

Researchers respond to Catholic hospital criticism of sterilization data: Analysis confirms data and exposes unqualified ethicists at hospitals

This analysis continues the initial study of Texas *Inpatient Hospital Discharge Public Use Data Files* regarding sterilization, abortion, and contraceptive data from US Catholic hospital systems operating in Texas 2000 through 2003 (see www.wikileaks.org/wiki/Catholic_hospitals_betray_mission). Knowledge of the methodology and findings of the initial study is presumed.

Some US Catholic healthcare systems and their individual hospitals have raised allegations against the claim of the initial study that the 9,684 cases of patients with V25.2 diagnostic code represent direct sterilizations forbidden in Catholic hospitals. The researchers are accused of inadvertently inflating the numbers or incorrectly labeling permitted sterilizations as prohibited procedures. In particular, some systems and hospitals insist that the V25.2 code can be used for pathological cases calling for “medically indicated” sterilizations and that their ethicists have stated these are indirect sterilizations permitted in Catholic hospitals. No one has provided evidence from the study’s database, actual clinical practice, diagnostic code manuals, or Catholic ethicists to substantiate these allegations.

In response to these allegations, the researchers went back to the initial study data. To confirm the meaning of the codes, the researchers reviewed the actual use made of the codes in the hospital data, the laws related to sterilization, the use of the codes by Medicaid and Catholic insurance programs, and Vatican pronouncements on sterilization. Researchers found it increasingly difficult to account for how informed Catholic health care professionals could clinically or ethically suggest that the V25.2 code represents anything other than a call for direct sterilization and found no reason to alter the initial findings of the study. The evidence seemed to suggest a situation like the one described recently by Dr. John Haas of the National Catholic Bioethics Center, namely, that prohibited direct sterilizations are taking place nationwide at some Catholic hospitals and that this practice is linked to a “shocking lack of understanding” about sterilizations and Catholic ethics at Catholic hospitals, and including the ethicists used by the hospitals (see Haas interview in *Our Sunday Visitor*, July 13, 2008 at www.osv.com/OSVNav/OSVNewsweeklyJuly132008/InFocusShockinglackofunderstanding/tabid/6388/Default.aspx).

The researchers were unable to find any description of the way ethicists are accredited by the individual hospitals, the hospital systems, or the Catholic Church to ensure that their judgments of hospital protocols and practices are actually in accord with Catholic belief. In the end, the researchers faced overwhelming evidence that the personnel from the hospital systems or individual hospitals making good faith claims that V25.2 can be a request for a permitted “medically indicated” or indirect sterilization are under the influence of unqualified ethicists who misidentify direct sterilizations as indirect sterilizations because they are inexplicably ignorant of or knowingly departing from established clinical and Catholic practice. Given the scope and prominence of the hospital systems involved this would mean, as Dr. Haas indicated, a national problem, not limited in any way to Texas. Given the gravity of this conclusion and its national implications for Catholic health care, the researchers wish to share their review with the bishops and the general public.

V25.2 diagnosis and accompanying sterilization procedure codes in the study

The original study extracted the records of 10,792 patients at Catholic hospitals from the Texas database because of potential violations of the *Ethical and Religious Directives for Catholic Health Care Services* (ERD) authored by the United States Conference of Catholic Bishops. In

determining potential violations of the ERD, the study relied on the diagnostic and procedure codes from the ICD-9-CM (International Classification of Diseases, 9th edition, Clinical Modifications) classification present in the records. ICD-9-CM diagnostic codes are used by physicians, hospitals, and allied health workers to indicate diagnostic conditions for all patient encounters. ICD-9-CM procedure codes are used to identify as specifically as possible surgical and others procedures completed to address the patient's diagnostic condition. These codes are commonly used in claims to federal, state and private insurance programs.

The original study asserted that the presence of a V25.2 diagnostic code in 9,684 records indicated that the accompanying procedure was a direct sterilizations prohibited by the ERD. It is this claim that has been contested by some of the hospitals criticizing the study. It is important to note that the original study made no assertion regarding the approximately 900 other cases of sterilizing procedures done without a V25.2 diagnostic code. Those cases would have to be reviewed individually and are not considered in the present analysis.

