ABSTRACT

Catholic Healthcare in the United States:
A Study of the Adherence to the Sterilization Religious
Directives of Ascension Health in Texas

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The United States Conference of Bishops created the *Ethical and Religious Directives* (*ERD*s) in order to provide clear ethical rules for American Catholics. Included was the prohibition of both female and male sterilization: the tubal ligation and the vasectomy. In some instances, Catholic hospitals continue to perform forbidden procedures to keep the business of a not devoutly Catholic populous. In order to determine the degree of adherence to the ethical guidelines, post partum tubal ligations and vasectomies were tabulated for hospitals in the Ascension Health group in Texas. The data demonstrated that the hospitals are performing these procedures at similar rates as non-Catholic hospitals in the state. The lack of a unified Catholic behavior may negatively impact the upcoming Supreme Court cases contesting the *Affordable Care Act.* If the current trend continues, hospitals that completely follow Catholic mandates may no longer exist.

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CATHOLIC HEALTHCARE IN THE UNITED STATES:
A STUDY OF THE ADHERENCE TO THE STERILIZATION RELIGIOUS DIRECTIVES OF ASCENSION HEALTH IN TEXAS

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CHAPTER ONE

Introduction

As the world's largest Christian denomination, the Catholic Church contains many faithful practitioners. These faithful are expected to follow the strict ethical guidelines of the Church, regardless of the field in which this person may be employed (United States Conference of Catholic Bishops, 2009). As entities held by the Catholic Church, Catholic hospitals and health care systems should abide by the ethical decrees of the Church on a variety of issues (Conlin, 2000). The most relevant topic to health care institutions, and to this thesis, is the preservation of life.

The Catholic Church views all human life as sacred (United States Conference of Catholic Bishops, 2009). The entirety of the Church's ethical doctrine on health focuses on the preservation and sustenance of life. One of the subsets of the discussion about life is the practice of sterilization, both the male form as a vasectomy and the female form as a tubal ligation. These procedures, which will be discussed in depth later, are a deliberate cessation to the reproductive capacity of an individual and are therefore viewed as "intrinsically immoral" (United States Conference of Catholic Bishops, 2009). As part of the preservation of life, a person may not alter their reproductive capacity because he or she is altering God's will for the future of the species. The official Church stance on sterilization in the United States is outlined in the Catholic *Ethical and Religious Directives (ERDs)*. The United States Conference of Catholic Bishops created this document in 1971 and it has been updated through the years as more ethical dilemmas

emerge (O'Rourke, Kopfen-Steiner, & Hamel, 2001). The *Ethical and Religious Directives* outline the Catholic interpretation of many life, death, and reproduction issues that a devoutly practicing member of the Church is expected to agree with and follow.

The Catholic Church reserves the right to take away the Catholic status of a hospital that is not following the teachings of the church, as will be discussed later. It is the responsibility of the bishop of each diocese, as a representative of the Vatican, to oversee the hospitals in his diocese and ensure that the *Ethical and Religious Directives* are being followed (Conlin, 2000). Many Catholic hospitals do not abide by the religious directives but are still part of the Catholic denomination because the bishop of the diocese in which the hospital is located is either unaware of the misconduct or is deliberately allowing the prohibited procedures (Nelson, 2009). A bishop that chooses to ignore the *ERD*s disconnects his diocese from the united stance of the Catholic Church, which creates repercussions that will be discussed more in depth in a later chapter. Often due to mergers, some hospitals intentionally provide sterilization and abortion procedures in order to continue business and be competitive in an area (Nelson, 2009). By continuing to provide women's health services, the hospitals keep the business of women that want these procedures and may retain the women and their families as customers for life.

Ascension Health is the largest Catholic health care institution in the United States ("Ascension Health," 2015). The various hospitals of this system encompass many different states and dioceses all over the country that are each run by their own bishop. Due the different levels of involvement by different bishops, these individual institutions follow the *Ethical and Religious Directives* to varying degrees. This health care system, with a specific focus on the hospitals in Texas, will be used as the model for this study.

First, the degree of adherence of Ascension Health hospitals to the Catholic *Ethical and Religious Directives* on sterilization will be analyzed. Then, the implications of ignoring the religious directives will be postulated in light of the current legal battle against the contraceptive coverage requirements in the *Patient Protection and Affordable Care Act of 2010*. If Catholic hospitals continue to become more secular by ignoring church teachings, religious groups may face more difficulties fighting for ethical exemptions.

