VOLUME 19, NUMBER 1
2025

HCEUSA

Health Care Ethics USA

A resource for the Catholic Health Ministry

2025

FEATURES

ALSO IN THIS ISSUE

 ISSN 2372-7683

CHA Catholic Health Association of the United States

SAINT LOUIS UNIVERSITY

The Sixth Annual Catholic Health Care Innovation in Ethics Forum

The Sixth Annual Catholic Health Care Innovation in Ethics Forum (CHIEF) was hosted virtually in October by the Hospital Sisters Health System (HSHS). This year's conference successfully accomplished CHIEF's mission: to provide a dynamic forum for ethicists to exchange innovative ideas and promote effective integration of ethics in Catholic health care. The conference was coordinated by the CHIEF planning committee that consisted of membership representing Catholic health care. Members were ethicists from CHRISTUS Health, CommonSpirit Health, Franciscan Missionaries of Our Lady Health System, Mercy Health, OSF Health care, Providence Health, SSM Health, and Trinity Health.

Similar to prior years, CHIEF welcomed presentations on a variety of topic areas such as:

- Community and Belonging
- High Reliability in Clinical Ethics
- Beyond the Common Consult
- Ethics & Data Science
- Professionalism and the Ethicist

This year's conference took place over the course of three days and included three types of learning sessions: a keynote address, lightning talks, and workshops.

KEYNOTE ADDRESS

M. Cathleen Kaveny, PhD, JD, MPhil, MA, delivered the CHIEF 2024 Keynote Address titled, 'Prophet, Priest, or Royal Ruler: The Identity Crisis for Catholic Ethicists Today.' Dr. Kaveny's thought-provoking and insightful talk had three parts. First, she explored the evolution of Catholic ethics in the second half of the 20th century. She described the shift that occurred from a time when moral theologians addressed issues in medicine to the present time of "Christian ethicists of the Catholic persuasion." Second, she articulated two problems leading to a crisis in Christian and Catholic ethics. The first problem is the division within the field, specifically that methods, foci, and presuppositions are deeply fragmented. The second problem she identified is the halted state of Catholic moral theology. Due to these two problems, Dr. Kaveny argued that Catholic health care ethicists face challenges in grounding current thinking and in finding a voice that carries authority. In the third part, Dr. Kaveny drew on the Munus Triplex as a source for constructive reflection for the role of an ethicist.

During her talk, Dr. Kaveny offered remarks on the current role of the ethicist in Catholic health care. She concluded that four common roles are dispenser of judgment, risk manager, negotiator, and translator. After sharing her

thoughts, she challenged attendees to consider what additional roles they feel they assume in their work as an ethicist. The post-conference survey asked attendees to answer Dr. Kaveny's question. Since CHIEF is about sharing ideas and prompting dialogue, we want to publish the responses that were submitted by CHIEF attendees: counselor, translator, protector, witness bearer, ERD police, jack of all trades, co-carrier of burdensome decisions, alleviator of moral distress, trusted thought partner, knowledge sharer, guide, co-deliberator, navigator, convener, inspirer of moral discourse, colleague, mission leader, enforcer of Catholic identity, prompt of a third way, creative problem solver, faithful partner, interpreter, advocate, advisor, educator, teacher, learner, collaborator, preserver of Catholic moral teaching and tradition, leader, supporter, clinician supporter, one who accompanies people through difficult situations, moderator, listener, facilitator, and architect of safe spaces.

LIGHTNING TALKS AND WORKSHOPS

Lightning talks are 7-minute presentations that are limited to 3 slides of content. In total, there were 18 lightning talks that included time for Q&A with the presenters. Of the many fascinating topics, 5 talks focused on normothermic regional perfusion (NRP) and donation after circulatory death (DCD). To compliment the lightning talks, Anji Wall, MD, PhD, FACS, a transplant surgeon at Baylor Scott & White Transplant Services and a doctorally-trained bioethicist, joined CHIEF for the final session to provide background on the clinical care involved in NRP. Dr. Wall's presentation and the round of lightning talks led to a Q&A session with a dynamic discussion about the ethical complexities of NRP.

CHIEF 2024 also offered a choice between two concurrent workshop sessions. Laura B. Webster, DBe, RN, HEC-C, led 'Assessing Ethicists: A Competency-Based, Milestone Approach.' This workshop examined current approaches of evaluating the attributes and characteristics of an ethicist. Dr. Webster then articulately presented a new approach for assessing an ethicist through their competencies and significant milestones.

Jennifer M. Dunatov, DHCE, MA, facilitated 'Obstetric Violence? How Ethicists Can Mitigate Harm in Birthing Spaces.' This workshop presented the prevalence and harmful impact of obstetric violence on mothers. Dr. Dunatov identified various factors that contribute to the violence and shared ideas to promote safety, trust, and accountability in birthing spaces.

CELEBRATING OUR FIELD

New to CHIEF this year was the exciting addition of the Emerging Ethics Leader Award. The award was established to recognize an ethicist who has been working full time for two to seven years in Catholic health care. The intent of the award is to recognize an ethicist who has moved beyond the start of their career and is emerging as an established, consistent contributor within a Catholic health care organization and the broader field. The inaugural winner of the Emerging Ethics Leader Award was Amy Warner, DO, MA. Dr. Warner serves as the Director of Ethics at Mercy Health. She was nominated by Jenny Heyl, PhD, HEC-C, who has been at Mercy

Health for 23 years and currently serves as Executive Director of Ethics.

In addition to the new award, CHIEF recognized attendees' publications from the prior year (September 2023 through September 2024). This collection of writings identified the exciting contributions of many ethicists. CHIEF attendees published 21 articles in 14 peer-reviewed journals during the prior year. Additionally, 8 articles appeared in trade and popular magazines, and attendees contributed to 5 book chapters. These publications highlight the significant contributions ethicists in Catholic health care are making to the field of bioethics.

FEEDBACK ON THE CONFERENCE

Following the conclusion of CHIEF 2024, post-conference survey results showed a 4.9 (out of 5) overall rating – a tremendous success! Of the 32 respondents, 87% of the attendees indicated they were "very likely" or "somewhat likely" to implement changes to their ethics services from content learned at the conference. Regarding the new aspects of this year's conference, 100% of the respondents want to continue the Emerging Ethics Leader Award.

