Long-Acting Contraceptives for Adolescents

A Critique of the Policy of the American Academy of Pediatrics

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Abstract. In 2014, the American Academy of Pediatrics published its policy statement on contraception for adolescents, which provides, in effect, a mandate to temporarily sterilize all adolescents with long-acting reversible contraceptives for five to ten years. The author reviews the AAP guidelines and their effects on Catholic adolescents, their families, and adolescent health care providers. He then discusses medicolegal issues raised by the policy, outlines Catholic strategies for combating it, and proposes a diocese-based physician-led program for teaching and counseling elementary and high school students. *National Catholic Bioethics Quarterly* 16.1 (Spring 2016): 63–81.

On September 29, 2014, the American Academy of Pediatrics (AAP) published both its policy statement and technical report on contraception for adolescents.[1] This paper reviews the AAP policy and takes the position that the policy is opposed to the

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1. American Academy of Pediatrics (AAP) Committee on Adolescence, "Policy Statement: Contraception for Adolescents," *Pediatrics* 134.4 (October 2014): e1244–e1256, cited

teaching of the Catholic Church. Catholic strategies for dealing with the immoral prescription of contraceptives to Catholic adolescents are suggested. It should be noted that the AAP policy statement does not contain a proper conflict-of-interest statement or full disclosure by either the AAP or the main author. The statement says only that the AAP has not accepted any commercial involvement "in the development of the content of this publication." There is no statement with respect to whether AAP accepts donations from any of the following manufacturers of long-acting reversible contraception: Merck (the Nexplanon implant); Bayer Healthcare Pharmaceuticals (the Mirena and Skyla IUDs); or Teva Women's Health (Paragard, the copper IUD). This omission is glaring, given the AAP recommendations of specific contraceptive products, by brand name, with terms such as "highly effective," "ideal for adolescents," "appropriate for adolescents," and "outstanding choice."[2]

In part 1 of this paper, I will critique the recommendations and guidelines of the American Academy and Pediatrics (AAP) in its September 29, 2014, policy statement and technical report on contraception for adolescents. I will comment on their effects on Catholic adolescents, families, Catholic pediatricians, and other adolescent health care providers.

In part 2 of the paper, I will discuss the medicolegal issues raised by the AAP policy statement. These include how the AAP policy statement is the basis for the standard of care, the risk of claims of medical malpractice based on the failure to prescribe and implant long-acting reversible contraceptives (LARCs), the dilemma facing Catholic physicians, and how Catholic physicians can avoid malpractice claims.

In part 3 of the paper, I will discuss some possible responses of Catholic clergy, physicians, and laity. In part 4, I will state the need for a diocesan model and propose a model to be led by Catholic physicians with no cost to adolescents or parents.

Critique

The 2014 AAP Policy Statement and Technical Report

The 2014 AAP Policy statement follows the American College of Obstetricians and Gynecologists (ACOG) Committee opinion no. 539 of October 2012 (reaffirmed 2014), titled "Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices." The ACOG opinion concludes, "Adolescents should be encouraged to consider LARC [long-acting reversible contraception] methods."[3]

The AAP policy statement begins by noting in its introduction that "pediatricians play an important role in adolescent pregnancy prevention and contraception." It is further noted that "adolescents consider pediatricians and other health care providers

hereafter as AAP Policy Statement; and Mary A. Ott, Gina S. Sucato, and the Committee on Adolescence, "Technical Report: Contraception for Adolescents," *Pediatrics* 134.4 (October 2014): e1257–e1281, cited hereafter as AAP Technical Report.

2. AAP Technical Report, e1261.

3. ACOG Committee on Adolescent Health Care, "Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices," *ACOG Committee Opinion* 539 (October 2012), conclusion.

a highly trusted source of sexual health information." This trust is attributed to "long-term relationships with adolescents and families."[4] Although the trust of adolescents is based in part on the pediatrician's relationship with the family, under the heading "Confidentiality and Consent," the technical report asserts: "The AAP believes that policies supporting adolescent consent and protecting adolescent confidentiality are in the best interests of adolescents."[5] This means that sexually transmitted infections (STIs) and adolescent consent for contraception should be held confidential and not reported to parents or guardians. The AAP explains that the reason for this is that "careful attention to minor consent and confidentiality is important, because limitations on confidentiality and consent are linked to lower use of contraceptives and higher adolescent pregnancy rates."[6]

After noting that abstinence is 100 percent effective in preventing pregnancy and STIs, the AAP then states, under "Counseling about Abstinence and Contraception," that "adolescents should be encouraged to delay sexual onset *until they are ready*."[7] This "until they are ready" qualification on the encouragement of abstinence is new. Unlike prior AAP policy statements, there is no recommendation that the word abstinence be used by pediatricians communicating with the adolescent. Rather, the phrase "delay sexual onset" is the phrase to be used. Furthermore, in the eleven recommendations at the end of the policy statement, there is no mention of abstinence or even the encouragement to "delay sexual onset until they are ready."

This new phrasing is a dramatic change from even the last two AAP policy statements on contraception and adolescents. In the AAP 2007 statement "Contraception and Adolescents," the very first recommendation was "Pediatricians should encourage sexual abstinence as part of comprehensive sexuality education . . . offered to their adolescents."[8] The first recommendation in the 1999 policy statement recommendation was even stronger: "Pediatricians should encourage and promote sexual abstinence to their adolescent patients at every appropriate opportunity."[9]

The 2014 AAP statement, however, gives no indication that pediatricians should discuss with the adolescents the concept of when they might be *ready*. There is no mention made of the virtue of chastity; no suggestion that the adolescent discuss with parents or clergy; no reference to love, responsibility, or marriage; and no recommendation that the spiritual health of the adolescent be considered. The only thing mentioned is the vague concept "until they are ready."