The History of Catholic Health Care

As a proper analysis of the current state of the Catholic health care systems in the United States, the history of the formation of the systems must first be discussed. Catholic hospitals were first founded in Europe in conjunction with monasteries and convents. Following the teachings of Christian charity, these groups provided outreach to the poor with sick houses for the indigent in their communities (Kauffman, 1995). As the Catholic countries of Europe, such as France and Spain, settled the Americas, the groups of religious orders moved West as well.

One of the groups that moved to America was the Daughters of Charity. Founded in 1633 by St. Vincent de Paul in France, this group spread to America through Elizabeth Seton ("Ascension Health," 2015) (Kauffman, 1995, p. 34). Through Elizabeth Seton's community in Baltimore and others like it in the Colonies, Mexico, and Canada, Catholic hospitals started to form in the Americas. "Voluntary hospitals, sponsored by religious denominations and medical colleges, developed alongside state and city institutions" (Kauffman, 1995, p. 27). These new hospitals became integral parts of their local communities.

As the Industrial Revolution occurred, the Catholic hospitals grew and changed with the societies around them. Hospitals sprung up on the frontier to support new communities. In the newly bustling cities, the need for more health care became evident as the cholera epidemic of the 1800s ravaged the population (Nelson, 2009, p. 84). In this period, hospitals also began to specialize. As characterized by historian Paul Starr, this new phase in hospital structure consisted of "ethnic hospitals and institutions organized by religious groups for care of special diseases or for particular groups of patients, women, and children" (Kauffman, 1995, p. 131). These specialized structures provided focused care that still exists in entities such as children's hospitals today.

In addition to hospitals that specialized in cholera and women and children, Irish hospitals opened to support the new and heavily impoverished Catholic population that fled the Irish Potato Famine of 1845. The Irish immigrants were harshly discriminated against in urban populations for their faith and new hospitals helped provide ministry to them to ease their suffering (Nelson, 2009). One of the factors influencing the spread of Catholic health care institutions was religious discrimination. During the 1800s, bishops felt the need to spread "because of the widely prevalent anti-Catholicism and the tendency to proselytize in Protestant hospitals" (Nelson, 2009, p. 84). Catholic institutions helped foster Catholic faith in the Protestant New World.

Catholic hospitals had a large impact on their communities, especially with respect to their aid for the poor. "The provision of health care to the poor was viewed by… religious orders as 'an extension of the ministry of the Church" (Nelson, 2009, p. 84). Part of the Catholic mission passed down from the original Christians includes outreach to those in need. Catholic hospitals infused charity into their structure to comply

with this mission. At the turn of the 20th century, "Catholic benevolence was dedicated to nurturing the immigrant population of the urban ethnic villages" (Kauffman, 1995, p. 69). The services of the church were even desired in non-Catholic communities because of their assistance and dedication. This was helpful on the frontier where a Catholic hospital in some areas was the only health care facility nearby (Kauffman, 1995). Catholic hospitals continue this mission and outreach today as they admit 20% of patients in 22 states and Washington D.C. and comprise 12% of the beds in the United States as a whole (Catholic Health Association of the United States, 2013; Uttley, Reynertson, Kenny, & Melling, 2013).

The twentieth century represented a large change in structure for the Catholic held health care facilities. Originally, religious hospitals were structured with nuns as the caretakers of the patients. These nuns would train others, becoming some of the original nursing programs. During this time period secular nursing schools were formed. This took away the role of the nuns as trainers because they were no longer needed. As larger hospitals formed, the nuns and monks shifted to positions on the board of directors overseeing the Catholic mission of the hospital (Kauffman, 1995). During this time period, Catholic hospitals also became "semi-public institutions" when hospitals opened that were funded the government but managed by a religious order (Nelson, 2009, p. 85). This structure created some legal conflicts due to the separation of Church and State, but it was determined that this type of hospital was considered non-Catholic in the eyes of the law.

With the social upheaval of the 1970s, less Americans took holy orders. As the nun and monk base diminished, hospitals began to use lay employees. The role of the

clerical staff in hospitals shifted from primary caretaker to only the administrator. A new relationship between hospitals and religious orders emerged wherein the religious order was more of a sponsor of the institution rather than directly controlling the heath care (Nelson, 2009, p. 85). As the number of Catholic hospitals in America grew and the number of nuns continued to be small, the number of ordained employees in each Catholic hospital became limited to just a few on the board of directors or none at all (Kauffman, 1995).