For the first time, CHIEF provided 7.25 hours of Continuing Medical Education (CME) for attending the conference. The post-conference survey sought feedback on the value of offering CME. Half of the 32 respondents indicated that they are not pursuing HEC-C and therefore do not need CME, while 14 respondents stated they would report the CME hours to meet their HEC-C requirements.

Feedback also showed that the virtual forum of CHIEF is highly valued. The virtual setting balances out other in-person opportunities and provides an accessible opportunity for people to attend, even amongst their busy schedules. The 3 partial-day schedule of CHIEF was also strongly affirmed in the post-conference survey.

SAVE THE DATE!

For those who missed the 3-day CHIEF conference, recordings of day 1 and day 3 are available at this link.

Thank you to all the attendees who participated in this year's conference. We are excited to return for the Seventh Annual Catholic Health Care Innovation in Ethics Forum, hosted by SSM Health, from September 9-11, 2025! Please contact Michael.Miller@ssmhealth.com for any questions or comments on the 2025 conference.

Thank you to the following CHIEF Planning Committee Members for collaborating and providing input on this conference summary: Mary Homan & Theresa McCruden.

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Balancing Mission and Margin: Addressing the Needs of Unsheltered Populations in Emergency Medicine

AGE-OLD CHALLENGE: MISSION V. MARGIN

Catholic health care has long dealt with the challenges of balancing the organization's mission versus the margin of operating a business in the 21st century. In its purest sense, the margin of an organization is what remains when expenses are subtracted from revenue. Our modern era is not immune from navigating this balancing act, primarily within emergency medicine, or in under-resourced or rural communities lacking sufficient governmental programs including shelters, subsidized housing, food banks or soup kitchens, and behavioral health resources. Moreover, this lack of support system drastically impacts individuals with low social determinants of health, such as unsheltered, unemployed, or unrepresented individuals. The Mercy Health System is commonly susceptible to this age-old problem, which causes organizational tension in stewarding a business while upholding the mission, "…[to] bring to life the healing ministry of Jesus through our compassionate care and exceptional service." Sr. Mary Roch Rocklage, RSM, aptly described the tension of mission and margin: "[w]e wouldn't be here if we didn't attend to the business…we [also] have our mission, and if we don't attend to both—if we don't do the ministry part, somebody ought to close our doors. If we aren't attending to the finances, our doors will close. So we [need to] have that healthy tension."[i]

We found that two hospitals within the Mercy Health System were explicitly dealing with this challenge, which affected two very different communities: one a sizeable metropolitan trauma center and the other a midsized tertiary care hospital. This discovery showed that despite the community or location, the need of this population outweighed the available support. Therefore, we found ourselves asking this question: how do we balance the social needs of unsheltered populations in an emergency medicine setting while being faithful to our mission and wise stewards of our resources?

In addition to the organizational tension around stewardship, there are burdens on the individual caregivers who find themselves struggling with conflicting interests. These caregivers desire to serve patients, and their inability to help with non-medical needs often causes moral distress. Such distress can

cause resentment between the caregiver and the patient, fracturing the sacred bond within medicine. Moreover, individual caregivers want to meet the regulatory requirements set forth by EMTALA and CMS.

Oftentimes, hospitals exist in the liminal space between social support and medical support with health care. An institution needs a balance of supporting both, as such imbalances increase social or inappropriate admissions within an acute care setting. There are many definitions for social admission, but the common understanding is as follows: a hospital admission for individuals with no acute medical needs but rather social circumstances leading to a lack of support or inability to care for oneself adequately.[ii] There are many complications to social admissions, such as longer length of stays, over-utilization of limited resources such as staff time and attention, lack of available beds for acute medical patients, frequent readmissions, and a lack of long-term social support and follow-up for the patient with increased morbidity and mortality rates. Therefore, institutions must get creative within these tense spaces by partnering with various local specialties and community resources to maintain an ever-challenging balance.

PERSPECTIVES: METRO V. RURAL

Mercy Hospital Springfield is an 886-bed Level I trauma center in a metropolitan area. Mercy Hospital Ardmore is a 190-bed tertiary hospital and a Level III trauma center in a rural area. Figure 1 shows some of the differences faced by the Mercy Springfield and Ardmore hospitals with regards to the frequency of encountering unsheltered persons and the community and hospital resources available to refer them to.

Figure 1. Perspectives

Springfield: 886 Bed Trauma Center	Ardmore: 190 Bed Tertiary Hospital

• Frequency:
  • Daily (1110+ unsheltered population)
  • Staff abuse/distress
• Community Resources:
  • Emergency shelters
  • Halfway/transitional housing
  • Rehabilitation programs
  • Food banks
• Hospital Resources:
  • Food, hygiene, clothing
  • Bus passes, cab vouchers
  • CHW support
  • Weather respite
	• Frequency:
	  • Varies seasonally
	• Community Resources:
	  • Soup Kitchen
	  • Food bank
	  • Community Blessing Boxes
	• Hospital Resources:
	  • Food, hygiene, clothing
	  • CHW support
	  • Weather respite

SOLUTIONS: METRO V. RURAL

Due to the differences in environment and available resources, the approach to unsheltered persons presenting to the Emergency Department had to be different. For instance, while there is a greater volume of unsheltered persons in the Springfield area, along with more violent offenders, compared to Ardmore, there are fewer community resources available to support this population. Thus, Ardmore discovered they had to meet needs that were going unmet. Both hospital settings required education around appropriate medical admissions and expectation setting with emergency medicine caregivers and the unsheltered persons seeking aid. Of critical importance throughout creating and operationalizing the solution was the involvement of key stakeholders. The stakeholders were similar at both locations. They included Finance, Legal/Ethics, Case Management, Dietary, Public Safety, ED Leadership (Physician/Nursing), Behavioral Health, Mission, and Mercy Health Foundation.

Figure 2 depicts some of the different solutions from collaboration with stakeholders to provide the best care for this patient

population. Springfield's solutions centered around involving appropriate partners within the community to support these patients in finding assistance outside of the Emergency Department. Of note, is the partnership with the hospital's Foundation to acquire three trailers at a strategic location within the unsheltered campground supported by a groundskeeper to provide temporary housing for unsheltered patients cleared of acute medical needs without a safe place to discharge. If available, the unsheltered person would receive a cab voucher and a ticket to one of the trailers to spend a night out of the elements with a boxed meal and water. At Ardmore, the Foundation helped with transportation costs through paying for taxis or bus passes.