The ICD-9-CM describes the V25.2 diagnostic code as indicating "contraceptive management" by means of "sterilization admission for interruption of fallopian tubes or vas deferens." The V25.2 code is a contraceptive management diagnosis calling for a sterilization procedure, not a diagnosis of pathology calling for a therapeutic procedure. Because V25.2 expresses the patient's choice of means for contraception, it requires no underlying pathology to justify it. Any additional diagnostic codes appearing in an individual patient record therefore refer to the present condition of the patient, not to a reason for the V25.2 request for sterilization. The V25.2 code is usually entered in the patient's chart by the physician, and under federal and state regulations an informed consent signed by both the physician and patient is required indicating the entirely voluntary nature of the procedure being requested.

In the 9,684 patient records examined with a diagnosis of V25.2, the accompanying ICD-9-CM procedure code is entered by the hospital to describe the procedures completed for sterilization by interrupting the fallopian tubes or vas deferens. Of the seven male patients with V25.2 diagnosis, six received vasectomies which are procedures only used for sterilization, and in the seventh case sterilization was done by a procedure on the spermatic cord. The following points from an analysis of the data for the 9,677 female patient records containing the V25.2 code clearly reveals that the purpose of the accompanying procedure is for voluntary direct sterilization not for treatment of an existing pathology (see appendix for a table with sample records):

- 1) 97.6% of the cases (9,445 of the 9,677) took place in the context of the delivery of a live child. It should be noted that while tubal procedures for sterilization may also occur in an outpatient setting, pregnant women usually elect to have the procedure done post-partum as a matter of convenience. Of the cases reporting delivery with a live childbirth:
 - a. 32.6% had diagnostic admission codes for normal delivery (ICD-9-CM 650) or previous cesarean delivery (ICD-9-CM 654.21) with one or no additional diagnostic codes indicating the condition of the mother or child.
 - b. The other 67.4% had an admission code plus two or more additional diagnostic codes. Some were associated with the child such as cord entanglement, malposition of the baby, and abnormality in fetal heart rate. Others involved the mother, for example: hypertension, viral or bacterial infections, reactions to anesthesia, assisted delivery, obesity, tobacco use, drug use, advanced age of the

mother (35 plus), multiparity (given birth two or more times), and grand multiparity (given birth five times or more). These codes are not presented as justifications for the V25.2 diagnosis, but to express the present condition of the patient.

- c. 98.3% of all admissions with live births reported a procedure code for bilateral ligation, destruction, or crushing of the fallopian tubes (ICD-9-CM codes 66.21, 66.22, 66.29, 66.31, 66.32, and 66.39). 0.4% reported a procedure for unilateral ligation or destruction of a fallopian tube (ICD-9-CM code 66.92). Such procedures are rarely, if ever, used for treating any pathology.
- 2) 2.4% (232) of female patients with the V25.2 code did not record delivery of a live child. 110 cases were stillborn deliveries or did not indicate the outcome. The remaining 122 sterilizations were done at the same time as another surgical procedure treating an existing pathology (for example, stress incontinence, benign neoplasm of the ovary, and tubal or ectopic pregnancy). Of these 122 sterilizations, 13 had a diagnosis of tubal pregnancy (ICD-9-CM 633.1) or ectopic pregnancy (ICD-9-CM 633.8 and 633.9) that was treated by a unilateral removal of a fallopian tube, salpingostomy, or destruction of ovary (ICD-9-CM 66.62, 66.02, 65.25). 10 of the tubal and ectopic pregnancy cases had additional procedures for bilateral or unilateral destruction, occlusion, or ligation of the fallopian tubes or total bilateral salpingectomy (ICD-9-CM codes 66.92, 66.32, 66.29, 66.39), signifying that functioning fallopian tubes were interrupted in order to achieve the sterilization called for by the V25.2 diagnostic code.
 - 3) It should be noted that codes for procedures which sterilize appear to be absent in a small number of the V25.2 cases (less than 0.75%). These may represent coding errors.