The movement to lay management presented a large shift in focus for Catholic hospitals. Less devout employees meant less rigid adherence to Catholic doctrine by the management. Another issue that began to occur was the changing political focus of some of the orders of nuns. "Gradually many sisters and lay women involved in health care absorbed a feminist perspective into the new religious consciousness that profoundly affected the critique of society, church, and educational and health-care institutions" (Kauffman, 1995, p. 245). These changes of focus caused the hospitals under their leadership to break with tradition and knowingly offer services that are forbidden by Catholic teaching.

In the 21st century, Catholic hospital systems with a large financial base are expanding through mergers and acquisitions. Each addition of a hospital includes a risk to the identity of the Catholic institution or to that institution with which it merges. When taking over a secular hospital, some agreement must be reached as to the state of the *Ethical and Religious Directives* in the new hospital. Many non-Catholics in the community often fear the transition of a hospital to Catholic, as it will cease to provide reproductive services on which they have come to rely. In some instances, the

administrators are able to reach an agreement and require the new addition to become Catholic or at least to follow the *ERD*s. Other times, the Catholic hospital system relents and allows non-doctrinal services to continue (Nelson, 2009). These situations often lead to compromises that risk the Catholic identity of the hospital and, as discussed later in this work, may lead to the alienation of the hospital from the church (Conlin, 2000).

Ascension Health

Ascension Health was formed in 1999 after a merger of multiple Catholic healthcare entities. One of these institutions was the system controlled by the Daughters of Charity. This organization was "established as a secular[1] institution (confraternity) in order to avoid cloister and practice active ministries" (Nelson, 2009, p. 121). The Daughters of Charity was not originally chartered by the Church, so the women involved were not nuns and were not cloistered. The women were able to be physically active in their communities as healthcare providers. In 1668 the Daughters of Charity was officially recognized by the Pope and the sisters involved became nuns of the Church ("Ascension Health," 2015). By this time the group had spread to 163 hospitals all over France (Nelson, 2009, p. 121).

In America, Elizabeth Seton created the Sisters of Charity, which followed the mission and doctrine of the Daughters of Charity. She helped expand the group into several hospitals until it merged with the French Daughters of Charity in 1850 (Nelson, 2009, p. 121). The Daughters spread West during after the Louisiana Purchase and created a St. Louis hospital in a log cabin after the urging of a local bishop ("Ascension Health," 2015). The Daughters continued to achieve success and expand their hospital

[1] Not officially associated with the Catholic Church

system through their savvy business sense. For example, “to finance their hospital in Saginaw, Mich., the sisters visited lumber camps and sold all-inclusive hospital service tickets for $5” (Nelson, 2009, p. 122). The sisters also became known for “their willingness to ‘make tough decisions, like selling unprofitable hospitals or investing enough money to make them profitable.” This led the group to “one of the highest credit ratings in the health care industry” (Nelson, 2009, p. 122). The Daughters of Charity, with their large monetary base, was a large asset to the beginning of the Ascension Health system.

St. Joseph of Carondelet, like the Daughters of Charity, also dates back to 17th century France. (“Ascension Health,” 2015) A few religious women in Le Puy, France gathered with the Jesuit priest Jean Pierre Medaille to form a group that assisted their community (“Ascension Health,” 2015). These sisters were an unusual religious order. They were not cloistered but lived in their community. They also did not wear habits, the traditional attire of a nun, but instead wore normal clothes for the time period (“Sisters of St. Joseph of Carondelet,” 2012). The women prayed together and dedicated their lives to addressing the needs of their communities through service (“Sisters of St. Joseph of Carondelet,” 2012).

While in France, the sisters created an orphanage for their community. They soon expanded into other forms of service by “running schools, hospitals, … and institutes for the deaf” (“Ascension Health,” 2015). These forms of outreach were well known outside their community and spurred the request by Bishop Joseph Rosati for the sisters to come to St. Louis so that their service could be of use in America (“Sisters of St. Joseph of Carondelet,” 2012). In America, the Sisters of St. Joseph set up a school for the deaf and

an orphanage in Carondelet, Missouri. Due to the strained connections caused by distance between France and the United States, the sisters split off to become the Sisters of St. Joseph of Carondelet ("Ascension Health," 2015).

The Sisters of St. Joseph were important during the cholera epidemic of 1849. Like their counterparts the Sisters of Charity, who cared for 1,500 cholera patients, the Sisters of St. Joseph "nursed the sick and dying in [a] heavily afflicted area of the city" (Kauffman, 1995, p. 60). The Sisters worked in one of the most impoverished areas of St. Louis and helped sustain the community there.