The ethicist's role varied. At Ardmore, Addison was involved from an administrative approach, offering support where department leaders needed it and guidance regarding expectation setting. At Springfield, Amanda played a dual role of administrative support by creating a task force of key stakeholders to develop strategic initiatives, education, consistent and trackable goals among leadership, and flowcharts on appropriate admission criteria, as well as being a consultant for one-off cases.

Figure 2. Solutions

Springfield	Ardmore
• Educating on medical vs. social admissions • Food/clothing/bus pass/cab voucher • Purchasing 3 trailers • Partnering with shelters • Partnering with Rehabilitation Centers • Partnering with police (violent patients)	• Partnering with Foundation • Accommodating social needs • Food/clothing/bus passes • Expectation setting

LESSONS LEARNED

One of the most important lessons learned in navigating this challenge was that we would have to make hard decisions about caring for people on this side of the Kingdom. One of the fundamental challenges will constantly be navigating the delicate tension of mission and margin, as the Sisters of Mercy before us. As we strive to innovate in areas like this, progress will often be hard-won and certainly be iterative. Neither of us has this challenge solved in our respective locations, and we never expect to. Another key lesson learned throughout this process was hospitals cannot be all things to all people. They must rely on community partners (where able) and work within the community to support (but not own) initiatives that help address social needs.

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Clarifying Cardiac Death in DCD through Aristotle and Aquinas: Active and Passive Potentiality

The definition of death has recently come into question, which has caused some authors to propose changes to the definition of death. Some of these concerns stem from questions about the compatibility of current practice in organ donation after cardiac death (DCD) and the definition of death in the Uniform Declaration of Death Act (UDDA). The lack of agreement on what changes should be made, or whether changes should be made at all, led to the recent abandonment of efforts to change the definition.[i]

A key distinction in the theory of causality found in Aristotle and Aquinas has so far been absent from this debate. The concepts of active and passive potentiality can avoid some of the concerns raised by those advocating for changes to the UDDA without resorting to a new definition. Instead, a re-understanding of the words in question can hopefully serve as a starting point for agreement. While the disagreement about the definition of death is multifaceted, this discussion is limited to cardiopulmonary death and does not include brain death.

A QUESTION OF DEFINITION

The UDDA defines death as "either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem."[ii] Some authors propose changing the word "irreversible" to "permanent" in the first part of the definition related to circulatory and respiratory functions.[iii] While there is no universally accepted definition of "permanent," one suggested definition is "loss of function that cannot resume spontaneously and will not be restored through intervention."[iv] This definition contrasts with the that of irreversible, which proponents of this change define as "loss of function or a condition that cannot be restored by anyone under any circumstances at a time now or in the future."[v] This suggests a categorical impossibility in which circulatory and respiratory function cannot resume even if resuscitation is attempted.

Proponents of this change typically provide at least three reasons for it. First, they argue that "irreversible" makes the determination of death in the context of DCD dependent upon the decision not to attempt resuscitation.[vi] Circulatory and respiratory function are irreversible not because it is impossible to do so, but because the medical team treating the patient chooses not to do so. If the care team attempted resuscitation after asystole, it might be possible to achieve circulation again in some

DCD donors. This does not mean they would recover from their illness, only that circulation might resume for a short period of time before stopping again. If death is truly a description of metaphysical status, then a decision of action or inaction should not affect it. This means some DCD donors might still be alive since circulatory and respiratory function could be reversed if attempted. Thus, "permanent" would help avoid this conflict.

Second, proponents of "permanent" believe it will align more with current practice.[vii] Since DCD requires the patient or surrogate to agree that resuscitation will not be attempted after asystole, then the loss of circularity and respiratory function is truly permanent rather than irreversible, according to their definitions. Moreover, it is standard practice in DCD to wait for a set period of time after asystole before actually beginning organ procurement. While the amount of time varies (usually two to five minutes), the purpose is the same: to ensure that cardiac activity will not spontaneously restart. This autoresuscitation would result in the resumption of circulatory function, meaning the patient would no longer be dead. Since there has never been a recorded case of autoresuscitation in DCD after more than five minutes of asystole, it is thus assumed the patient will not return to life on their own, even though circulatory function might be able to be restored in some cases if attempted. According to the above definition of irreversible, some patients are not yet dead because circulatory function could be restored if attempted.

Third, the care team cannot definitively determine death if it is defined as "irreversible" because they cannot know if resuscitation attempts will be successful until they are attempted and have failed. The current practice of waiting two to five minutes is not long enough after asystole to ensure resuscitation cannot be successful. Thus, proponents argue that replacing "irreversible" with "permanent" is better than changing current practice to align with the UDDA definition.[viii]

CLARIFYING IRREVERSIBILITY

One option not considered by either side so far is to clarify what is meant by "irreversible" rather than to throw it out. While this may be seen as a reinterpretation or new understanding of "irreversible", it is how I have always understood it, so it seems more accurate to call this a clarification. The proposed clarification is as follows.

When we call something "irreversible" in any context we mean to say that it cannot be reversed. More to the point, it lacks the potential to return to its former state. For example, a car that is irreversibly damaged means that no one or nothing can repair it. Even the best mechanic with new parts could not fix the problem. No matter what interventions occur, the car remains damaged.

In the context of death, this is the sense of "irreversible" that proponents of "permanent" seem to use: circulatory and respiratory function cannot be restored no matter what interventions occur. Regardless of how proficient the attempts at resuscitation are, the loss of function cannot be reversed. However, this understanding neglects another possible interpretation of "irreversible" that hinges on the concept of potentiality.

POTENTIALITY IN ARISTOTLE AND AQUINAS

As far back as Aristotle, and continuing with Aquinas, there has been a distinction between two types of potentiality: active potentiality and passive potentiality.[ix] A passive potentiality is the capacity to be changed, while an active potentiality is the capacity to induce a change. For example, a tree has a passive potentiality to become a table, and a carpenter has an active potentiality to build a table. An active and passive potentiality for the same change can sometimes exist in different entities, as with the tree and carpenter, and they can also exist in the same entity. For example, an acorn has an active potentiality to become a tree.