This "counseling" suggestion is then followed by a caution to the health care provider to not trust that there will be any adherence to abstinence by the adolescent.

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4. AAP Policy Statement, e1244.

5. AAP Technical Report, e1258.

6. AAP Policy Statement, e1245.

7. Ibid., emphasis added.

8. AAP Committee on Adolescence, "Policy Statement: Contraception and Adolescents," *Pediatrics* 120.5 (November 2007), 1145.

9. AAP Committee on Adolescence, "Contraception and Adolescents," *Pediatrics* 104.5 (November 1999), 1165.

The statement does not recommend anything on strengthening any resolve to abstain. Instead it assumes that there will not be adherence and provides that even if the adolescent states a preference for abstinence, the health care provider should "reassess intentions to remain abstinent at every visit and additionally … provide access to comprehensive sexual health information, including information about EC [emergency contraception] and condom use … to all adolescents."[10] AAP policy further stated that if an adolescent even considers the initiation of sexual activity, then "counseling additionally includes *initiating contraception*, supporting adherence to the contraceptive method."[11] *Initiating* means causing a process or action to begin. Thus, health care providers are being encouraged by AAP to use their trusted position to disregard any preference for abstinence stated by the adolescent but rather provide him or her with contraception information and prescribe contraception if the adolescent is even thinking about initiating sexual activity at any time in the future.

After "Setting the Stage," various methods of contraception are then discussed. The AAP statement acknowledges that the most common contraceptive method used by adolescents is the male condom with up to 52 percent of female and 75 percent of male adolescents reporting condom use at last intercourse. It also acknowledges that the male condom is prevention against STIs. But it is then critical of its "typical use failure rate" in preventing pregnancy of 18 percent.[12]

The AAP discusses long-acting reversible contraceptives, hormonal implants, and intrauterine devices. In the introduction the AAP acknowledges that the use of LARCs was much lower than 12 percent. Nevertheless, the AAP, in a push to have LARCs used by all adolescents, suggests that "pediatricians are encouraged to counsel adolescents … that LARCs are the most effective contraception and to discuss them first." However, the AAP fails to suggest that pediatricians discuss the risks of hormonal implants and IUDs, including increased risk for STIs, increased risk of certain cancers, and risk of future infertility.

The Semantics of Pregnancy *and* Abortifacient

An *abortifacient* is a medication or substance that causes a pregnancy to end prematurely. Historically, conception and pregnancy were defined as occurring at fertilization, approximately ten days before implantation. During that time the embryo is a young, unborn human being. In establishing guidelines that promote the use of hormonal contraceptives, however, both ACOG and the AAP rely on a 1965 change by ACOG in the definitions of "conception" and "pregnancy." ACOG redefined pregnancy as beginning at implantation, ignoring the scientific fact that there have been several hundred cell divisions by the embryo in its blastocyst stage prior to implantation and that the cells have a different DNA than either the embryo's mother or father.

10. AAP Technical Report, e1260.
11. AAP Policy Statement, e1245, emphasis added.
12. Ibid., e1249.

ACOG's redefinitions in 1965 were designed to gain the public's acceptance of the hormonal contraceptives made by the pharmaceutical industry which are known to act as abortifacients prior to and after implantation. Thus did ACOG create two new definitions: (1) *fertilization* is the union of spermatozoon and ovum, and (2) *conception* is the implantation of fertilized ovum.[13] Hence, with a quick redefinition of conception in 1965, ACOG pronounced that pregnancy, henceforth, began at implantation; not at fertilization. And therefore an abortifacient became a substance that causes termination after implantation. The Catholic Church has never accepted the redefinitions of the words conception and pregnancy.[14]

Hormonal implants and IUDs are designed to prevent ovulation and inhibit sperm motility by thickening cervical mucus, but they also act as abortifacients by creating a hostile environment in the uterus in cases where ovulation does occur and is followed by fertilization (i.e., conception). The AAP technical report states that "the primary mechanism of action of both types of IUD is preventing fertilization by inhibiting sperm motility."[15] The policy statement does not state that the hormonal IUDs prevent or inhibit ovulation.

If we accept the AAP technical report's statement on the primary mechanism of both types of IUDs, then we can conclude that preventing ovulation is not a primary mechanism of the IUDs. But it is not clear how IUDs inhibit sperm motility because if ovulation occurs, cervical mucus will promote sperm motility. Therefore, it is probable that the true primary mechanism of IUDs is to promote early abortions as a foreign body which creates a hostile environment in the uterus, which in turn facilitates the rejection of the developing embryo or fetus. Indeed, the AAP acknowledges that IUDs prevent the survival of an embryo both before and after implantation when it states "the copper IUD can be used as emergency contraception within 5 days of unprotected intercourse."[16]

The AAP, in its section on emergency contraception, describes several orally administered hormones and states that they "prevent pregnancy when initiated up to 5 days after an act of unprotected sexual intercourse."[17] Since ovulation and conception can occur in the first four days after intercourse, it is clear that AAP is acknowledging that hormonal implants also act as abortifacients. The AAP policy states that "advance prescription for EC should be part of routine adolescent care," and further that "advance provision of EC should be a part of anticipatory guidance."[18]

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13. ACOG, "Terms Used in Reference to the Fetus," *Terminology Bulletin* 1, September 1965.