This data indicates that these Catholic hospitals have allowed procedures whose direct purpose is to prevent a future pregnancy rather than to treat an existing pathology. The ICD-9-CM diagnostic code V25.2 explicitly states the contraceptive purpose of the accompanying procedure; therefore, the sterilizing procedures accompanying the V25.2 diagnostic code cannot be correctly interpreted as if they were treatments for a pathological diagnosis. Not only is this clear from the definition of V25.2 in the ICD-9-CM, but also from the use made of the procedure codes in the hospital data. Over 96% of cases diagnosed with V25.2 use tubal procedures that rarely, if ever, have a therapeutic use (ICD-9-CM codes 66.21, 66.22, 66.29, 66.31, 66.32, 66.39 and 66.92). In the remaining cases a surgical procedure that might be used to treat an existing pathology is employed for sterilization and the V25.2 code states the purpose is, in fact, contraceptive. When a diagnostic code for existing pathology (such as stress incontinence) appears in addition to the V25.2 code, the patient receives both a treatment for the pathology and a sterilization procedure in accord with the V25.2 request. All these sterilizations called for by the V25.2 code, therefore, have been done to avoid a future pregnancy and are direct sterilizations prohibited by the ERD, not indirect sterilizations arising from the treatment of existing pathologies.

The meaning and use of the V25.2 code and related sterilization procedural codes can be verified not only from the codes themselves and the actual use made of them by the hospitals in the study, but by considering how Medicaid and Catholic insurance programs interpret and use the codes.

V25.2 diagnosis and sterilization procedure codes in Medicaid and Catholic Insurance

Federal law governing Medicaid reimbursement defines sterilization as “any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing” [Title 42 Code of Federal Regulations 441.251, Subpart F]. Such a procedure requires informed consent, and that consent in turn requires providing the patient “a description of available alternative methods of family planning and birth control” [441.27 (ii)]. Thus, the Federal government recognizes that sterilization, that is, purposefully rendering a patient permanently incapable of reproducing, is a voluntary act whose effect of avoiding pregnancy can be obtained by alternate means. Sterilization is not considered medically necessary by Medicaid.

California’s Medicaid program (Medi-Cal) explicitly notes that: “Under the regulations, human reproductive sterilization is defined as any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations which are performed because pregnancy would be life threatening to the mother (so-called “therapeutic” sterilizations) are included in this definition” [http://files.medi-cal.ca.gov/pubdoco/publications/masters-mtp/part2/ster_m00i00o03.doc; page 1]. Medi-Cal is correct in noting the later situation is “included” in the definition of sterilization because danger from a future pregnancy does not alter the fact that the proposed procedure has “the purpose of rendering an individual permanently incapable of reproducing.”

Medi-Cal acknowledges that the V25.2 code is exclusively a request for a sterilization procedure. For example, when discussing a particular sterilization procedure, the Essure system, Medi-Cal states that the procedure will only be covered for sterilization purposes, not for experimental uses, and therefore will “only be reimbursed when billed in conjunction with ICD-9-CM diagnosis code V25.2 (sterilization)” (page 21-22).

When discussing Medicaid reimbursement for procedures, Medi-Cal notes: “A sterilization *Consent Form* (PM 330) is required for claims submitted for sterilization services. Claims submitted with any of the following CPT-4/HCPCS or ICD-9-CM procedure codes that are not accompanied by a sterilization *Consent Form* will be denied... ICD-9-CM Volume 3 procedure codes: 63.70, 63.71, 63.72, 63.73, 66.21, 66.22, 66.29, 66.31, 66.32, 66.39, 66.51, 66.52 or 66.63” (page 25-26). In other words, these codes are interpreted as sterilizations that require consent and not as treatment of present pathology.

Medi-Cal acknowledges that some of the procedural codes requiring a sterilization consent form can be used for purposes other than rendering a person permanently incapable of reproducing. When not used for the purpose of sterilization, these procedures do not require a consent form, but at least one of the following must be recorded with the claim (quoted from page 26):

- The surgery was a unilateral procedure and did not result in sterilization.
- The surgery was unilateral or bilateral but the patient was previously sterile. (On a signed attachment to the claim, the physician must explain the cause of the sterility.)
- The procedure was not elective and was done for an acute condition.

The Medi-Cal protocols, based in ICD-9-CM codes, would seem to parallel the requirements of the ERD regarding the identification of direct sterilization for contraceptive purposes and

distinguishing it from sterilization arising indirectly from a medical procedure treating present (i.e., acute) pathology.

