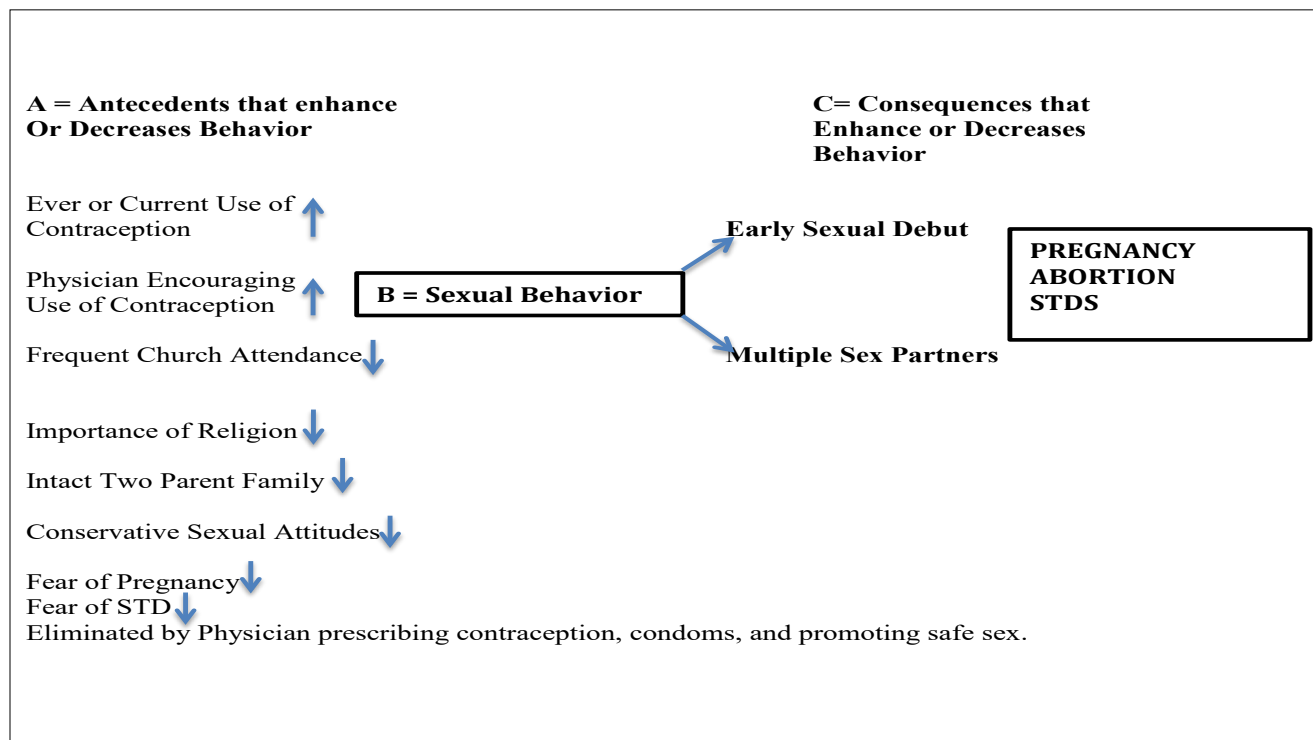
⁴ "Center for Disease Control Fact Sheet," National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Centers for Disease Control and Prevention Reported STDs in the United States, 2019 National Data for Chlamydia, Gonorrhea, and Syphilis.

⁵ R.L. Rosenfield, "The Diagnosis of Polycystic Ovary Syndrome in Adolescents," *Pediatrics* 136/6 (2015): 1154-65; M. Youngster, M.R. Laufer, and A.D. Divasta, "Endometriosis for the Primary Care Physician," *Current Opinions in Pediatrics* 25/4 (2015): 454-62.

⁶ R. Fehring, K. Cheever, K. German, and C. Philpot, "Religiosity, Sexual Activity, and Attitudes of Sexual Permissiveness among Older Adolescents," *Journal of Religion and Health* 37/3 (1998): 229-48.

Figure 1

A-B-C Model of Adolescent Sexual Behaviors



Note: Up Arrows Indicate Factors that Lower Barriers to Sexual Activity and Down Arrows Indicate Factors that Lower the Odds of Sexual Activity.

Protective Factors

There are protective factors that help adolescent and young adult women to remain virgins and to reduce sexual risk. Past research has shown that those adolescents and young women who hold religion to be very important in their lives and attend church at least once a week have an older age of sexual debut, less sexual intercourse, and fewer male sexual partners than those who are less religious.⁷ Having intact families, good communication with parents, private school, and simply pledging being a virgin until marriage are also factors that lead to less sexual risk among adolescents and young adult women.⁸

Further Evidence for the Problem

A previous study among all reproductive age women, including adolescents and young adults, showed that there was a greater likelihood of abortion among those women who ever used methods of

⁷ L. Edwards, R. Fehring, K.M. Jarrett, and K. Haglund, "The Influence of Religiosity on the Sexual Behaviors of Latina/o Adolescents," *Hispanic Journal of Behavioral Sciences* 30/4 (2008): 447-62; K.A. Haglund and R.J. Fehring, "The Association of Religiosity, Sexual Education, and Parental Factors with Risky Sexual Behaviors among Adolescents and Young Adults," *Journal of Religion and Health* 49 (2010): 460-72; K. Haglund, L. Edwards, R. Fehring, and J. Pruzynski, "Religiosity and Sexual Risk Behaviors Among Latina Adolescents: Trends from 1995 to 2008," *Journal of Women's Health* 20/6 (2011): 871-77.