14. For an excellent treatise on the beginning of human life, see Maureen L. Condic, "When Does Human Life Begin: A Scientific Perspective," *Westchester Institute for Ethics and the Human Person*, white paper, October 2008, reprinted in *National Catholic Bioethics Quarterly* 9.1 (Spring 2009): 129–149.

15. AAP Technical Report, e1262.

16. AAP Policy Statement, e1247.

17. AAP Technical Report, e1269.

18. Ibid., e1269–e1270.

Clearly, the AAP's position, albeit not expressed in its policy statement or technical report, is that life does not begin with conception and that life does not begin until implantation. However, the Catholic Church teaches, and intellectual honesty demands, that life begins at conception, and conception occurs on the completion of fertilization. Many adolescents believe that life and conception begin at fertilization, not implantation. However, the AAP makes no provision for this possibility; indeed, it does not suggest discussing it in a "motivational interview," nor does the AAP suggest referral to a member of the clergy or even a trained child psychologist who might be more adept at understanding what the adolescent believes and how these beliefs may be important to his or her decision making. Adolescents are entitled to know the mechanisms of all contraceptives and pregnancy terminating abortifacients, especially LARCs.

Hormonal Contraceptive Risks of Disease

Hormonal contraceptives increase a woman's risk of breast cancer and sexually transmitted infections.

Breast Cancer. The AAP technical report states, "Families can be reassured that COC [combined oral contraceptive] has not been shown to increase the risk of breast cancer."[19] However, only an ACOG bulletin from 2006 is cited as authority. This is a disingenuous statement. Recent medical literature has linked COC use to an increase of 50 percent in breast cancer for women aged twenty to forty-nine and also to increases in cervical cancer, liver tumors, and even prostate cancer.[20]

Sexually Transmitted Infections (*STIs*). The AAP policy has been and continues to be the recommendation of condoms as dual contraception because condoms provide higher STI protection than hormonal methods. However, the technical report notes that the use of condoms "tends to drop off over time."[21] The AAP does not acknowledge that the high effectiveness of near-sterilization provided by LARCs will make unnecessary the use of the condom as a contraceptive and will therefore result in a significant "drop-off"sooner, with a greater risk for STI. Also, there is an increased chance of STIs because hormonal contraceptives compromise the immune system.[22] The AAP should have warned that the use of LARCs will result in a higher incidence of STIs.

Motivational Interviewing

Under "Adherence and Follow Up," the AAP recommends motivational interviewing in a couple of short paragraphs. Policy states, "Pediatricians can use motivational interviewing approaches to increase effective and consistent

19. Ibid., e1266.

20. Elisabeth F. Beaber et al., "Recent Oral Contraceptive Use by Formulation and Breast Cancer Risk among Women 20 to 49 Years of Age," *Cancer Research* 74.15 (August 1, 2014): 4078–4089.

21. AAP Technical Report, e1249.

22. Ellen Grant, *The Better Pill: How Safe Is the Perfect Contraceptive?* (London: Elm Tree Books, 1985).

contraceptive use."[23] No motivational interviewing is mentioned to encourage abstinence. The AAP policy of initiation and recommending the installation of LARCs is inconsistent with a recommendation of abstinence. The AAP guidelines are designed to have adolescents consent to LARC installment and then to tell them to "delay sexual onset until they are ready."[24] No special training in motivational interviewing is required or even suggested, other than references to two footnoted articles.

Medicolegal Implications

The Risk of Medical Malpractices Claims

In the United States, medical malpractice causes of action have been recognized for "wrongful pregnancy," "wrongful birth," and "wrongful life."

Wrongful Pregnancy. A wrongful pregnancy cause of action is a claim that, as a result of a physician's negligence, a woman was caused to have an unplanned pregnancy or remained pregnant after decision to abort. Forty-four states recognize this cause of action under one or more of the following circumstances: a failed tubal ligation or vasectomy which resulted in a pregnancy, a failed contraceptive pill or device, or a failed attempt to abort after which the woman remained pregnant. Damages for wrongful pregnancy cases can include the medical costs of the pregnancy and delivery, the woman's loss of earnings, damages for emotional distress and pain and suffering related to the pregnancy and the delivery, damages for injury or death of the woman as a result of the pregnancy, and loss of consortium. Damages may also include the cost of raising a healthy child to the age of majority; however, this may be offset by the pecuniary and nonpecuniary benefits conferred to the woman by the child.

Wrongful Birth. A wrongful birth cause of action is a woman's claim that the defendant physician's malpractice prevented her from making an informed choice about whether to terminate a pregnancy and that it resulted in her child being born with a congenital impairment. These cases include:

- Failure to diagnose a woman or her partner as carriers of genetic markers associated with a specific impairment
- Failure to inform the woman prior to conception that she and her partner actually carried these genetic markers
- Failure to diagnose the fetus with genetic or congenital disorder
- Failure to inform the woman that the fetus has a genetic or congenital disorder

More than half the states currently recognize wrongful birth claims. Some of these states permit plaintiff to recover extraordinary damages which are the costs of caring for an impaired child.

Wrongful Life. A wrongful life cause of action is one brought by an impaired child alleging that because his mother was not informed of a choice to terminate the

23. AAP Policy Statement, e1251.
24. Ibid., e1245.

pregnancy, the child was born and is forced to live a life with considerable pain and suffering such that nonexistence would have been preferable.