When an active and passive potentiality for the same change exist in different entities, the intervention of an external agent is required for the change to occur. A tree cannot become a table without the carpenter's work. Yet, when an active and passive potentiality exist in the same entity, that entity can achieve the change on its own without an external agent. In the right circumstances (soil, light, and water), an acorn will become a tree without any assistance from an external agent. While it might help if a gardener plants the acorn and tends to its needs, it is not required for the acorn to change into a tree. This self-reliance is a key distinction for the example of DCD.

When applying this distinction to "irreversible" the active potentiality to return to a previous state can also reside in the entity that lost the function or in an external agent. A car has only a passive potential to be fixed when damaged but it has no active potentiality to repair itself. It always requires a mechanic who has the active potentiality to fix it in order to be repaired. In fact, a car even requires an external agent with active potentiality to function at all, namely a driver. Even a self-driving car requires someone to give it a destination.

A living organism, however, is different. In some cases, an organism has the ability to heal and repair itself, meaning the active and passive potentiality for healing exist in the same entity. In other cases, healing requires the intervention of someone else, meaning the passive potentiality for healing exists in the organism and an external agent like a nurse or veterinarian has the active potentiality to heal. Of note, Aristotle and Aquinas considered the soul to be the first actuality in a body potentially having life.[x]

Regarding death, a living body has both an active and passive potentiality to perform circulatory and respiratory functions. On its own, without assistance from others, it can perform both of these functions. A dead body has lost that active potentiality; its potential for these functions is now passive. After death, it might be possible to regain these functions through resuscitation, or miraculous divine intervention in the case of Lazarus, but this requires an external agent to intervene either medical or divine. At some point after death, even the passive potentiality is lost. If death is the separation of body and soul, it seems reasonable to say that, at least in the Aristotelian-Thomistic view, death has long been viewed as the loss of the active potentiality of circulatory and respiratory function.

ACTIVE POTENTIALITY IN DCD

Returning to DCD, the distinction between

active and passive potentiality sheds new light on the proposal for changing the UDDA to replace "irreversible" with "permanent". The capacity for autoresuscitation is an active potentiality. Once that active potentiality is lost, at least according to Aristotelian-Thomistic theory of causality, the person is dead. The person is still dead even if a passive potentiality for circulatory and respiratory function remains. In other words, simply because someone might be able to restart these functions does not mean the person is alive. By understanding "irreversible" to refer only to an active potentiality to return to the prior state, it means the capacity for autoresuscitation is the hallmark of life and its loss the sign of death.

On the other hand, proponents of this change seem to define "irreversible" as the passive potentiality for cardiac and respiratory function. They seem to think this is the only way to interpret the word irreversible in this context. However, if "irreversible" is understood as an active potentiality only, and not a passive potentiality, it seems to resolve the three concerns discussed above: 1) it describes the metaphysical reality for itself as the state of death is not dependent upon a decision of action or inaction; 2) it aligns with the current practice of waiting for the possibility autoresuscitation to dissipate; and 3) the care team can accurately determine death once cardiac and respiratory function stop rather than requiring resuscitation to be attempted and fail.

A PATH FORWARD

Understanding the potential for the circulatory and respiratory to restart as an active potentiality and not a passive potentiality addresses the above arguments of proponents for changing the language of the UDDA from "irreversible" to "permanent." Proponents may raise other arguments for "permanent", especially as it relates to neurological criteria for death, but seeing "irreversible" as the loss of an active potentiality for circulatory criteria can address their concerns. This understanding is not new but perhaps has not been clear up to this point. It is also consistent with the current UDDA language, current DCD practice, and many understandings of death that have existed for centuries. While this clarification may not resolve all disagreement about the UDDA's definition of death, it can hopefully serve as a foundation for more discussion and possible agreement. ✣

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Ethical Guidelines for Use of NRP cDCD

Catholic health systems across the United States are increasingly encountering requests from Organ Procurement Organizations (OPOs) to utilize a new technique for organ procurement, normothermic regional perfusion in controlled donation after circulatory death (NRP cDCD). This technique involves restoring oxygenated blood flow to organs after the declaration of death by the circulatory standard with the arch and cerebral vessels often clamped in the process.

Ethicists and ethics committees have a unique opportunity to support hospital leaders in evaluating ethical considerations around whether to use NRP cDCD. Many ethicists are already engaged in this dialogue.[i] If your ministry has decided to allow NRP cDCD in some form (i.e. abdominal or thoracoabdominal NRP), or if you discovered the protocol is already used at your ministry, I offer rationale to make the case for developing ethical guidelines for use of NRP and a project management strategy to identify and implement the guidelines that best serve your ministry, diocese, patients, and staff.

WHY ETHICAL GUIDELINES?

As the Ethical and Religious Directives state, "new medical discoveries, rapid technological developments, and social change, … can either be an opportunity for genuine advancement in human culture, or … lead to policies and actions that are contrary to the true dignity and vocation of the human person."[ii] At least four reasons suggest Catholic health care should establish ethical guidelines for use of NRP cDCD:

1. *Minimize harm to donors:* Bernard Lo, discussing potential harm to donors of medications administered pre-mortem to preserve organs, cautions that "[T]he best interests of organ donors should not be compromised to retrieve organs and benefit the recipient."[iii] Since respecting the dignity of the donor prohibits doing further harm to the donor, even for the sake of the common good of the organ donor.
2. *Remove and/or manage conflicts of interest:* The dichotomy in organ donation, namely that one person's death is necessary for others to live, inherently poses conflicts of interest. Such conflicts are augmented by the business context around organ donation. Recognizing this, Lo states: "Decisions about the potential donor's care must be separate from and take priority over decisions about procurement and transplantation."[iv] The ERDs similarly encourage mitigating conflicts: "the physician who determines death should not be a member of the transplant team."[v] Managing conflicts can also prevent possible scandal from arising.
3. *Respect for the dying process:* The relative newness of NRP, the intimacy with which

it uses the donor's body, and the significant implications of analyses on the ethicality of NRP demand special attention to Catholic health care's role in caring for the seriously ill and dying. The ERDs urge Catholic health care to provide patients "with appropriate opportunities to prepare for death," (no. 55) which in organ donation could mean providing the dying patient with a compassionate space for loved ones to be present that is not the sterile, rigid environment of the Operating Room (OR).