⁸ M.D. Resnick, P.S. Bearman, and R.W. Blum et al., "Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health," *Journal of the American Medical Association* 278 (1997): 823-32.

contraception, compared with women who never used contraceptive methods.⁹ Recent studies also showed that those adolescents and young adults who ever used oral hormonal contraception and condoms were more likely to have had an abortion, pregnancy, a sexually transmitted disease, and behaviors that contribute to those outcomes compared to those adolescents who never used contraception.¹⁰ Another recent study among 1,365 adolescents and young adults in the 2011-2013 Natural Survey of Family Growth demonstrated that adolescents and young adults who were never married and are currently using contraception had ten times the odds to have a sexually transmitted disease, and surprisingly seven times the odds to become pregnant, the very outcome contraception is intended to prevent, compared to the non-contracepting group. This data also showed that users of contraception have significantly more male partners than their contraceptive naive counterparts and significantly earlier sexual debut. Protective factors such as importance of religion and being raised in an intact two-parent family were found to decrease the likelihood of sexual activity.

Current Standards of Practice

Contrary to these findings, the consensus among health professionals is that there is a great need to provide sexually active adolescents with the contraceptive pill and the condom to prevent unintended pregnancy and sexually transmitted diseases.¹¹ Although there is some mention of use of abstinence and fertility awareness methods, they claim that these methods are not effective and that pregnancy is a worse health outcome than the use of hormonal contraception. Moreover, these studies suggest that adolescents should have confidential office visits to discuss these issues apart from their parents. Yet these approaches are not solving the problem of unintended pregnancy, abortion, and sexually transmitted diseases. Since the goals of reducing pregnancy and sexually transmitted disease rates are not being achieved either with the widespread use of hormonal contraceptives and condoms, healthcare professionals should also provide information on other factors that reduce these consequences of risky sexual behaviors, including religiosity and an intact family.¹²

A Healthier Moral Approach

In light of the NFSG data, the claim that contraception is the best means of achieving reduced teen pregnancy rates, abortion rates, and sexually transmitted disease rates and of improving overall teen health needs to be seriously reconsidered. More efforts need to be given toward the total well-being of the adolescent, including spiritual well-being. Healthcare professionals can also provide mental health care for adolescents and their parents to help maintain intact families. Lastly, healthcare professionals can be trained to provide a non-contraceptive milieu and support to the adolescent and their parents when

⁹ R. Fehring, "The Influence of Contraception on Abortion among Women of Reproductive Age in the United States," *Life and Learning*, 21 (2014): 1-18.

¹⁰ R. Fehring, "Influence of Current Contraceptive use on the Abortion and Sexually Transmitted Disease Rates Among Adolescents," *Life and Learning XXVII*. In Proceedings of the Twenty Seventh (2017) Conference of University Faculty for Life. (Ed. J. Koterski). P 211-231; R. Fehring, T. Bouchard, and M. Meyer, "Influence of Contraception Use on the Reproductive Health of Adolescents and Young Adults," *The Linacre Quarterly*, 85 2, (2018): 167-177.

¹¹ P.K. Braverman, W.P. Adelman, E.M. Alderman, C.C. Breuner, D.A. Levine, A.V. Marcell, R.F. O'Brien, and AAP Committee on Adolescence, "Contraception for Adolescents," *Pediatrics* 134/4 (2014): e1244-56; ; M.A. Ott, G.S. Sucato, P.K. Braverman, W.P. Adelman, E.M. Alderman, C.C. Breuner, D.A. Levine, A.V. Marcell, R.F. O'Brien, and AAP Committee on Adolescence, "Contraception for Adolescents: Technical Report," *Pediatrics* 134/4 (2014): e1257-1281; R.E. Lawrence, K.A. Rasinski, J.D. Yoon, and F.A. Curlin, "Adolescents, Contraception, and Confidentiality: A National Survey of Obstetrician and Gynecologists," *Contraception* 84/3 (2011): 259-65.

¹² Haglund, K. A., & Fehring, R.J. The association of religiosity, sexual education, and parental factors with risky sexual behaviors among adolescents and young adults. *Journal of Religion and Health*, 49 (2010):460-472.

contemplating contraception. Health professionals can refer the adolescent teen and her mother to participate in teen sexuality programs that include fertility awareness education, Theology of the Body, and chastity education. Most Catholic dioceses have such programs. The Natural Womanhood organization has a listing of these programs. Follow this link: <https://naturalwomanhood.org/cycle-mindfulness-what-happens-when-you-teach-fertility-awareness-to-teen-girls/>

GENDER DYSPHORIA IN CHILDREN

Gender dysphoria (GD) in children is a term used to describe a psychological condition in which a child experiences marked incongruence between his or her experienced gender and the gender associated with the child's biological sex. Twin studies demonstrate that GD is not an innate trait. Moreover, barring pre-pubertal affirmation and hormone intervention for GD, 80 percent to 95 percent of children with GD will accept the reality of their biological sex by late adolescence.

The treatment of GD in childhood with hormones effectively amounts to mass experimentation on, and sterilization of, youth who are cognitively incapable of providing informed consent. There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves and adolescents who cannot understand the magnitude of such decisions.