Although combinations of these causes of action for wrongful pregnancy, wrongful birth and wrongful life can be brought, the courts will limit the damages and not permit double recoveries.[25]

The Standard of Medical Care and Departures from It

The AAP is clearly the prime authority on adolescent health care. When its guidelines make reference to counseling and initiating contraceptives, it is based on the concept of "anticipatory guidance." Pediatricians have a duty of anticipatory guidance in order to safeguard children and adolescents from being harmed. Advising parents to provide car seats when driving and to avoid allowing toddlers to come in contact with surfaces containing lead paint are other examples of anticipatory guidance.

The guidelines of AAP on counseling and prescribing contraception have the effect of creating a standard of care. The courts of some jurisdictions have actually accepted the AAP guidelines as *the* standard of care. Other jurisdictions allow reference to AAP guidelines by expert medical witnesses who opine on the standard of care.

But whether or not the AAP guidelines are accepted into evidence as the standard of care is not dispositive. A practicing physician is required to have that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where the physician practices. A physician is charged with the duty to exercise due care, as measured against the conduct of his or her own peers—the reasonably prudent physician standard. He or she is required to provide the type and level of care that an ordinary, prudent, health care professional with the same training and experience would provide under the circumstances in the same community.

When AAP or ACOG issues guidelines, the majority of physicians belonging to those organizations follow them, and the practices of the majority of physicians establishes the standards of care. Therefore, the AAP can, in fact, establish the standard of care, notwithstanding any disclaimers that AAP may make. And further, physicians not following the guidelines of AAP in the health care of adolescents do so at the risk of civil liability.

Thus, if the majority of physicians follow the AAP guidelines, then these guidelines define the standard of care. The AAP qualifies its recommendations with statements such as: "The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care." It matters not that the AAP guidelines carry a disclaimer. What matters is whether the majority of physicians follow what the AAP recommends. All health care providers treating adolescents will be held to this standard of care, including family practitioners, primary care providers, internists, ob-gyns, emergency room physicians, and hospitals providing clinical care, among others.

25. Candice A. Aredalin and Sheila S. Boston, "Know the Stakes When the Stork Comes: Danger and Defenses in Pregnancy Tort Actions," *DRIToday*, August 1, 2013, http://www.dritoday.org/.

There can only be one standard of medical care in a community. Therefore, if another organization, such as the Catholic Medical Association, issued guidelines that were different than the AAP guidelines, Catholic physicians could not safely rely on the CMA standards of care as a defense in a civil action for medical malpractice.

Unless a cause of action in a medical malpractice case can be dismissed as a matter of law, the trier of fact (juries and judges in non-jury trials) will determine, based on medical literature and expert testimony, whether there was a departure from the standard of care and the amount of damages to be awarded. The AAP has established a standard of care of first recommending and prescribing LARCs. All health care providers will be held to that standard of care. That includes Catholic physicians treating Catholic adolescents.

Furthermore, because of LARCs' effectiveness in preventing ovulation or implantation after pregnancy occurs, any deviation from the standard of care of first recommending and prescribing LARCs is, by definition, a departure from accepted medical practice. When a physician departs from the standard of accepted medical practice, any injury which the departure proximately causes (i.e., substantially contributes to) can be considered as the basis for a money award of damages for *medical malpractice*. The injury that would follow the failure to first recommend and prescribe LARCs would be the pregnancy itself and the consequences of the pregnancy (i.e., wrongful pregnancy). And if the child is born with an impairment (e.g., autism or genetic or other congenital defect), then there may be an award for lifetime care.

Prior to the 2014 AAP policy statement, any counseling by a pediatrician about contraception would not likely have led to a finding that the pregnancy was proximately caused by the departure of the health care provider. The reason is that with all other methods of contraception, the adolescent has an obligation to effectively (i.e., perfectly) use the contraception prescribed. That would include filling a prescription, using this prescription in accord with information provided by manufacturer of the contraceptive, and then renewing the prescription. LARCs eliminate all of those possibilities of mistake, and that is why they are being recommended by the AAP.

The AAP's Committee on Bioethics has issued a policy statement on refusal to provide treatment or information on the basis of conscience. The AAP policy recommends that physicians have a duty to prospective patients "to disclose standard treatments and procedures that they refuse to provide but are normally provided by other health care professionals." The AAP recommendations also include: "Physicians who consider certain treatments immoral have a duty to refer patients who desire these treatments in a timely manner when failing to do so would harm the patient."[26]

Although the AAP can establish the standard of medical care, I do not believe it can create a standard of how to refer for treatment that the physician finds objectionable. I take issue with the AAP statement that the physician has a "moral obligation to

26. AAP Committee on Bioethics, "Policy Statement: Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience," *Pediatrics* 124.6 (December 2009): 1692, reaffirmed and retired January 2014.

refer patients to other health care providers who are willing to provide those services when failing to do so would cause harm to the patient."[27]

The physicians' concerns can be set forth in an informed consent document in which the physician may note that he or she believes the AAP standard of care is unreasonable and that the physician believes the AAP recommended care may put the patient at risk of disease or physical harm, because LARCs are hormonal contraceptives and have significant risk of morbidity and mortality. The physician is not likely to know the policies and practices, let alone the philosophy of other health care providers. The physician may generally refer a patient to a medical association, local hospital, or the 911 phone number for any treatment not provided by the physician.

The Problem Facing Catholic Physicians

Prior to the establishment of the standard of care in the current AAP policy statement, a physician could recommend and initiate contraception on a patient-by-patient basis. The new AAP standard does not allow for that. If the health care provider does anything other than recommend LARCs "first" and consistently, then the health care provider can be held to have departed from the standard of care.

A Catholic medical physician with adolescent patients might not have been prescribing contraception prior to the AAP policy statement. But now, the prescribing of contraception (and LARCs, as the first-line contraception) is essentially required by the AAP standard of care.