Insurance programs operating under the ERD also recognize that particular ICD-9-CM codes, including V25.2, represent diagnostic requests for or provision of procedures that are prohibited under the ERD. For example, Suburban Health Organization (SHO; suburbanhealth.com) is an insurance program that has contracted its case management with Cooperative Managed Care Services (CMCS; cmcs-indy.com) which is sponsored by St. Vincent Health (a part of Ascension Health). Because CMCS is Catholic, claims filed under SHO coverage involving violations of the ERD are not managed by CMCS but must be filed directly with SHO. SHO publishes a list of these codes in a “Catholic Directive List” that states: “The following codes will be denied by CMCS and the provider will be directed to submit the claim to the healthplan.” Among the codes are: V25.2, 66.21, 66.22, 66.29, 66.31, 66.32, and 66.39 (see: www.suburbanhealth.com/PhysicianServices/materials/SHO_Catholic_Directive_List.pdf).

Vatican and ERD statements on direct sterilization

As demonstrated above, the meaning and use of the V25.2 code indicates a request for a direct sterilization. This is not a matter of opinion of the researchers but is established clinical practice. Some Catholic ethicists have tried for decades to assert that these types of sterilizations can in some circumstances be considered medically indicated or indirect, but the Catholic Church has insisted that their opinions are false and may not be used at Catholic hospitals. The Vatican pronounced this judgment in reference to US Catholic hospitals in 1975, reaffirmed it in 1993 and the Pope reiterated it to US bishops in 1998. These direct statements of the Vatican regarding the American situation provide a context for understanding the current ERD against direct sterilization (ERD 53).

The 1975 statement, *Quaecumque sterilizatio*, was issued by the Vatican in defense of a proper interpretation and implementation of no. 71 of the U.S. bishops' 1971 version of the ERD in response to efforts of Catholic ethicists seeking to permit sterilizations to prevent a future dangerous pregnancy (see *Origins* 10 (1976):33-35). These ethicists sought to justify so-called “therapeutic” or “preventative” sterilizations by appealing to concepts such as the “totality” of the person by which sterilization of reproductive organs would be in accord with the “totality” of the patient's well being. The Vatican affirmed the prohibition against direct sterilization in no. 71 of the directives and exposed the therapeutic preventative sterilization as nothing other than a prohibited direct sterilization. It noted that “the official approbation of direct sterilization and, *a fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil.” The document explicitly cautioned that the Vatican “is aware that many theologians dissent from it [i.e., the teaching on direct sterilization], but denies that this fact as such has any doctrinal significance, as though it were a theological source which the faithful might invoke” in justifying such sterilizations.

In 1993, the Vatican returned to the issue because ethicists in the United States were still trying to permit sterilizations as a means of avoiding the danger of a future pregnancy by calling them “uterine isolations.” The Vatican's *Responses to questions proposed concerning “uterine isolation” and related matters* provides a precise treatment of the distinction between direct sterilization and medical treatments that indirectly result in sterilization. It is worth presenting in its entirety:

Q. 1. When the uterus becomes so seriously injured (e.g., during a delivery or a Caesarian section) so as to render medically indicated even its total removal

(*hysterectomy*) in order to counter an immediate serious threat to the life or health of the mother, is it licit to perform such a procedure notwithstanding the permanent sterility which will result for the woman?

R. Affirmative.

Q. 2. When the uterus (e.g., as a result of previous Caesarian sections) is in a state such that while not constituting in itself a present risk to the life or health of the woman, nevertheless is foreseeably incapable of carrying a future pregnancy to term without danger to the mother, danger which in some cases could be serious, is it licit to remove the uterus (*hysterectomy*) in order to prevent a possible future danger deriving from conception?

R. Negative.

Q. 3. In the same situation as in no. 2, is it licit to substitute tubal ligation, also called “uterine isolation,” for the *hysterectomy*, since the same end would be attained of averting the risks of a possible pregnancy by means of a procedure which is much simpler for the doctor and less serious for the woman, and since in addition, in some cases, the ensuing sterility might be reversible?