4. *Respect the deceased:* Upholding Catholic health care's longstanding respect for the deceased, Pope Pius XII affirmed, "The human body deserves to be regarded entirely differently [from the dead body of an animal]. The body was the abode of a spiritual and immortal soul, an essential constituent of a human person whose dignity it shared. Something of this dignity still remains in the corpse."[vi] Since organs can be perfused in situ during NRP for minutes to hours, respecting the deceased might mean limiting perfusion to the minimum time necessary to confirm organ viability and arrange transfer plans.

APPLYING PROJECT MANAGEMENT FUNDAMENTALS

The Ethics Manager employed project management methodology can be used to establish ethical guidelines for use of NRP cDCD. Common in the information technology industry, project management involves developing project plans to oversee a project through five phases: *Initiation, Planning, Execution, Monitoring and Controlling,* and *Closing.*

INITIATION

Initiation: *team defines project purpose, objectives, scope, stakeholders, and constraints.*

Our purpose was to establish ethical use criteria for NRP cDCD. Objectives involved identifying the criteria, delivering education, developing an enhanced inform consent process, and integrating the criteria in the clinical process map for organ donation. The scope was for one hospital. Constraints included legal, risk, and ethical considerations, space, and resources.

Stakeholders spanned layers of subsidiarity: our hospital, the ministry market (region), and our national system. Local stakeholders included Clinical and Administrative leaders, Risk, Cardiac Surgeons, Ethics Committee Chairs, Hospitalists, Nurse Managers and Chaplains for units where donor patients receive care. Regional stakeholders included leaders in Transplant, Mission, Ethics, and Spiritual Care, Diocesan leaders, and OPO leaders. National stakeholders included leaders in Ethics and Legal, and counterpart Ethics and Transplant roles in another region using NRP.

PLANNING

Planning: *project manager builds a project plan with tasks, schedules, resources, budgets, and risk assessments.*

First, we discussed ethics and legal concerns with national stakeholders, then held multidisciplinary meetings locally to learn about the protocol, discuss clinical and ethical considerations, plan the effort, and assign tasks.

An Ethics Committee subgroup reviewed ethics literature and crafted guidelines to mitigate ethical concerns (see next section).

EXECUTION

Execution: *work the plan (one might prefer 'implementation' to this project management term).*

Enhanced informed consent language was developed by Clinical leaders, Ethicists, and Legal. A clinical process map was developed by Clinical Leaders, Ethicists, and Medical Educators. Education was developed and presented by Medical Educators and Ethicists to clinicians and staff involved in organ donation. Mission and Ethics leaders communicated with the Diocese.

MONITORING AND CONTROLLING

Monitoring and Controlling: *project performance is tracked in the project plan and monitoring practices are set for post-project administration.*

For monitoring, Ethics and Spiritual Care management were added to a monthly organ donation meeting with Clinical leaders and the OPO, and issue escalation plans were communicated.

CLOSING

Closing: *all project tasks are completed and accepted by stakeholders, project documents are shared, and a retrospective is conducted.*

Ethical use criteria were accepted and implemented before the launch date, with materials shared appropriately. Retrospective space occurs in monthly meetings.

ETHICAL GUIDELINES

This process allowed us to establish these ethical guidelines for NRP cDCD:

1. *Enhance the informed consent process.* Our informed consent language is used in verbal conversations between the OPO's Family Care Liaison and families consenting/authorizing for donation, and a Team Lead or Chaplain witnesses the conversation.
2. *Locate the dying process in the Post-Anesthesia Care Unit (PACU).* A separate PACU room provides a compassionate space for the dying process where family can be comfortably present without needing personal protective equipment, spiritual care and the Sacraments are accessible, and physicians experience less pressure to determine death. The PACU provides a visual ethical separation in addition to the separation of staff between the declaring and procuring teams.
3. *Educate all clinicians and staff involved in donation on clinical and ethical considerations.* Education involves clarifying our ethical approach for the purpose of clamping the arch and cerebral vessels.
4. *Observe the Dead Donor Rule (of course).* After death is determined in the PACU, a 5-minute hands-off period occurs, during which the donor is moved to the OR for second confirmation of death. Procurement only begins after the second confirmation.

Establishing ethical guidelines via this

process can help Catholic ministries maintain integrity to their mission, values, and ethical commitments throughout the organ donation process. ✠

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Policies and Prevention: Ending the Use of Restraints for Pregnant and Laboring Patients in Catholic Hospitals

While over 40 states have passed laws that restrict the use of restraints during the birthing process for patients coming from carceral settings, the practice of using technologies such as handcuffs, leg restraints and belly chains to restrain patients coming from carceral settings is still occurring, even in states with anti-shackling laws.[i] This can be due to exceptions written into anti-shackling laws that allow prison and jail staff to make determinations of whether or not a patient is deemed as a "threat to public safety" or at risk of escape, as well as pre-existing hospital policies that require patients coming from carceral settings to be shackled upon arrival to the hospital.[ii]

House, et al. have argued that commonly cited safety concerns that are used to justify the continued practice of shackling of patients coming from carceral settings to give birth in a hospital are unpersuasive for the following reasons:

"(1) physical demands of labor and delivery make escape extremely unlikely,

(2) no pregnant or laboring incarcerated individual has ever been documented as having escaped a hospital, and

(3) most women experiencing incarceration 'are not violent offenders, so restraining them to prevent attacks on workers is largely unnecessary.'"[iii]

Moreover, the practice of shackling while giving birth can also put patients at risk for physical harm. Shackling has been shown to put patients at a higher risk of physical complications such as placental abruption, maternal hemorrhage, and stillbirth as well as psychological harms, which is particularly troubling given the disproportionately high rates of post-traumatic stress disorder within the population of incarcerated women.[iv] The practice of shackling also disproportionately impacts Black women, given that Black women are incarcerated at a rate that is three times higher than White women.[v] For these reasons and more, shackling patients coming from carceral settings during the process of giving birth should be considered an inhumane and unsafe practice that contributes to unjust health inequities for a patient population that is incredibly vulnerable.

Catholic ethicists have a unique responsibility to help ensure that restraints are not used for pregnant and laboring patients coming from

carceral settings. This responsibility stems from Catholic social teaching regarding the social responsibility of Catholic health care services. We have identified four directives from the Ethical and Religious Directives for Catholic Health Care Services that support the claim that ethicists working within Catholic health care institutions have a responsibility to support these efforts to respect the dignity of patients coming from carceral settings through ensuring that restraints are not used while a patient is giving birth.