The Catholic medical physician should never have been prescribing contraception, because it constitutes *formal or immediate material cooperation in a sinful act*.[28] The Catholic Church teaching is that contraception by an adolescent or anyone else is sinful both before marriage, when 100 percent abstinence is required, and within marriage, when fertility appreciation methods of family planning should be employed.

Avoiding Malpractice

A Catholic physician who treats adolescents can avoid being found liable for a departure from the standard of medical care if he or she does the following:

- Determines to never prescribe any contraceptive to adolescents.
- Explains to all adolescent patients and the families that he or she does not prescribe contraceptives.
- Documents this information with an informed consent: "Agreement to treatment by a non-contraceptive-providing physician."

Furthermore, having advised the patient and family that he or she does not prescribe contraceptives, the Catholic physician should then do one of the following:

- Refer the adolescent to a health care provider who is known to follow AAP guidelines and prescribe contraceptives; *or, in the alternative*,

27. Ibid., 1689.

28. John A. DiCamillo, "Understanding Cooperation with Evil," *Ethics & Medics* 38.7 (July 2013): 1–4.

- Further advise the adolescent and the family that the physician does not refer for LARCs or other contraception for both medical and personal reasons *and* document this informed consent: "Patient knows and understands that Dr. Smith will not refer to another physician who prescribes contraception."
- It is probably prudent to include in the informed consent document a general statement to the effect that the patient can perform an internet search for the term "contraception provider" or visit the emergency room of any non-Catholic hospital, if the patient wants a contraceptive prescription or another opinion on the counseling the patient has received from the Catholic physician.

How Can Catholics Respond?

Based upon their ability to prescribe contraception to adolescents and their acknowledged acquiring of trust of adolescents from long-term relationships with families, physicians have assumed the roles of educators and counselors of adolescents on sexuality issues.

Adolescents and Occasions of Sin

Occasions of sin are external circumstances—either things or persons—which incite or entice one to sin.[29] Taking an oral contraceptive, purchasing a diaphragm, allowing the implant of a LARC, or carrying a condom in a wallet or purse are all occasions of sin because they prepare the adolescent for unchaste behavior (i.e., sin). Since the publication of the 2014 AAP policy statement, if not before, all physicians following the recommendations of the AAP are also the occasions of sin because they will "initiate," "prescribe," and "provide" contraceptives, including those that act as abortifacients.

As Catholics, we have an obligation to assist our adolescents (and adults) in avoiding occasions of sin. The only possible way to accomplish this, given the AAP policy statement, is to make it possible for adolescents and adults to be treated and managed by Catholic physicians who reject the AAP policies.

Faced with the prospect of our Catholic adolescents being prepared for immoral sexual activity by receiving hormonal implants or IUDs from a physician who wants to comply with the AAP LARC standards, Catholics really need to formulate a response. We should first suggest to all Catholic physicians who treat adolescents that they do whatever soul-searching they need to do, and determine whether they are going to reject Church teaching or reject the AAP standard of care on contraception for adolescents. It is appropriate to remember that physicians and medical personnel are called to value the superior demands of their Christian vocation. As Pope Paul VI declared in his prophetic encyclical, *Humanae vitae*:

> Likewise we hold in the highest esteem those doctors and members of the nursing profession who, in the exercise of their calling, endeavor to fulfill the demands of their Christian vocation before any merely human interest. Let

29. Joseph Delaney, "Occasions of Sin," *The Catholic Encyclopedia*, vol. 11 (New York: Robert Appleton, 1911), http://www.newadvent.org/.

> them therefore continue constant in their resolution always to support those lines of action which accord with faith and with right reason. And let them strive to win agreement and support for these policies among their professional colleagues. Moreover, they should regard it as an essential part of their skill to make themselves fully proficient in this difficult field of medical knowledge. For then, when married couples ask for their advice, they may be in a position to give them right counsel and to point them in the proper direction. Married couples have a right to expect this much from them.[30]

Prior to October 1, 2014, many Catholic physicians have been prescribing some contraceptives. They may have suggested the use of condoms to prevent STIs. They may have suggested barrier methods. They may even have written prescriptions for combined oral contraceptives. It is clear that they should not have been doing any of these things, because the Catholic Church teaches that contraceptives that are used for the primary purpose of preventing pregnancy are always morally wrong. No Catholic physician can participate in the moral wrong of prescribing contraception, because according to Catholic theology, that is *formal or immediate material cooperation.*

But the AAP has drawn a new bright line. While Catholic physicians may have attempted to rationalize their less than 100 percent opposition to barrier methods of contraception, cooperating with the use of LARCs in adolescents is absolutely morally wrong, not only because LARCs facilitate unchaste actions but also because they are known abortifacients. Catholic parents should advise their adolescents that they object to this procedure and they should also object to their children patronizing a physician who will recommend this procedure.

There is a need to have "abstinence only" physicians treat Catholic adolescents. Adolescents who start on hormonal contraceptives will be poor candidates for natural family planning (NFP) when they marry. There needs to be outreach on the diocesan level to promote education and counseling by Catholic physicians to students at Catholic schools and to also encourage Catholics to seek the care of Catholic physicians who practice medicine in harmony with Church teaching.

The above suggestions raise immediate problems: Catholic physicians who treat adolescents and make a determination to practice medicine in harmony with their Catholic faith will be faced with the possible loss of patient-base and income, and Catholic families with adolescents will have difficulty finding abstinence-only physicians.