Ethics alone demands an end to the use of pubertal suppression with GnRH agonists, cross- sex hormones, and sex reassignment surgeries in children and adolescents. The American College of Pediatricians recommends an immediate cessation of these interventions, as well as an end to promoting gender ideology via school curricula and legislative policies. Healthcare, school curricula and legislation must remain anchored to physical reality. Scientific research should focus upon better understanding of the psychological underpinnings of this disorder, optimal family and individual therapies, as well as delineating the differences among children who resolve with watchful waiting versus those who resolve with therapy and those who persist despite therapy.

Dr. Michelle Cretella
President, American College Pediatricians

Dr. Lester Ruppertsberger
Past President, Catholic Medical Association

RESOURCES FOR PARENTS OF CHILDREN WITH GENDER DYSPHORIA

Advice to Parents from a Gender Critical Therapist

As you seek out support, I invite you to do something incredibly difficult: try meeting your daughter or son where s/he is right NOW. Rather than clinging to the memory of who s/he was last year, last month, or even last week, get to know who s/he is becoming right now, even if it scares you—even if you desperately miss the more familiar child from your memories. Be patient, take it one day at a time, and remember that s/he is doing the best s/he can with the tools s/he has right now. By being open to your child's thoughts, ideas, and feelings, you will help validate your child as a person, without having to validate the trans identity.

An Online Support Group for Parents of Rapid-Onset Gender Dysphoria (ROGD) Children

<https://www.parentsofrogdkids.com/>

How to Find a Gender-Critical Therapist in Your Local Area

Due to the political climate, finding gender-critical therapists can be a challenge. Below are suggestions to help you in your search.

1. Avoid “Gender therapists” and “Gender clinics”

Consider searching for experts in body image & eating disorders, self-harm, trauma, anxiety disorders, women's issues, sexual abuse & domestic violence. You know your teen best. If they've struggled with depression their whole life, seek out an expert in teen depression. If they have obsessive-compulsive tendencies, seek out an OCD expert.

Therapists who practice Acceptance and Commitment Therapy (ACT) focus on helping clients accept natural emotions, like pain and suffering, and live value-driven lives. Jungian analysts, psychodynamic and psychoanalytic therapists may take a more nuanced and symbolic approach to your child's declaration, viewing it as an attempt to seek meaning and validation in their life, or as a psychological defense mechanism. Somatic therapies are particularly adept at addressing dissociation which is a disconnected relationship with the body.

Seek out specialists like these by entering “[Type of therapist] in [city]” into your search engine. For example, “Jungian Therapists in San Francisco.”

2. Avoid / leave therapists who shame or blame your child. One therapist asked a 13-year-old, “Don't you see how selfish you are behaving and how that is hurting your mother?” To the mother's credit, she sought out a new therapist.

A moralistic, shame and blame approach is not psychologically helpful. Instead, it teaches the girl that she is bad and there is something wrong with her. Her belief or desire to dissociate from her sex is a psychological reaction to either objective or perceived trauma (shame, blame, rejection, attachment loss, social contagion). She is not consciously choosing to feel this way to spite those around her.

Therapy should seek to uncover what psychological purpose the trans identity serves; what possible events and/or relationships may be contributing to it. Sometimes parents' well intended behaviors

may have contributed to the daughter's gender dysphoria. Some teen girls subconsciously reject their sex because they cannot live according to socially imposed sex stereotypes. Barring rare cases of objective abuse, therapists should not "take sides."

Good therapists will help parents and children better understand themselves and each other, improving family communication and family connectedness in the process.

3. Interview your potential therapist. Ask them if they believe trans identities are innate, fixed, and treatable only with medical intervention. If they do, avoid them. Ask them directly about how they help children in your child's situation. Therapists are ethically obligated to be transparent when describing their therapeutic methods. If a therapist ever pressures you with the claim that your child must "transition or else become a suicide statistic" leave with your child.

****If you fail to find a local therapist you may reach out to those listed below.****

The therapists below are Christian and/or espouse conservative values. They have expertise in helping youth with sexual identity and gender identity issues. Some also provide therapy by Skype if you are unable to locate a local gender critical therapist. You can find more information about these therapists by visiting: <https://www.acpeds.org/find-a-therapist>

David Pickup, M.A.

(888) 288-2071

davidpickuplmft@gmail.com

Alliance for Therapeutic Choice

(888) 364-4744 | contactus@therapeuticchoice.com

Thomas Aquinas Psychological Clinic

tapc1@earthlink.net | <http://www.josephnicolosi.com/contact/>

Marc Dillworth, Ph.D

(941) 794-1009

Christopher Doyle, M.A., L.C.P.C

(703) 367-0894

Robert Vazzo, L.M.F.T

(844) 480-6534

Petrit Ndrio, M.D.

(630) 689-1022

Albert Lameroux, L.M.H.C.

6034 Chester Ave, Ste 119, Jacksonville, FL 32217

(904) 448-5521

Maryellen Ebert, L.M.H.C.

(305) 383-6565

The therapists below have expertise in helping girls who struggle with gender dysphoria. They are left-leaning gender critical therapists who do not espouse traditional Christian beliefs.

Sasha Ayad is a Licensed Professional Counselor (LPC) who works with children between the ages of 11 and 18.

I've spent the last several years doing research on gender identity, gender dysphoria, and medical transition I've worked with teens and adults who have lived through challenging experiences around these issues. I've developed a unique approach to helping kids who struggle with their gender: I use non-judgmental, compassionate, dialogue that focuses on exploration rather than immediately seeking to affirm and transition your child.

Kaitlin Staples, M.A., A.T.R.-B.C., L.P.C., is a registered Board-certified art therapist and licensed professional counselor in Philadelphia, Pennsylvania working with tweens, teens, and adults. Kaitlin offers both in-person and virtual therapy to patients in Pennsylvania and beyond.