R. Negative.

Explanation

In the first case, the *hysterectomy* is licit because it has a directly therapeutic character, even though it may be foreseen that permanent sterility will result. In fact, it is the pathological condition of the uterus (e.g., a hemorrhage which cannot be stopped by other means), which makes its removal medically indicated. The removal of the organ has as its aim, therefore, the curtailing of a serious present danger to the woman independent of a possible future pregnancy. From the moral point of view, the cases of *hysterectomy* and “uterine isolation” in the circumstances described in nos. 2 and 3 are different. These fall into the moral category of direct sterilization which in the Congregation of the Doctrine of the Faith's document *Quaecumque sterilizatio* (AAS LXVIII 1976, 738-740, no. 1) is defined as an action “whose sole, immediate effect is to render the generative faculty incapable of procreation.” And the same document continues: “It (direct sterilization) is absolutely forbidden ... according to the teaching of the Church, even when it is motivated by a subjectively right intention of curing or preventing a physical or psychological ill-effect which is foreseen or feared as a result of pregnancy.” In point of fact, the uterus as described in no. 2 does not constitute in and of itself any present danger to the woman. Indeed the proposal to substitute “uterine isolation” for *hysterectomy* under the same conditions shows precisely that the uterus in and of itself does not pose a pathological problem for the woman. Therefore, the described procedures do not have a properly therapeutic character but are aimed in themselves at rendering sterile future sexual acts freely chosen. The end of avoiding risks to the mother, deriving from a possible pregnancy, is thus pursued by means of a direct sterilization, in itself always morally illicit, while other ways, which are morally licit, remain open to free choice. **The contrary opinion which considers the interventions described in nos. 2 and 3 as indirect**

sterilizations, licit under certain conditions, cannot be regarded as valid and may not be followed in Catholic hospitals (emphasis added).

The closing remark of the *Response*, similar to the caution in *Quaecumque sterilizatio*, is noteworthy. The Vatican was aware that dissenting theologians were being invoked to permit direct sterilizations and deemed it necessary not only to reaffirm the true teaching and expose the errors, but to warn Catholics and Catholic hospitals against following the false theories.

In 1998 Pope John Paul II addressed the bishops of Texas, Oklahoma, and Arkansas during their every-fifth-year meeting with him. While speaking on the role of bishops as moral teachers, he took the occasion to speak of conscience, dissent, and Catholic hospital practice, including sterilization:

As Bishops you have to teach that freedom of conscience is never freedom *from* the truth but always and only freedom *in* the truth. This understanding of conscience and its relationship to freedom should clarify certain aspects of the question of dissent from Church teaching. By the will of Christ himself and the life-giving power of the Holy Spirit, the Church is preserved in the truth and “it is her duty to give utterance to, and authoritatively to teach, that truth which is Christ himself, and to declare and confirm by her authority those principles of the moral order which have their origin in human nature itself” (*Dignitatis Humanae*, 14). When the Church teaches, for example, that abortion, sterilization or euthanasia are always morally inadmissible, she is giving expression to the universal moral law inscribed on the human heart, and is therefore teaching something which is binding on everyone’s conscience. Her absolute prohibition that such procedures be carried out in Catholic health care facilities is simply an act of fidelity to God’s law. As Bishops you must remind everyone involved – hospital administrations and medical personnel – that any failure to comply with this prohibition is both a grievous sin and a source of scandal (For sterilizations cf. Congregation for the Doctrine of the Faith, *Quaecumque sterilizatio*, March 13, 1975, AAS [1976] 738-740). This and other such instances are not, it must be emphasized, the imposition of an external set of criteria in violation of human freedom. Rather, the Church’s teaching of moral truth “brings to light the truths which [conscience] ought already to possess” (*Veritatis Splendor*, 64), and it is these truths which make us free in the deepest meaning of human freedom and give our humanity its genuine nobility.

Evidently, the Vatican has been aware for over 30 years that dissenting ethicists were presenting false theories justifying what were, in fact, direct sterilizations and has sought to support the US bishops in proclaiming the truth and ensuring that human dignity is promoted at Catholic hospitals.