Financial Issues of Contraception Prescription

Catholic physicians who do not prescribe contraceptives place themselves at a financial disadvantage. Those Catholic physicians who do prescribe contraceptives have been co-opted by the pharmaceutical industry whose products they "push." There is substantial money to be made by pushing contraceptives as the AAP guidelines recommend. Some family-medicine practitioners may earn as much as 40 percent of their income from prescribing contraceptives and monitoring their use. The prescribing of hormonal contraceptives is probably the only medical procedure that

30. Paul VI, *Humanae vitae* (July 25, 1968), n. 27.

intentionally makes a healthy system dysfunctional. It is unfortunate that the shutting down of the woman's healthy reproductive system results in so many unhealthy side effects and risks of disease.

Those physicians who have chosen not to prescribe contraceptives did not, prior to the Affordable Care Act, have any way to compensate for the loss of income from prescribing contraceptives. In its "preventive services for women," the ACA indicates that women are entitled to all contraceptives without co-pays and with the frequency "as prescribed." However, the ACA requires that health plans cover not only the prescribing of contraceptives but also counseling and education about contraceptives. The ACA also provides for education and counseling on STIs.[31] There is nothing in the ACA that requires a physician to prescribe a contraceptive after he or she educates and counsels a patient regarding contraception and STIs. Indeed, the physician might well recommend abstinence and continue to monitor for commitment to abstinence.

Education and counseling on contraceptives should include discussions of the following:

- The various forms of contraception including condoms, diaphragms, spermicides, sterilization, combined oral contraception, pills, progesterone-only pills, patches, injections, IUDs, hormonal implants, and abstinence as the most effective way of avoiding both pregnancies and STIs.
- The mechanisms of action of all of the contraceptive methods especially the hormonal contraceptive.
- The effective rates, contraindications, and risks of each of the contraceptive methods.
- The fertility appreciation methods and the benefits of using these methods in marriage with partners who are fully committed to each other.
- A full discussion of each of the viral and bacterial STIs.

The Catholic physician who does not prescribe contraceptives should of course offer to treat and manage all patients in a nonjudgmental way, including patients who are using contraceptives. The side effects, risks, and occurrence of disease occasioned by the use of hormonal contraceptives are best monitored by a physician who did not prescribe the contraceptive being used by the patient.

The Response Needed from the Catholic Clergy, Catholic Physicians, and the Catholic Faithful

As a result of the 2014 AAP policy statement, the standard of medical care requires physicians to initiate, recommend, and implant LARCs in our adolescents, because the AAP considers that the "safest" way to get them through adolescence without becoming pregnant. Indeed, LARCs are reported to be 99 percent effective. But the real issue is the virtue of chastity. As eloquently stated by Paul VI in *Huma-*

31. HRSA, "Women's Preventive Services Guidelines," *US Department of Health and Human Services*, accessed March 15, 2016, www.hrsa.gov/.

nae vitae and later by Pope St. John Paul II in his Theology of the Body, the use of contraceptives is by definition "unchaste behavior."[32] Prior to marriage, contraception facilitates sex between two people who have not made a full commitment to give themselves entirely to each other. Within marriage, the use of contraception separates the unitive from the procreative. Instead of sexual embrace leading to the bonding of the husband and wife, the contraceptive facilitates the withholding of the self and the using of the spouse.

The AAP policy statement creates a standard of care that requires all physicians treating adolescents to use the trust that they have gained from treating the family to make recommendations and prescriptions that will lead to the abandonment by the adolescent of any attempt to abstain. No longer are physicians to use that trust to recommend that the adolescent abstain from sexual activity. Instead of a recommendation to abstain, the physician is to recommend to the adolescent to "delay sexual onset until you are ready." At the same time, the physician is to initiate contraception in counseling by first recommending LARCs, and the standard also requires "advance provision of EC" as part of "anticipatory guidance."[33] The AAP considers the latter better medical advice because if abstention is recommended, the adolescent might try but fail. The assumption that AAP makes is that adolescent sexual activity is not a failure nor is it unvirtuous; the only failure is getting pregnant.

It is reported that Catholics contracept, abort, and divorce at the approximate rate as the general population. The reason for this is that the leadership has failed the faithful. The leadership is the clergy and the medical profession. Rev. Dan McCaffrey of Natural Family Planning Outreach has stated, "*Humanae vitae* was never rejected; it was just never preached."[34] The majority of the clergy not only did not accept the prophetic teaching of Paul VI, but they also declined to endorse it and even taught against it. The Catholic physicians, therapists, and counselors likewise ignored the teaching in *Humanae vitae* and rejected Paul VI's call to the medical fraternity.

There are two hundred thousand primary care providers in the United States treating and managing women of reproductive capacity, including adolescents. Of these two hundred thousand, perhaps more than fifty thousand are Catholic. Of the fifty thousand, only five to six hundred are NFP-only and do not prescribe contraceptives.[35] There are an unknown number of other Catholic physicians who covertly try not to prescribe contraceptives or who prescribe them reluctantly. They are covert because they do not want to become stigmatized by being known as a physician who won't prescribe a contraceptive to a patient requesting it. They fear the loss of

32. See Paul VI, *Humanae vitae*; and John Paul II, *Man and Woman He Created Them: A Theology of the Body*, trans. Michael Waldstein (Boston: Pauline Books and Media, 2006).

33. AAP Technical Report, e1270.

34. Rev. Daniel McCaffery, director of Natural Family Planning Outreach in Oklahoma City, quoted in John Mallon, "The Teaching Must Be Preached," *Inside the Vatican*, special issue, *A Prophecy for Our Time: Paul VI's* Humanae vitae *on the 30th Anniversary of Its Publication*, August–September 1998, http://johnmallon.net/.