Directive 3: "In accordance with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination"

Directive 5: "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel"

Directive 23: "The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status"

Directive 33: "The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or the use of technology"[vi]

Individuals coming from carceral settings are certainly "people whose social condition puts them at the margin of our society" and require our advocacy and support to ensure that the care that they receive in Catholic health care settings is free of discrimination and undue harm, while protecting their inherent human dignity. Ending the use of restraints, which is a dangerous practice without medical benefit or factually-grounded reasons for implementation, is a way in which Catholic health care institutions can embody their social responsibility and protect the dignity of a highly vulnerable patient population.

Given that restraints are still often used in hospitals located in states in which there are anti-shackling laws, ethicists working within Catholic health care institutions can support anti-shackling efforts through participating in the development of policies, providing education, and facilitating communication efforts between health care caregivers and employees coming from carceral settings when issues of safety arise. For ethicists working in Catholic health care institutions, we offer the following recommendations:

1. Review your hospital's policies regarding patients delivering who are coming from carceral settings. Consider the following when reviewing and updating policies: "Organizational policies should comply with applicable federal and state law, be concise and easily readable, use language that reinforces all patients' personhood and dignity, and limit exceptions in accordance with 3 features of model policy:
   i. A pregnant patient in any stage of delivery may not be placed in restraints at any time.
   ii. A patient in postdelivery recuperation shall not be placed in restraints, except under extraordinary circumstances (ie, the patient

presents immediate, serious threat to self or others or presents immediate, credible risk of escape that cannot be curtailed by other measures). If clinicians determine that restraints must be used, restraints shall be the least restrictive and most reasonable available.

iii. Leg or waist restraints shall not be used on a pregnant or postpartum patient"[vii]

2. Provide education to caregivers regarding:

i. hospital policies.

ii. any exceptions included in state laws, as well as how to approach discussions about those exceptions.

iii. how to communicate with prison or jail staff who may accompany patients to Labor & Delivery units.

By creating hospital policies that are aligned with dignity-enhancing, medically-indicated best practices, and equipping hospital employees with the education and resources to support the implementation of hospital policies, ethicists working in Catholic health care institutions can do their part to ensure that pregnant and laboring patients coming from carceral settings receive the safe, respectful care that they and their babies deserve.

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Literature Review: Recent Contraception Literature

Not only did the 2022 *Dobbs v. Jackson* Women's Health Organization decision lead to the implementation of abortion restrictions in some states, but it also affected clinician and patient behavior in the realm of contraception due to access to these services being inextricably linked. In states which have enacted the most restrictive bans post-*Dobbs*, there are concerns that contraceptive restrictions will also be enacted, especially on emergency contraception (EC). Many family planning clinics have closed in these 26 states, eliminating a source of contraceptive access that approximately one in ten women rely on.[i] Others fear that clinicians will pressure or coerce patients to adopt their preferred methods in contraceptive counseling.[ii] *The Ethical and Religious Directives* (ERDs) echo the Catholic Church's prohibition of contraceptives utilized with the purpose "either as an end or a means, to render precreation impossible," because this violates the inseparability of the unitive and procreative facets of the marital act.[iii] ERD 52 states: "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning." It may appear, therefore, that restrictions on contraception have no effect on the provision of Catholic health care services. However, the ERDs note two instances in which the use of contraception is permissible. First, in ERD 36, the USCCB outlines the licit usage of medications which "prevent ovulation, sperm capacitation, or fertilization" for women who are victims of sexual assault. Although it is impermissible to remove, destroy, or interfere with the implantation of a fertilized ovum, the provision of "compassionate and understanding care" may call for the use of contraceptives as a form of defense against conception following rape. In ERD 54, "procedures that induce sterility" can be licit via the doctrine of double effect, under which "the direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." Legal shifts affecting the availability of contraceptives, therefore, may impact the ability of Catholic health care systems to provide adequate medical care. The articles reviewed below capture trends in oral and emergency contraceptive use post-*Dobbs*, as well as changes in clinician counseling of adolescents following the landmark decision.

Qato, Dima M., Rebecca Myerson, Andrew Shooshtari, Jenny S. Guadamuz, and G. Caleb Alexander. "Use of Oral and Emergency Contraceptives After the US Supreme Court's Dobbs Decision." *JAMA Network Open* 7, no. 6 (June 26, 2024): e2418620. https://doi.org/10.1001/jamanetworkopen.2024.18620

Qato et al. examined the effects of the

Dobbs decision on monthly fill rates of oral contraceptive pills (OCPs) and emergency contraceptives (ECs), comparing states which implemented full abortion bans (12 states) following the decision with comparison states (14 states), which maintained a consistent level of restrictions pre- and post-Dobbs. Using IQVIA's National Prescription Audit, PayerTrak, and the 2021 American community survey, the authors calculated the monthly rates of pharmacy-dispensed oral contraceptive fills per 100,000 women of reproductive age during four time periods: pre-Dobbs oral arguments, between the Dobbs oral arguments and the announcement of the decision, the first year post-*Dobbs*, and more than one year after the decision.

142.8 million prescriptions for OCPs and 904,269 prescriptions for ECs were filled nationally at pharmacies between March 2021 and October 2023, spanning the duration of the study. The monthly fill rate declined 25.6% nationally between these time points, dropping from 6784 to 5049 fills per 100,000 women. Fill rates for non-oral hormonal contraceptives also declined steadily over this time span. When examining EC rates, the authors found that the period during which Dobbs was under review witnessed an increase from 33.3 to 40.5 fills per 100,000. This number peaked at 52.6 following Dobbs in July 2022, but declined to reach pre-Dobbs levels (32.9/100,000) and fell even lower in the most restrictive states.

When examining the states which became the most restrictive with comparison rates, the authors found that states which implemented full abortion bans experienced a 4.1% decline in OCPs (285.9/100,000 fewer fills) in the year following the decision. Past the one year mark, the most restrictive states underwent an additional 5.6% decline (386/100,000 fewer fills) compared to comparison states. While EC fills increased in both groups of states in the first year following the decision, the most restrictive states saw a 65% decrease in EC fills (13.2/100,000 fewer fills) after the one-year mark. At the same time point, levonorgestrel and ulipristal fills had declined by 48% (5.8/100,000 fewer fills) and 89.9% (7.4/100,000 fewer fills) in these states, respectively. Using a sensitivity analysis, the authors determined that declines in oral contraceptives were not offset by increases in use of other contraceptive methods.