In 2001 the US bishops issued the fourth edition of the ERD and left unchanged the longstanding prohibition against direct sterilization:

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or

alleviation of a present and serious pathology and a simpler treatment is not available. (a footnote references the 1993 *Response on "uterine isolation"*)

Note that the sole criteria in ERD 53 for permitting procedures that can result in sterility is the presence of a present and serious pathology for which no simpler treatment is available. The V25.2 diagnostic code expresses no existing pathology and, moreover, is an explicit call for a contraceptive sterilization. As such the sterilization procedure given in response to a V25.2 diagnostic request is a clear and certain violation of ERD 53.

Why some Catholic hospitals insist that V25.2 diagnosis can include a “medically indicated” indirect sterilization

The ICD-9-CM definition of the V25.2 code, its use in the hospital records, the definition of sterilization in the Federal Medicaid regulations, the use of the V25.2 code by Medic-Cal and SHO, the Vatican statements of 1975, 1993, and 1998, as well as the 2001 ERD are in complete agreement that a request for a procedure intended to render a person permanently incapable of reproduction is a voluntary sterilization, not a medically necessary procedure. Regardless of the reason why a person intends to avoid pregnancy, clinically the requested procedure is called a sterilization and the ERD call it a direct sterilization.

Clinical practice and the ERD take into account that some procedures that result in sterilization can be used to treat present pathologies and distinguish these procedures from sterilizations. This distinction is indicated in the ICD-9-CM by the V25.2 code not being used in such pathological cases; in Medi-Cal by noting a non-contraceptive purpose through establishing a pathological treatment; and in the ERD by allowing procedures that result in sterilization when no simpler treatment exists for a present pathology. Clinically and in the ERD, these procedures are not called sterilizations but simply procedures for an existing pathology. In some documents of the Catholic Church these procedures are said to be, or to result in, “indirect sterilization” because the direct purpose and effect of the procedure is the treatment of an existing pathology.

Catholic hospitals would, therefore, seem to be without any clinical or ethical basis for denying that the V25.2 code requests a direct sterilization or for insisting that it can be used to request a “medically indicated” indirect sterilization permitted by the ERD when, in fact, it represents no existing pathology. Yet in response to the study of Catholic hospital data in Texas, some Catholic hospital systems and individual hospitals have made exactly these claims and have attempted to discredit the integrity of the researchers’ data analysis, their knowledge of the ICD-9-CM codes, and/or their understanding of direct sterilization in the ERD. What would cause the hospitals to do this?

First, this should surprise no one familiar with Catholic medical ethics. If the Vatican in 1975 and 1993 had to identify and condemn various theories by Catholic ethicists in the United States who were permitting direct sterilizations under a different name, then there is evidently a long established practice by some Catholic ethicists to refuse to accept the judgment of the Catholic Church. Why these ethicists would want to justify direct sterilizations by renaming them “therapeutic,” “medically indicated,” “medically necessary,” “uterine isolations,” or “indirect sterilizations” would be a matter of speculation. That they have continually made such attempts is an established fact documented in two Vatican statements issued in the last 33 years. The 1998 remarks of the Pope indicate that the Vatican remained concerned that Catholic hospitals were following the counsel of dissenting ethicists despite previous warnings and that, as a result, direct sterilizations continued.

These ethicists' decades-long persistence means that they are either unaccountably ignorant of clinical practice as well as Catholic teaching or they are determined to invent a way to permit what is known to be prohibited under the ERD. For example, doggedly refusing to call direct sterilizations what they are, creating new phrases to describe them, using old phrases in novel ways, or employing new ethical theories that render the concept of "direct sterilization" meaningless would be ways to avoid identifying these procedures as prohibited under the ERD. People not familiar with the ERD, clinical practice, or the details of Catholic theology who were taught by these ethicists would have no reason to believe the ERD prohibit the procedures. They could then in good faith, but erroneously, maintain that they were complying with the ERD. This seems to be what is happening.

A larger issue made evident by the hospital data in the study and by the insistence of some hospital systems and individual hospitals that V25.2 is not a call for a direct sterilization, but can be used to call for sterilization procedures that are permitted by the ERD, is that these Catholic institutions evidently continue to employ ethicists who provide ignorant or dissenting guidance. Like the ethicists they hire, some of the leadership at the hospital systems and within the sponsoring religious communities must be either unaccountably ignorant or willfully determined to permit what is prohibited. At the highest levels of Catholic healthcare in the United States, representing annual revenues and assets totaling tens of billions of dollars and enormous professional competence, ignorance cannot be the explanation for everyone. The systems and the religious communities either have no effective oversight of the drafting and implementation of individual hospital protocols and so are unaware of what the ethicists are permitting, or among the leadership there are some who concur with the discredited ethicists.