35. HRSA, "Women's Preventive Services Guidelines."

patient base and income if they become known as a physician who do not prescribe contraceptives.

The AAP and ACOG guidelines on contraception for adolescents have the effect of recruiting the youth to become early customers of the contraception products of the pharmaceutical industry. Targeting adolescents to get them hooked on a product is a successful model developed by the tobacco industry and manufacturers of other products. Further, the ACA mandates that all contraceptives are to be made available to all women of reproductive capacity for no co-pay or other payment.

The Catholic clergy, physicians, and laity must join together to draw a line in the sand. They must make a commitment to not surrender Catholic adolescents to the AAP policy on contraception. The Catholic dioceses have an underused advantage in waging this battle: it is the Catholic elementary and Catholic high school systems. But the battle cannot be won with volunteers and teachers. The battle cannot be won by a Catholic school teacher telling students to be chaste when they thereafter go to see their trusted family pediatrician and are given contrary advice. The diocese must bring the Catholic physicians who make a commitment to not prescribe contraceptives to the faithful and announce and praise this commitment. The physicians must be brought into the schools to treat and manage the students on the issue of chastity, including contraception.

They should begin with seventh and eighth grade students with a comprehensive program teaching the benefits to good health, both physical and spiritual, that accompanies chastity and the disease and unplanned pregnancies that follow unchaste behavior.[36] Catholic physicians must take care of their patients and make sure that they do not get different advice from other physicians so that they should therefore refer to other Catholic physicians who have made a commitment to not prescribe contraceptives.

The physicians must be given the opportunity by the diocese to establish physician–patient relationships with the adolescent and must follow their patients after graduation from elementary school and continue to treat and manage those adolescents in high school and after.

A Model for Opposing the Implanting of LARCs in Catholic Adolescents

Catholic adolescents will not be properly counseled on contraception by the primary care and ob-gyn physicians who treat and manage them under the ACOG/

36. The Teen STAR Program, developed by Dr. Hanna Klaus, a medical missionary nun and ob-gyn physician, is the gold standard for sexuality teaching in the context of adult responsibility. It undergirds virginity and/or facilitates a return to chastity. Adolescents are taught the basics of menstrual cycle charting, which enables them to "own their fertility." This program has been extremely successful in other countries where the government pays for the program. It has not been widely accepted in the United States because of the program's costs. It should be considered and accepted on a diocesan basis and would be an excellent complement and base for the recommendations in this paper.

AAP guidelines. An alternative model of adolescent health care is necessary to safeguard the physical and spiritual health of adolescents.

The Need for a Diocesan Model for a Physician-Led Program of Teaching and Counseling Students in Catholic Elementary and High Schools

In this section I will discuss a model in which Catholic adolescents can be educated and counseled by Catholic physicians and physician extenders at diocesan Catholic elementary and high schools.[37] This alternative adolescent health care model first needs the full support and blessing of the bishop.

The model is premised on the assumption that we are in competition for the physical and spiritual health needs of Catholic adolescents and that we want them to be saved from being victimized by those physicians following the ACOG/AAP guidelines. If we lose the battle for our adolescents, they will become reliant on the contraceptive products of the pharmaceutical industry, which are promoted by the medical societies and physicians. To put it in marketing terms, our goal is to seek 100 percent market share of Catholic adolescents in our alternative model.

To effectively compete with prescribers of contraceptives to patients for no co-pay, and also for charitable reasons, the diocesan plan should not involve a cost or co-pay to either female adolescents or their parents.[38] A successful physician-led program will require no financing from or costs to the diocese.

Our anti-contraceptive marketing plan up until now has consisted of lukewarm promotion of NFP by some of the clergy and ineffective promotion by physicians and laity, notwithstanding the dedicated work of the teachers and practitioners of the many fertility appreciation methods. NFP-only physicians, even those who have been trained in NaProTechnology at the Pope Paul VI Institute for the Study of Human Reproduction in Omaha, Nebraska, do not often emphasize the teaching of fertility appreciation methods of avoiding pregnancy. Rather, they concentrate on a holistic alternative to assisted reproductive technology for infertility. NFP training is something that is left to the NFP teachers. The physicians who do offer NFP training in their offices mostly do it through independent NFP-trained lay persons who charge somewhere between thirty and sixty dollars an hour. The payments have to be cash, because the NFP-only physicians really do not want to bill for NFP education. Most NFP-only physicians are not offering effective competition to physicians who are getting handsomely paid for providing contraceptives at no charge and no co-pay to patients.

The NFP lay teachers are unable to bill health care plans for NFP training and education unless they are licensed medical care professionals working as physician

37. Physician extenders are licensed medical professions who can either bill health care plans directly or bill through a physician. The services of physician extenders during patient visits can be billed even if the physician is not present at the location.

38. "The ACA provides for education and counseling on contraceptives and STIs with a frequency of 'as prescribed' under 'preventive services for women' on a no co-pay basis. There is no similar provision for male patients" (HRSA, "Women's Preventive Services Guidelines").

extenders and billing through the physician. So they must charge thirty to sixty dollars per session or waive any payment. The marketing plan has also been inadequate, because the NFP teachers' targets have been women and couples who are either married or plan on marrying shortly. This is no way to compete with physicians following AAP guidelines who are attempting to insert LARCs in every adolescent.

The pharmaceutical companies that manufacture contraceptive products have an enormous head start on this and have a 99 percent market share. This 99 percent market share is accomplished because they have 99 percent of the sales representatives, who are the primary care physicians in the United States.