The authors attribute these results to the closure of family planning clinics, one-third of which provide contraceptive prescriptions – both OCPs and ECs – to be filled at pharmacies. Supporting this claim is the fact that "post-Dobbs declines in ECs were greatest in the most restrictive states that had closed a larger share of their family-planning clinics". They also hypothesize that confusion regarding the legal status of ECs may have led to the decline in fills of ECs following the decision; recent policies such as "the exclusion of ECs from contraceptive coverage mandates, the lack of Medicaid coverage for over-the-counter ECs, and policies that allow pharmacists to refuse to dispense contraceptives due to moral, ethical, or religious objections" may be contributing factors to the decreased rates in the most restrictive states. The authors conclude by pointing to the need for further research on changes in the use of long-acting and permanent contraception post-*Dobbs*.

Bullington, Brooke W., Emily S. Mann, Madeline Thornton, Joline Hartheimer,

Kavita Shah Arora, and Bianca A. Allison. "Clinician Perspectives on Adolescent Contraceptive Counseling Following Dobbs v. Jackson: Implications for Young People's Contraceptive Autonomy." *Journal of Pediatric and Adolescent Gynecology* 38, no. 1 (February 2025): 75–78. https://doi.org/10.1016/j.jpag.2024.10.007.

Bullington et al. hypothesized that, post-*Dobbs*, clinicians prescribing contraception to adolescents may prioritize pregnancy prevention and pressure patients to adopt specific methods over their preferences or to utilize contraception against their wishes. The authors attribute this pressure to worries about the consequences of unintended pregnancy and efforts to maintain the national public health goal of preventing adolescent pregnancy.

After conducting semi-structured interviews with 16 clinicians (15 physicians and one nurse practitioner, all of whom see adolescent patients) sampled from an American Academy of Pediatrics conference, three themes emerged. First, participants spoke of an increased focus on pregnancy prevention in counseling, with one participant noting, "I like [pregnancy] prevention rather than [abortion] so, if we can just avoid it altogether, it would be ideal." Second, participants spoke of using the *Dobbs* decision to promote long-acting reversible contraceptive (LARC) methods – such as one respondent who noted they are "pushing IUDs much, much more and much earlier". One participant said, "Oh, [the *Dobbs* decision] is actually helping me, because I'm saying, listen, I don't know what else they would do [if they got pregnant]", as well as how the Supreme Court decision "added a talking point to [their] push for LARC." Another explained that they advised caution for a patient who was moving to a state with limited abortion access for college, skewing their recommendation towards LARC. The third and final theme identified was that location of practice and the state's abortion legislation influenced the counseling provided, with some counseling not changing significantly in areas unaffected by *Dobbs* and some counseling becoming highly influential following abortion restriction.

In their discussion of the results, the authors note that physicians must be aware of the potential biases created and amplified by the *Dobbs* decision, which inhibit adolescent autonomy and act as barriers to achieving the national recommendations of "person-centered, impartial contraceptive counseling." Clinicians must examine their values and beliefs and ensure that they are not emphasizing their priorities and public health goals at the cost of excluding patient preferences and needs. The authors call for a change in practice to include "comprehensive contraceptive care provision, provider training in unbiased and affirming contraceptive counseling, and continued refinement of developmentally tailored contraceptive decision aids" so that reproductive care does not come to constitute an assault on reproductive justice.

RECENT NATURAL FAMILY PLANNING (NFP) LITERATURE

Natural family planning refers to the use of knowledge of "natural biologic markers to estimate a woman's fertile phase within her menstrual cycle" in order to avoid or achieve pregnancy.[iv] Catholic proponents of NFP claim that this practice, incorporating periodic abstinence, maintains the proper

expression of conjugal love, as opposed to the use of contraception, which stands in opposition to the virtue of chastity.[v] Non-religious proponents claim that the use of NFP can strengthen marriage by facilitating a greater understanding of fertility, as well as increasing communication, self-mastery, intimacy, appreciation for intercourse, and spiritual well-being; others raise concerns of detriment and stress caused by NFP due to challenges in implementation, lack of spontaneity, and fear concerning pregnancy. Either way, there has been an increase in the number of women who wish to manage their fertility through non-hormonal methods (from 1.1% use of fertility-based awareness methods in 2008 to 3.2% use in 2015), such as through applications which chart and track the menstrual cycle, due to hormonal contraception's side effects.[vi] Considering the effects of *Dobbs* on contraceptive use behaviors and attitudes towards contraception, we should examine the effectiveness and effects of NFP methods, which require no prescription but need education and consistency to be effectively implemented. The articles below detail a study of the effectiveness of the Marquette NFP Method and the effects of NFP on marital relationships to determine whether NFP can serve as a suitable alternative to prescription contraceptives.

Mu, Qiyan, Richard J. Fehring, and Thomas Bouchard. "Multisite Effectiveness Study of the Marquette Method of Natural Family Planning Program." ***The Linacre Quarterly*** **89, no. 1 (February 2022): 64–72. https://doi.org/10.1177/0024363920957515.**

The use of NFP and other fertility-based awareness methods for contraception raises concern among health care providers; these methods are not deemed effective due to "worries and concerns of user inappropriateness, lack of accurate knowledge of female fertility and of NFP methods, and clinical time constraints to teach the method." Modern NFP incorporates more advanced technology, but still presents a typical use failure rate between 2 and 23% depending on the method. The Marquette Method, developed in 1998, uses urine hormonal monitoring technology to estimate the cycle's fertile window. Traditional aspects of NFP like mucus monitoring and temperature taking may also be incorporated, and the method must be taught by a teacher who has been trained with a theory course, practicum course, and medical applications course.

Mu et al.'s study was a retrospective and longitudinal investigation over the course of 12 months, using the teaching records of ten Marquette Method teachers in the United States and Canada. This group of teachers was comprised of professional nurses, advanced practice nurses, a family practice physician, and a physician assistant. The average woman receiving the education was 29.63 years old, and of these women, 32.9% had regular cycles, 60.7% were postpartum and breastfeeding, and 5.6% had irregular cycles. The 1,221 women used a variety of indicators, with women using basal body temperature, cervical mucus monitoring (CMM), electronic hormonal fertility monitoring (EHFM), luteinizing hormone urine monitoring (LH test), or a combination of these. The majority (61.8%) used a combination, with the most popular choice being the use of the LH test with either CMM or EHFM (38.6%), followed by EHFM only (27.2%), then the combination of CMM

and EHFM (23.2%), and finally, the use of CMM alone (9.3%).