Certainly local administrators, doctors, and staff at these hospitals know that voluntary sterilizations have taken place, even if only to prevent a potentially dangerous future pregnancy. This explains why they have entered the V25.2 diagnostic request and the various procedural codes for sterilization into the patients' records and reported them to the State of Texas. It also explains the likely fact that they have obeyed the law and obtained and filed informed consent documents for these voluntary sterilizations. Apparently, however, someone has misled them into believing that these types of direct sterilizations are considered permissible indirect sterilizations by the ERD.

Some of the confusion for the medical personnel at Catholic hospitals may also arise from a distinction sometimes found in secular medical ethics literature between a "therapeutic" or "medically indicated" sterilization done to prevent unwanted impact on the health/life of a mother or child in a future pregnancy and an "elective" sterilization done for other reasons. Such language is imprecise and can be misleading to those not familiar with the clinical and ethical issues. The procedure is not therapeutic because it treats no existing pathology and actually damages the patient's reproductive system. Clinically speaking, there may be "medical indications" suggesting that a woman avoid a future pregnancy, but the specific means by which she avoids pregnancy is not "medically indicated" since there are a variety of means that would achieve the same purpose (i.e., abstinence, Natural Family Planning, contraception, vasectomy of her partner, sterilization).

Choosing to avoid pregnancy by sterilization, for whatever reason, is an ethical decision not mandated by medical condition. This is why, in part, federal regulations require those receiving sterilization to be told how other means of birth control might be used in place of permanent sterilization. Ethical decisions at Catholic hospitals are to be made in accord with human dignity and the Gospel in harmony with the ERD. This is why the ERD mandate that all doctors and staff

be educated about the ERD and agree to use them as the ethical standard for all care given at the Catholic hospital. But these mandates are meaningless if the hospital ethicist explaining the ERD is making judgments not rooted in a solid knowledge and acceptance of Catholic belief and practice.

By allowing so-called “medically indicated” sterilizations, the hospitals are allowing the subjective ethical judgment of the doctor and patient to appear as an objective clinical necessity rendering a sterilization indirect under the ERD when, in fact, it is a voluntary procedure and a direct sterilization. The Catholic hospitals could avoid subjective and misleading criteria such as “medically indicated” by using objective clinical criteria such as the ICD-9-CM codes (as found, for example, in Medi-Cal’s manual and SHO’s “Catholic Directive List”). Direct sterilization could then be readily and accurately distinguished from indirect sterilization. The codes would allow the hospital protocols to be directly linked to the coding used for hospital billing and the state data base. This would minimize confusion and facilitate implementing and auditing hospital compliance with the ERD. It would also allow hospital protocols across the United States to employ a common set of criteria.

Closing appeal

The researchers have placed their analysis and rationale before the bishops and the general public. We will publicly correct any mistaken representations of the data found in our study. The researchers invite the Catholic hospital systems and individual hospitals making accusations against the integrity of the data or speculating on how the data has allegedly been clinically or ethically misinterpreted by the researchers to undertake a more constructive and open discussion of the public data. We request that they:

1) Provide the public with the hospital protocols for procedures prohibited under the ERD as well as the name of the ethicists and officers of the hospital system who approved them. These protocols involve nothing confidential or secret and are known to all hospital employees. There is no reason to prevent the public from being able to evaluate them in light of the Catholic directives. If the policies are in accord with the ERD, this will be clear to everyone.

2) Describe the oversight mechanisms by which the hospital systems ensure that the protocols and education at individual hospitals represent the ERD as interpreted by ethicists in accord with Catholic belief and practice. This should include a description of the criteria used in selecting the ethicists and establishing that their judgments are formed by accurate clinical knowledge and acceptance of Catholic teaching.

3) Acknowledge or deny the data in the study. If denying, then provide examples from the study in which the codes have been fabricated or miscounted.