I have many years of experience working with addictions, eating disorders, relational trauma, family dysfunction, depression, and anxiety. I am an active member of the eating disorder and body image communities. In the eating disorder community, we have recognized for some decades now that the nature of body image issues and eating disorders stem from a symbolic connection to the individual's internal world. I have been working with tweens and teens in agency settings for a few years now, and as I have listened to more and more stories of ROGD and trans teens I have recognized so many common threads to that of eating disorders and body dysphoria in general. These threads have led me to further working with this population.

In my private practice, I now work with teens/tweens and their parents to help repair relationship ruptures and create space for a symbolic understanding of all that is happening internally and externally. My approach aims to make sure all involved in the process are seen, heard, and understood. Our process will explore all angles with an organic and fluid approach leaving no stone unturned. I help to create space and time to make informed and conscious decisions

Through artwork, dreamwork, and traditional verbal psychotherapy we will explore beneath the surface of the individual to uncover the roots of dysphoria. While I of course support the LGBTQ community, I recognize that there is a recent epidemic of "social contagion" within the adolescent community and we need to proceed with caution and care to avoid permanent damage to those seeking transition.

Anne Rettenberg, L.C.S.W. is a Licensed Clinical Social Work psychotherapist in Manhattan who works with adults, including parents. She is trained in family and couples counseling. Anne finished her MSW at New York University in 1991 and worked in mental health clinics and substance abuse treatment facilities prior to starting private practice. She is also a consultant to a state agency. Anne has been in private practice since 2001. She conducts in-person individual, couple and family sessions.

"My perspective comes from psychodynamic and family systems theories, and from feminist theory. I'm opposed to unnecessary medical procedures. I am a humanist as well as a feminist, and I believe in compassion for the body and in taking a holistic approach to healthcare."

COMPREHENSIVE SEX EDUCATION PROGRAMS VERSUS ABSTINENCE PROGRAMS

All the comprehensive sex education programs come from one of three sources: SIECUS, Planned Parenthood or Advocates for Youth. These programs desensitize children to sexual behavior, encourage them to explore their sexuality as something “natural” and groom them for sexual abuse from online predators, other adults or their peers. These programs teach children to question and abandon the values taught at home and direct them to websites and social media sites that encourage promiscuity, sexual experimentation and fringe behaviors. These sites are frankly pornographic. Children no longer respect themselves or others. The American College of Pediatricians say these programs are a dangerous assault on the health and innocence of children.

These programs give lip service to abstinence or waiting until the child is “ready” and they contain activities that treat sexual behavior as a “good” as long as you both consent—even minor children—and use condoms and other contraceptives. The use of condoms is demonstrated in the classroom. These programs encourage children to reject their parents’ values and to seek contraception without parents’ knowledge. Under the Affordable Care Act of 2010 this education includes children as young as ten years of age. Only the advantages of all the contraceptives, including implants, Depo Provera injections, intrauterine devices and oral birth control pills are presented. Side effects such as an increased risk of breast, liver and cervical cancer; an increased risk of blood clots causing strokes or pulmonary emboli; and other serious side effects such as depression are not mentioned. Children are taught in a positive way to engage in masturbation, oral and anal sex. Having multiple partners is fine. Gender is fluid and is something you can choose. What is the first thing that is said when a baby is born? It’s a boy or it’s a girl! Abortion is presented as safe and legal in dealing with an “unwanted,” “unplanned” pregnancy.

The video describes what would be covered with young people:

<https://www.breitbart.com/politics/2018/11/14/watch-planned-parenthood-sex-ed-video-sparks-parent-outrage/> Don’t watch with children nearby!