Correct-use unintended pregnancies (pregnancy resulting despite avoidance of intercourse in the fertile window) are contrasted from incorrect-use unintended pregnancies (pregnancy resulting from intercourse in the fertile window or an incorrect calculation of the fertile window). A total of 42 unintended pregnancies were reported in this study, with 11 of these marked as correct use unintended pregnancies. The overall typical use pregnancy rate was calculated to be 6.7 per 100 women over the course of 12 months; when examining each subgroup, the rates are 2.8, 8.0, and 4.3 pregnancies per 100 women for the regular cycle group, the postpartum and breastfeeding group, and the irregular cycle group, respectively. When examining pregnancy rate by method, the rates were 4.1 per 100 women who used LH with CMM or EHFM, 8.1 per 100 women who used EHFM alone, 14.1 per 100 women who used CMM and EHFM in combination, and 15.6 per 100 women who used CMM alone.

These findings are consistent with previous research on the Marquette Method's effectiveness. The Marquette Method is also comparable to other NFP methods, and the unintended pregnancy rates are close to that of the hormonal contraceptive pill (8/100 unintended pregnancies in a 12-month period) and the male condom (12/100 unintended pregnancies in a 12-month period).

The authors note several limitations of the current study: the retrospective design does not allow for the calculation of correct use pregnancy rates by correct months of use, and the data set lacks demographic information about religion, economic status, race, ethnicity, marital status, and level of motivation for avoiding or achieving pregnancy (once motivation levels fall below 8 on a 1-10 scale, there is a significant increase in unintended pregnancies). Despite these limitations, this study demonstrates that "health care providers who completed the Marquette Method teacher training program can successfully teach women and couples NFP and achieve consistent results comparable to those of previous effectiveness studies.

Fehring, Richard J., and Michael D. Manhart. "Natural Family Planning and Marital Chastity: The Effects of Periodic Abstinence on Marital Relationships." ***The Linacre Quarterly*** **88, no. 1 (February 2021): 42–55. https://doi.org/10.1177/0024363920930875.**

Fehring et al. set out to examine the influence of contraception and the use of NFP on divorce, separation, and cohabitation rates in women of reproductive age. They begin with a review of the current literature surrounding NFP and periodic abstinence (PA), concluding that the majority of male and female users of NFP report that the practice has helped their marriages despite some difficulty adhering, and these individuals may even demonstrate higher self-esteem, higher levels of intellectual, relational, and sexual intimacy, and greater spiritual well-being when compared to contraceptive users. Small sample size and convenience sampling present limitations in this literature, but one cited study shows that 62% of couples using NFP reported that the practice improved their relationship, while 1.4% stated it worsened their relationship. When examining contraception, the same

study found that 12.5% of contraceptive-using couples felt it improved their relationship, while 22.5% reported that use worsened their relationship. The authors' review of the literature led them to conclude that there was no significant difference in frequency of intercourse between NFP and contraceptive users. Finally, they present the strong claim that ever-use of family planning methods like sterilization, vasectomy, OCPs, condoms, and abortion were all associated with increased odds of divorce when compared with women who had never used these methods in one study; however, they point out the very small sample size of women who have ever-used NFP and that many other factors (such as religiosity) could lead to or prevent divorce.

Fehring et al.'s study hypothesized greater odds of divorce and cohabitation for women who ever-used the aforementioned contraceptive methods when compared to those who never-used those methods, as well as lower odds of divorce for frequently church-going women who have ever-used NFP and report religion's import in their lives. They used the data set from the National Survey of Family Growth, including interviews with 2,582 women who had ever been married. Of these women, 70.8% were married, 19.7% divorced, 7.8% separated, and 1.7% widowed. 51.4% of women were Protestant, 20.5% were Catholic, 17.9% reported no religious affiliation, and the remaining 10.1% were of other faith systems.

Results of this study showed that the most common method of contraception was sterilization; comparatively, only one % of women reported current NFP use. Divorce and separation rates were 39.4% for women who had ever-used sterilization, 27.7% for those who had ever-used condoms, and 14% for those who had ever-used NFP. As demonstrated, "women who had ever-used NFP had lower odds of divorce compared to those women who never-used NFP." Ever-use of oral contraceptives increased the odds of divorce or separation by 40%, and sterilization did so by 60%; ever-use of NFP decreased the odds by 31%, and church attendance did so by 49%. Cohabitation, which religiosity significantly protected against, was also associated with a 2.4 times increase in the odds of divorce or separation compared to women who had never cohabitated. This finding ties into the study because the ever-use of sterilization, OCs, and condoms is associated with between a 1.7 times and 3 times increase in the odds of cohabitation when compared to women who never-used these methods. These findings are limited by the low number of NFP users and the investigation of ever-use of NFP as opposed to consistent use, but the results indicate that the use of periodic abstinence as a component of NFP serves to strengthen the marital relationship.

CONCLUSION

Evidently, the historic overturning of *Roe v. Wade* did not only impact abortion access in the United States. The ripple effects of shifting abortion legislation on contraception decisions are merely beginning to be investigated, and the reproductive landscape will continue to shift as states continue to deliberate their abortion services and provision of reproductive care service. These shifts make it critical to devote attention to changes in reproductive health and the effects of different family planning means on relationships. Evidence suggests that the inaccessibility of abortion may lead to a

greater push, both by women and their health care providers, for contraceptive use. Although increased utilization of NFP techniques – performed while the couple remains open to procreation – stands in alignment with the teachings of the Catholic tradition, contraceptive use which disrespects the marital act by separating union from procreation does not. In light of these shifts, Catholic health care systems may need to emphasize and clarify the Church's position on contraceptives while continuing to provide compassionate and understanding care to all women.

The opinions and statements in this article are those of the author and do not necessarily reflect the opinion of CHA. The text and the articles discussed within are for educational purposes only and are not intended to guide practice or policy.

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ENDNOTES

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HCEUSA | A Quarterly Resource for the Catholic Health Ministry

Health Care Ethics USA © 2025 is published by the Catholic Health Association of the United States (CHA) and the Albert Gnaegi Center for Health Care Ethics (CHCE) at Saint Louis University.

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