4) Demonstrate from clinical manuals and actual practice that the V25.2 diagnostic code or any other codes are legitimately used in a fashion other than claimed by the researchers.

The hospital systems and individual hospitals have a long history of avoiding public disclosures regarding their practices and protocols. They tend to answer all questions by stating they work in conjunction with the local bishop and in accord with the ERD. Under the present circumstances, their assurance that they are following the ERD is of little value since the assurance depends entirely on the accuracy of their understanding of the ERD—which is no better than their ethicists.

Appendix: Samples of Actual Patient Records with the V25.2 Diagnostic Code

| 6 Patient Records | | Diagnostic Codes | | | | | | | | | | | Procedure Codes | | | | | Rec | |
|-------------------|--------|--|---------------|---------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------------|----------|----------|--------|--------|--------|----|
| Dischg Qtr | | Sex | Admit Dx Code | Princ Dx Code | Other Dx1 | Other Dx2 | Other Dx3 | Other Dx4 | Other Dx5 | Other Dx6 | Other Dx7 | Other Dx8 | Princ Proc Code | Other P1 | Other P2 | Oth P3 | Oth P4 | Oth P5 | ID |
| #1 | 2000Q2 | <i>Columns for hospital ID, name, system, city & diocese</i> | F | 650 | 650 | V27.0 | V25.2 | | | | | | 73.6 | 66.32 | | | | | |
| #2 | 2001Q3 | | F | 654.2 | 654.2 | V25.2 | V27.0 | | | | | | 74.1 | 66.32 | | | | | |
| #3 | 2001Q4 | | F | 648.4 | 648.4 | 305 | 305 | V25.2 | V27.0 | | | | 66.22 | 73.4 | | | | | |
| #4 | 2003Q4 | | F | 659.4 | 659.4 | 70.5 | 648 | 658 | 663 | 648 | 306 | V25.2 | V27.0 | 66.32 | 73.59 | | | | |
| #5 | 2001Q2 | | F | 633.1 | 633.1 | V25.2 | | | | | | | 66.62 | 66.29 | | | | | |
| #6 | 2002Q4 | | F | 625.6 | 625.6 | 618 | V25.2 | 245 | 311 | 723 | | | 70.52 | 59.79 | 66.29 | | | | |

Rows #1 through #4: These sample records represent 9,445 women giving birth to a live child.

The records all have the ICD-9-CM V25.2 code (admission for contraceptive sterilization by interruption of fallopian tubes or vas deferens). 98.3 % of these cases reported an accompanying procedure for bilateral ligation, destruction, or crushing of the fallopian tubes (ICD-9-CM codes 66.21, 66.22, 66.29, 66.31, 66.32, or 66.39). In these specific sample records, the accompanying procedures indicate that the fallopian tubes were made inoperative through procedures 66.32 and 66.22.

Rows #1 & #2: These samples represent approximately one-third (32.6%) of the women giving birth who had admission codes for normal delivery (ICD-9-CM 650) or previous cesarean delivery (ICD-9-CM 654.2) with one or no additional diagnostic codes. The procedure code (66.32) not related to delivery is the procedure on the fallopian tubes specifically for sterilization in response to the V25.2 code.

Rows #3 & #4: These samples represent the other 67.4% of women giving birth who had two or more additional diagnostic codes plus the admission code. The other diagnostic codes express various complications or other conditions of the mother or child and do not affect the purpose of the accompanying sterilizing procedure since V25.2 is not based on any pathology, but is a request to sterilize for contraceptive purposes. The procedure codes for sterilization in these specific examples are 66.22 and 66.32.

Row #5 & #6: These samples represent 232 patient records with the V25.2 code which did not record the delivery of a live child. Record #5 has a code of 633.1 indicting a tubal pregnancy and accompanying procedure code for removal of the tubal pregnancy (66.62). The additional code is for a bilateral ligation of the fallopian tubes (66.29) to sterilize in response to the V25.2 code thus preventing further pregnancy which could result from the remaining functioning fallopian tube. Record #6 has a diagnosis of stress incontinence (625.6) and procedures to correct the problem (70.52 and 59.79). The record has an additional procedure code (66.29) done at the same time for contraceptive purposes in response to the V25.2 code.