Although Catholic teaching faces a daunting task, we do have a better idea: it's called truth, and what we need is a marketing plan that more effectively delivers the truth.

What We Should Not Do

Under the ACA, the contraceptives provided by our opposition will cost a woman nothing whether she is on a health plan or Medicaid. So our model should not charge anything for the alternative to educating and counseling on contraception and sexually transmitted infections: promoting the virtues and good health of abstinence. No adolescent or parent should be charged anything for the counseling that we provide to the adolescent. It is far better to ask for donations from those who appreciate the Church's active role in providing education and counseling and from those who can better afford to donate than the young and the poor.

What We Should Do

We should use the strengths that we have. The clergy should use the pulpit to recommend the benefits of our program and the physicians and medical personnel that are working with our program. The diocese should provide access to our Catholic elementary and high schools so that our physicians can establish physician–patient relationships and provide counseling and education at the schools.

Our physicians and physician extenders should bill the health plans and Medicaid for the services provided to the adolescents. The laity and especially the Family Life and NFP offices of the diocese can be extremely helpful in making available the Catholic schools and assisting and obtaining the parental consent for the programs to be provided to the adolescents.

One or more Catholic-led physician(s), whose practice includes acting as a primary care provider for adolescents, should offer to meet with the adolescents starting in the seventh and eighth grades on an annual basis for new patient visits and then, annual patient visits. Thereafter, the physician should supply a series of video courses with lessons on the various aspects of human sexuality, beginning with basics such as how the male and female reproductive systems, fertilization, conception, implantation, the stages of fetal growth, and the appreciation of fertility by learning the individual's menstrual cycle patterns.

Physician extenders should go to schools and follow up with assigned student-patients. These physician extenders should become trusted advisors to the adolescent patients.

The Lead Physician and Physician Team Members

Each diocese should have one or more lead physicians whose first task will be to assemble a team. The team should consist of all physicians in the diocese who treat adolescents for primary or ob-gyn care and who have vowed not to prescribe contraceptives to their patients. Team members would include pediatricians, family medicine physicians, ob-gyns, general medical practitioners, and perhaps others. However, it is not necessary to have licensed team member physicians with specialties such as radiology and oncology. Team members should also include licensed psychologists, therapists, counselors, and nurses.

The lead physician should be prepared to visit every Catholic elementary and high school in the diocese on an annual basis. In the alternative, there could be several lead physicians in a diocese, perhaps as many as ten, each of whom would have the responsibility for ten elementary schools in a diocese with a hundred elementary schools. The lead physicians and the team members must have the full support and blessing of the bishop. The team members must commit to refer only to each other or other physicians who they know will not prescribe contraceptives to their adolescent patient. There must be a continuous effort by clergy, physicians, and laity to evangelize new physician team members.

After the assembly of the initial team, the lead physician must establish a program. The original team should be requested to design lesson plans for the making of video courses. The lesson plans on various subjects should be short, three-and-a-half-minute presentations by the team members that can be used by parents and other educators in the system to teach not only adolescents but also adults. The lead physician, with the help of volunteer laity and paid administrative personnel, must seek the parental consent to establish physician–patient relationship at the schools.

The parents should understand the program and that working with the lead physician and his team in the diocese does not mean that the parents have to abandon their current physician–patient relationships. The lead physician and his team are assembled for a particular purpose and that is to work with the adolescents by educating them, providing them with motivational counseling, and monitoring them on contraception and abstinence. The parents should understand that during the school year the students will be receiving, via e-mail, semi-weekly lessons in the courses designed by the team members. The e-mails that will be sent to the students should be sent a week ahead of time to the parents and to the sexual education teachers in the elementary and high schools. By giving the parents and school teachers the lessons in advance, the video can be used to consult with and teach the adolescents. If parents think any video is inappropriate, they can object to the lesson that they think is not suitable. It is anticipated that parents and teachers of adolescents will themselves learn from watching the video lessons.

The lead physician must then set about recruiting and training physician extenders. These are licensed medical personnel who, working under the supervision of the lead physician or other team members, can visit the schools on periodic basis and meet with the students. These physician extenders, who in most cases will be licensed nurses or therapists, will be advisers on the adolescents' sexuality issues.

This will include the training of female student-patients in the basic ovulation method charting of menstrual cycles.

The lead physician will be able to bill the health plans and Medicaid for student-patient visits and for the visits at schools of the physical extenders working under his or her supervision. The lead physician will not be able to bill and collect for the video courses discussed. The individual physician members of the team will be able to bill for any time that they spend in treating and management of the student-patient.

The lead physician and all team members and physician extenders will ideally continue to follow the seventh and eighth graders when they get into high school and thereafter into college and into the work force, and they will continue to work with them on issues of human sexuality which would include NFP training. All of these patient visits, which involve the education and counseling with respect to contraceptives, abstinence, and fertility problems, will be billable under the Affordable Care Act.

Support for Faithful Catholic Physicians

The recent policy statement and technical report of the AAP amounts to nothing less than a mandate to temporarily sterilize all adolescents with LARCs for five to ten years. The goal of the AAP will promote more extramarital sex and will prepare the adolescents of today to use contraception in the marriages of tomorrow. The recommendations of the AAP directly contradict the teaching of the Catholic Church on sexual morality.

Catholic adolescents are entitled to receive education, counseling, and treatment from Catholic physicians who practice in accord with the teaching of the Church. In turn, Catholic physicians practicing in harmony with Church teaching, and risking the loss of patients and income, are entitled to full support of the faithful and the clergy.