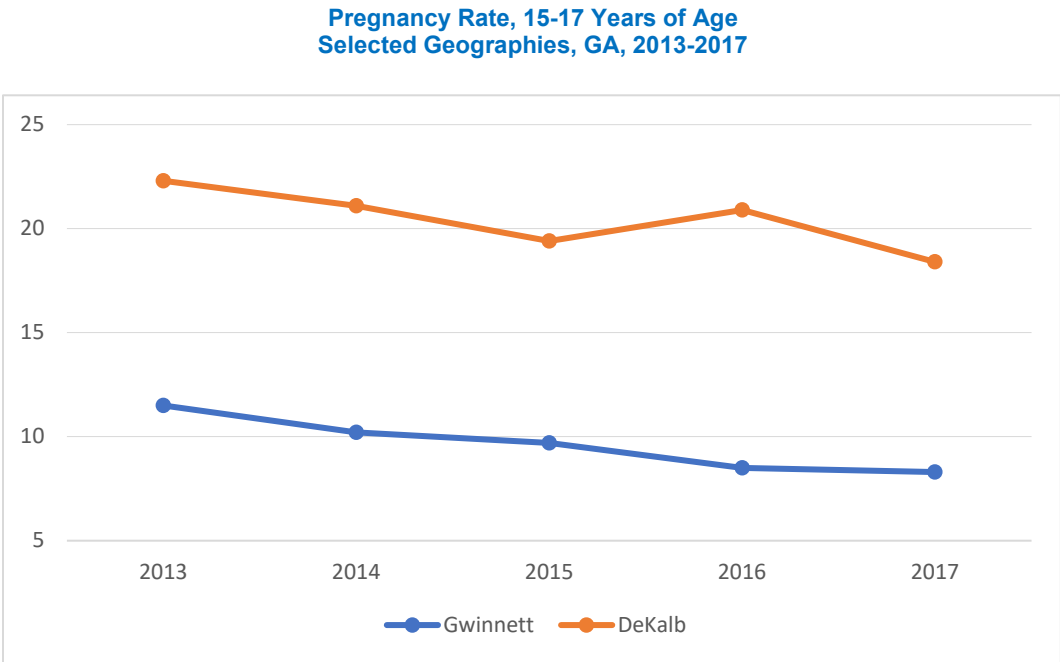
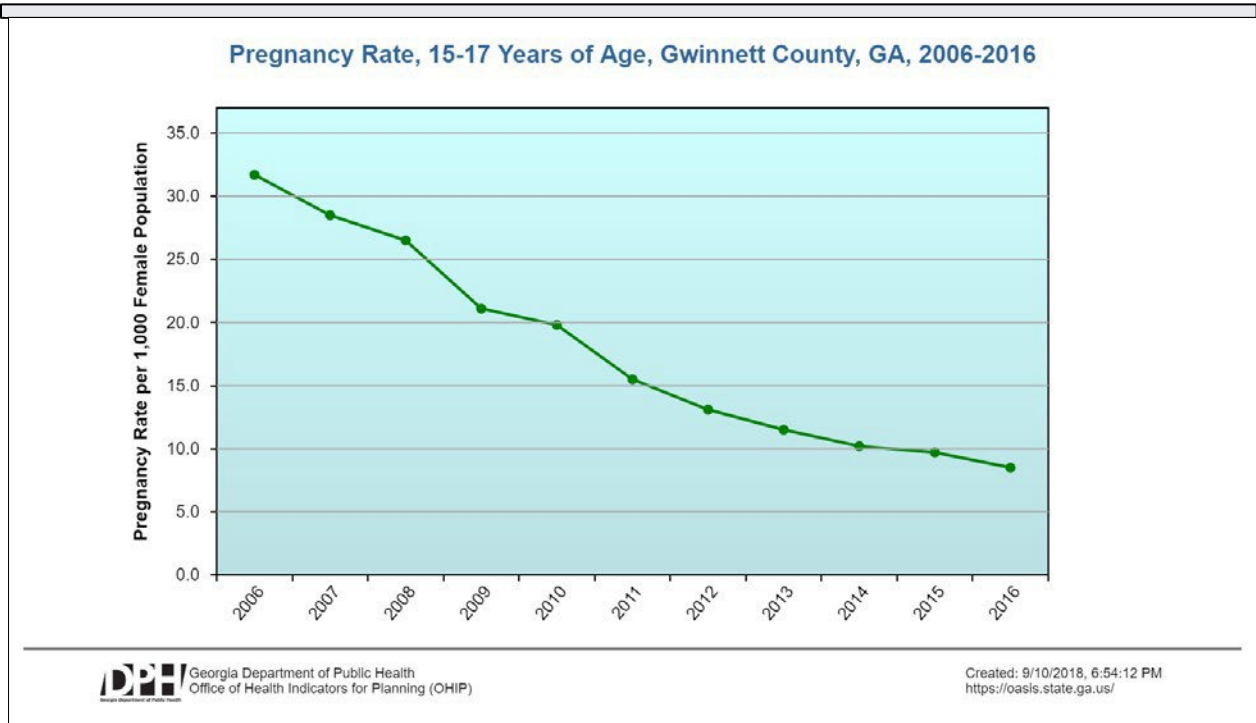
Sexual behavior in children and teens has consequences—emotional, physical and spiritual—especially for girls. This is seen on a daily basis in pediatric, gynecological and family practice offices. More than two (2) million cases of chlamydia, gonorrhea and syphilis were reported to the CDC in 2016—the highest number ever. However, there are many cases that go unreported. The numbers of STDs have increased every year for the past three years. The long-term consequences for girls include chronic pain and infertility. There are other STDs such as human papillomavirus and herpes that do not get reported but have serious consequences, especially for women and their newborns. What is the only sure way to prevent an STD? Abstinence! What is the best way to prevent an unplanned, out of wedlock pregnancy? Abstinence!

Are abstinence programs effective at promoting delaying sexual activity? The answer is yes. Even if the child has already started engaging in sexual behavior, these programs give the tools to revert to chaste living.

In the Atlanta metro area, Gwinnett County Public Schools, the school system with the largest number of children in the state of Georgia, currently uses an abstinence program called *Choosing the Best*. Since it was implemented 16 years ago, Gwinnett has seen a decline of 69% in the teen pregnancy rate.

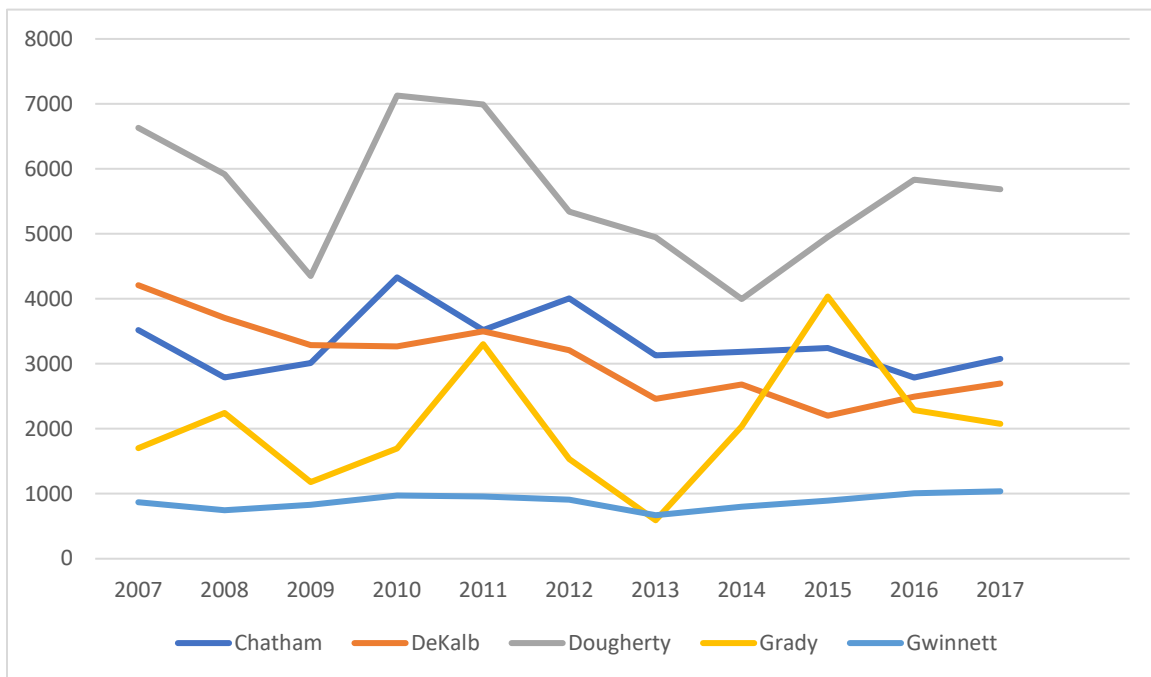
Other counties in Georgia, including DeKalb County Public Schools which is also in metro Atlanta, use the comprehensive sex ed program Family Life and Sexual Health (FLASH). The counties with FLASH have 2.5 to 7 times the rates of STDs in teens compared to Gwinnett County.

These three graphs show the decline in pregnancy rates over time in Gwinnett County, compares the teen pregnancy rates of Gwinnett and DeKalb Counties, and compares Gwinnett’s teen STD incidences with the other Georgia counties that use the comprehensive sex ed program FLASH:



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Health

**STD Rate, All STD Except Congenital Syphilis, 15-17 Years of Age
Selected Geographies, GA, 2007-2017**



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Health

Parents need to be vigilant to prevent these programs from becoming part of their child’s curriculum, attempt to remove them if they are already there and substitute abstinence programs such as Choosing the Best or TeenStar. If comprehensive sex ed programs are in your child’s school, exempt your child from these classes and work to get them out of your county and state.

Additional Resources

Further Reading:

You’re Teaching My Child What?

Miriam Grossman, M.D., Regnery Publishing, Inc., 2009.

Video:

Visit: <https://canavox.com/dear-katy/> and scroll to watch the following:

Evaluating Sex Ed Curricula: Tough Conversations with Kids: Teens Coming Out as Bisexual

Resources to help you talk to your preteen and teen:

IMPORTANT: Please preview all resources before sharing them with your child so you can discern if your child is ready for them! Those that are Catholic are listed as such.

Beyond the Birds and Bees

Greg and Lisa Popcak

A Catholic book for parents to help them understand Church teaching and how to talk to their children about the facts of life from a Catholic perspective.

Raising Pure Teens: 10 Strategies to Protect or Restore Your Teenager's Innocence

Jason Evert and Chris Stephanik (Catholic book for parents)

Visit: <https://www.youtube.com/watch?v=EDoCIIEivOO> to watch a short video explaining book

Theology of His/Her Body

Jason Evert

Written for high school teens, this reversible book may help lead them to living a chaste and pure life according to the teachings of the Catholic Church. Filled with examples and metaphors, young men and women both are sure to enjoy.

Made This Way: How to Prepare Kids to Face Today's Tough Moral Issues

Leila Miller and Trent Horn

Catholic teaching and how to talk to both young children and teens (2018)

The Parent Big Talk Book

Choosing the Best Sexual Risk Avoidance program

Helps parents talk to kids on ten (10) topics regarding sex, relationships, setting goals and abstaining from sex. (This book is put out by the same sex education program currently used in Gwinnett County Public Schools.) Easy to read and very practical Visit: <http://choosingthebest.com/parent-resources>

Collier Community Abstinence Program

Four (4) workbooks that can be used by parents and teens together. Excellently done and suitable for middle and high school. Also, perfect for parents who want to opt their children out of unsuitable sex education programs and want to make sure their children get a healthy sex education program and understand the abstinence message. The workbooks are free, but please consider making a donation. Approved by Catholic Bishop Dewane of the Diocese of Venice in Florida. Visit: www.projectccap.org/

Preview of a Birth

A 16-minute video covering fertilization and prenatal development. (Appropriate for middle school.) Available from the Human Development Resource Council.

Visit: <https://hdrc.org/product-category/for-me-individuals/parent-resources/>

Canavox online videos

Excellent three (3) minute online videos for parents that deal with a wide range of difficult issues that parents often have to discuss with their children. Very concise and practical and free of charge!

Visit: <https://canavox.com/dear-katy/>

Canavox Tips for Talking to Your Child about Sex

Concise, practical, free

Download <https://canavox.com/wp-content/uploads/2017/06/Canavox-Tips.pdf>

Sex, Gender and Identity

A 38-minute video by Canavox

Visit: <https://canavox.com/> scroll down to watch video by Dr. Ana Samuel

PURE/y YOU!: Growing God's Way

Partnering with parents to help children understand growing up. Both Catholic English and Spanish. (includes puberty)

Visit: <https://purelyyou.org>

Alive to the World

Alive to the World is a continuous, story-based virtues/values program. It is aimed at all children, religious or not, from Kindergarten to Grade 12. The program has already been adopted by teachers of many faith backgrounds in 22 countries.

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. Visit: <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. Visit: <https://integrityrestored.com/>

“Integrity Starts Here”

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. Visit: <https://peterkleponis.com/>

Covenant Eyes

An online website which helps with blocking sites as well as accountability.

Visit: <https://www.covenanteyes.com/>

“Unbound” and “Heart of the Father Ministries”

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.

Visit: <https://www.heartofthefather.com/>

“Help for Men and Women Struggling with Pornography Use or Addiction”

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.

Visit: <https://www.foryourmarriage.org/help-for-men-and-women-struggling-with-pornography-use-or-addiction/>

“Bought with a Price: Every Man’s Duty to Protect Himself and His Family from a Pornographic Culture”

Bishop Paul Loverde (Arlington) 2014 pastoral letter

Includes resources for men, women and parents.

<https://www.arlingtondiocese.org/documents/bought-with-a-price-anti-pornography-letter>

Overcoming Pornography Addiction: A Spiritual Solution (book)

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.

Visit: <https://www.amazon.com/Overcoming-Pornography-Addiction-Spiritual-Solution/dp/0809147971>

“Create a Clean Heart”

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.

Visit: <https://www.usccb.org/issues-and-action/human-life-and-dignity/pornography/index.cfm>

“Institute for Media Education”

Judith Reisman, Ph.D.

As a researcher, author, historian and 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 her website.

Visit: <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

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.”

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

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?

Visit: <https://www.catholic.com/quickquestions/what-is-the-churchs-teaching-on-extraordinary-care-for-the-sick>

Ordinary vs. Extraordinary Care (American Life League)
<https://all.org/euthanasia/ordinary-vs-extraordinary-care>

⁴ Sacred Congregation for the Doctrine of the Faith, “Declaration on Euthanasia,” May 1980.

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 lifesaving 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 2004² 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

¹ Howland, J.S. and Gummere P.J., “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.

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

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).

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,” *The 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.

Additional Resources for the Laity

Catholic Teaching on Assisted Nutrition and Hydration
Father Thomas Berg

Visit: <https://www.catholicnewsagency.com/column/51098/catholic-teaching-on-assisted-nutrition-and-hydration>

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 Peter T. Morrow, M.D., "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 for the Laity

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

Advanced Directive: Protective Medical Decisions Document
Rita Marker, J.D., Patients' Rights Council

Visit: <https://www.patientsrightscouncil.org/site/advance-directive-protective-medical-decisions-document/>

Understanding the Catholic Living Will; Health Care Surrogate
<https://www.flacathconf.org/declaration-on-life-and-death>

National Right to Life, Will to Live Document
<https://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 National 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

¹ *What is POLST?* (Emphasis added.) Available at <https://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: <https://www.ebookily.org/ppt/health-care-north-carolina>.

³ Charles P. Sabatino and Naomi Karp, *Improving Advanced Illness Care: The Evolution of State POLST Programs*, 2011, page 24. Available at <https://polst.org/wp-content/uploads/2016/06/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. Visit: http://www.canhr.org/newsroom/newdev_archive/2010/POLSTWhitePaper.html

⁵ Sabatino and Karp, 2011, page 24.

What are the Criteria for POLST Decision-Making that Facilitators utilize with Patients?

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.

⁶ C. Brugger, Ph.D. et al., “The POLST Paradigm and Form: Facts and Analysis,” *The Linacre Quarterly* 80 (2) 2013, 103-138, page 117-118. Available at https://www.cathmed.org/assets/files/POLST_Paradigm_and_Form.pdf

⁷ *CANHR Policy Brief - Physician Orders for Life Sustaining Treatment (“POLST”): Problems and Recommendations*, p. 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: <https://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.

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

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,

¹¹ *Speaker Training Tool for POLST Presenters*, POLST California, page 9. Visit: <https://capolst.org/>

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?

<https://www.ncregister.com/daily-news/physicians-order-for-life-sustaining-treatment-helpful-or-a-new-threat>

Legalizing Euthanasia by Omission

<https://www.zenit.org/en/articles/legalizing-euthanasia-by-omission>

POLST Forms Seen as Threatening Dignity of Patients (Diocese of Green Bay)

<https://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>

<https://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.gbdioc.org/images/stories/News_Events/pdf/WCC-POLST-Statement_07-12-2012.pdf

PHYSICIAN ASSISTED SUICIDE (PAS)

More Commonly Known Synonyms: “Medical Aid in Dying,” “Death with Dignity,” “Assisted Dying,” “Physician Assisted Dying,” “Aid in Dying,” “Mercy Killing”

Medicine is a noble profession. Physicians are committed to the practice of medicine and the preservation of human life. The taking of one’s life, even if a physician assists, is not medical care. Medicalizing death does not address the needs of dying patients and their families. When a patient is suffering and seriously ill, their greatest concerns are for a loss of autonomy and fear of being a burden to their family and society.

Physician assisted suicide underscores the sentiment that certain lives are expendable. This includes the most vulnerable members of society such as:

- The Elderly
- The Disabled
- The Poor
- Members of Minority Groups
- Children

Physician Assisted Suicide harms the patient, the patient-physician relationship,¹ and undermines trust in Medicine. The centrality of the patient-physician relationship is to be respected as it serves to protect the dignity of the human person.

The passage of Oregon’s “Death with Dignity Act” in 1994 which legalizes Physician Assisted Suicide made this the first US state and one of the first jurisdictions in the world to permit some terminally ill patients to determine the time of their own death.²

Typically, this is accomplished when a physician intentionally helps a patient, who has been deemed to have six months or less to live, commit suicide by prescribing drugs (i.e., barbiturates/sedatives). The patient fills the prescription and voluntarily consumes the drugs resulting in their death.³

There are inherent flaws in this practice. The patient is not required to notify loved ones of their intent to commit suicide and so oftentimes they die all alone. There are instances in which it has taken several days for the patient to die after consuming the pills.

The patient is not required to undergo a psychological assessment and receive the proper management for any psychological/emotional issues (i.e., depression, anxiety, etc.) that may be driving their desire to commit suicide.

The physician is expected to falsify the cause of death on the death certificate by attributing the death to the underlying medical condition. Under ordinary circumstances the falsification of a death certificate

¹ Code of Medical Ethics, © 2017. Chicago, Illinois. American Medical Association. Opinion #1.1.1.

² Retrieved from www.Oregon.org

³ Code of Medical Ethics; © 2017, Chicago, Illinois. American Medical Association. Opinion #5.7.

would be considered a felony in this instance the physician is protected. It's almost impossible for a physician to predict with accuracy that a patient has six months or less to live.

The physician involved in this practice is often one who has not had a longstanding patient-physician relationship with the patient because "Physician Assisted Suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."⁴ Most physicians are not willing to participate in this practice.

Care of the patient at the end of life requires a multidisciplinary approach including physicians, nurses, social workers, and chaplains. Consideration should be given to:

- Palliative Care: Specialized medical care for people living with a serious illness. It stresses relief from symptoms and stress of the illness. It improves the quality of life for both the patient and the family. It's based on the needs of the patient.
- Hospice Care: Meant to enhance the end of life by providing care that allows people to live their final days to the fullest, in peace, and without pain, in the place that provides the most solace. It begins after treatment of disease is stopped and when it is clear that the person is not going to survive the illness.
- Good symptom/pain control
- Psychological/Emotional and Spiritual support
- Focus on correcting healthcare disparities which already exist towards minorities.
- Focus on assuring those who are disabled that they too are a valuable member of society and worthy of receiving the superior medical care already available in our country.

The Hippocratic Oath⁵ is an oath of ethics historically taken by physicians to uphold specific ethical standards. It was developed in the 5th century B.C. in response to corrupt practices at the time. It is the earliest expression of medical ethics in the Western world and has a clear prohibition against this practice. It states: "...neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."

Suffering is part of the human condition. It is "...a consequence of original sin, acquires a new meaning. It becomes a participation in the saving work of Jesus."⁶ Suffering and ultimately death are part of the life process.

"'You shall not kill.' This is the first precept from the Decalogue which Jesus quotes to the young man who asks him what Commandments he should observe....Life is entrusted to man as a treasure which must be used well. Man must render an account of it to his master (cf. Mt 25: 14-30, Lk 19: 12-27)."⁷

Physicians are encouraged to aggressively respond to the needs of patients at the end of life. Physicians:

- Should not abandon a patient once it is determined that cure is impossible.

⁴ Code of Medical Ethics; © 2017. Chicago, Illinois. American Medical Association. Opinion #5.7.

⁵ Retrieved from www.wikipedia.org.

⁶ Catechism of the Catholic Church (CCC), 2nd Edition, 1997. United States Catholic Conference, Inc. Paragraph #1521.

⁷ Encyclical Letter *Evangelium Vitae*, Pope John Paul II (1995). Chapter III, Paragraph #52.

- Must respect patient autonomy
- Must provide good communication and emotional support.
- Must provide appropriate comfort care and adequate pain control”(Palliative care)

Finally:

- “Patients rightfully expect their physicians to care for them as they live with eventually fatal illnesses”.
- The American College of Physicians (ACP™), the nation’s second largest specialty organization does not support the legalization of PAS or Euthanasia.
- The American Medical Association (AMA™) recently reaffirmed its opposition to PAS.
- There remains a broad coalition of opposition against PAS among Disability groups, members of the medical community, patient advocates, and religious organizations.
- Physician Assisted Suicide is not medical care. It is unethical and immoral.

Additional Resources

Code of Medical Ethics; copyright 2017

American Medical Association (AMA)

Opinion numbers: 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.7, 2.1.1, and 5.7.

The *American College of Physicians* (ACP) Ethics Manual; Seventh Edition 2019

Center to Advance Palliative Care

www.getpalliativecare.org

Hospice Care

www.hospicefoundation.org

Apostolic Letter *Salvifici Doloris*

(On the Christian Meaning of Human Suffering)

Pope John Paul II, 1984.

Encyclical letter *Evangelium Vitae*

(The Gospel of Life)

Pope John Paul II, 1995.

Disability Groups Opposed to Assisted Suicide Laws

www.notdeadyet.org

Catechism of the Catholic Church (CCC) 2nd Edition. 1997.

United States Catholic Conference, Inc.

See:

Suicide: #2280-83, 2325

Euthanasia: #2277-79, 2324

Pain: #164,272,385,1435,1460,1521

*Respectfully submitted,
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