The Sisters of St. Joseph of Carondelet continued to grow and cover more hospitals all over the United States and in other countries around the world. In 1981, the group brought together thirteen different health care institutions in order to form the Health Care Corporation of the Sisters of St. Joseph of Carondelet ("Ascension Health," 2015). This organization soon merged with the Daughters of Charity to create Ascension Health.

The merger between the Daughters of Charity and the Sisters of St. Joseph health care institutions occurred in 1999 to create Ascension Health ("Ascension Health," 2015). Multiple other healthcare institutions have joined since the original merger in order to expand the outreach of the entity. Other than the founding members, Ascension Health now encompasses what were formerly the Congregation of St. Joseph, the Alexian Brothers, and the Sisters of Sorrowful Mother. These different religious organizations had slightly different focuses in service that needed to be reconciled in order to function as a unit. The organization decided that its main focus as a whole would be a "Call to Action" ("Ascension Health," 2015). Ascension Health uses this vision to serve patients

in all of its communities.

In order to keep its Catholic identity, Ascension Health has an appointed juridic person. A juridic person in the canonical sense is effectively the "owner" of the non-profit who is in charge of decision-making (Morrisey, 2009). Until 2006, Ascension Health lead its ministry using the "Ascension Health Sponsors Council" of all ordained persons. The leadership changed when Vatican appointed a public juridic person in 2010 in order to improve administration of the group ("Ascension Health," 2015). According to the website of Ascension Health:

> The Vatican approved creation of a non-congregational[2] public juridic person (PJP) to serve as the sole Sponsor of Ascension Health. As the sole Sponsor, the PJP – known as Ascension Sponsor – assures the ministry will be sustained and strengthened over time, with both religious and lay persons serving as members of the Ascension Sponsor, being responsible for the ministry and welcoming others to join. ("Ascension Health," 2015)

The juridic person oversees the religious aspects of the hospital mission to ensure that they continue even with non-ordained leadership.

Ascension Health is the largest Catholic health care system in the United States. The system currently is composed of 1,500 locations in 23 states and the District of Columbia ("Ascension Health," 2015). Due to the size of the system, there is a wealth of knowledge about the interactions of the system and struggles that it has faced that will be utilized for this thesis. In order condense the amount of data, the hospitals that will be studied are those in the state of Texas. The Texas Department of State Health Services publicly releases patient diagnosis and procedural data for every year. This data will be used to determine the number of sterilization procedures performed in Catholic hospitals.

[2] A person that is not part of one of the sponsoring entities of the organization, referred to as religious congregations.

These hospitals will then be compared to non-Catholic hospitals in similar areas and Catholic hospitals owned by different entities in order to determine the nature of compliance.

CHAPTER TWO

Ethical Concerns

Catholic Perspective on Life: Encyclical Letters and Vatican II

In order to properly discuss the decisions surrounding sterilization and how it will affect the future of the Catholic healthcare system, the history of the arguments surrounding the issue and the ethical basis must also be discussed. The Catholic Church has a very strict interpretation on what constitutes life and whether or not it may be ended. This means that any medical intervention that threatens a person's life or the beginning of a new life, such as sterilization, is forbidden. During the twentieth century, the Catholic Church desired to reform and re-evaluate its social stances for the modern era. In order to do this, the Second Vatican Council convened under the direction of Pope Paul VI. One of the important pieces of Catholic doctrine that came out of the council is called *Gaudium Et Spes*, which is the *Pastoral Constitution on the Church in the Modern World* (Pope Paul VI, 1965). This document discussed many different topics surrounding the church, but one of note was of the view on marriage and reproduction.

In *Gaudium Et Spes*, chapter 1 is titled "Fostering the Nobility of Marriage and the Family" (Pope Paul VI, 1965). As the name suggests, this section discusses the views on marriage in the modern age. This important piece of Catholic doctrine states that marriage is founded in God's love and laws (Pope Paul VI, 1965). This connects the church's views on reproduction to the sacrament of marriage. In the view of the Church, since God created marriage, those that are united in marriage are in union with God and

must follow his commandments (Pope Paul VI, 1965). This creates a large responsibility for the couple to plan a family responsibly and raise children in the Catholic Church. Pope Paul VI further expanded on these concepts on marriage and family in his encyclical letter *Humanae Vitae.*

Pope Paul VI wrote *Humanae Vitae* in 1968 (Pope Paul VI, 1968). The purpose of a papal encyclical is to express the opinion of the current Pope in order to influence society; the statements made in it are not infallible. This encyclical was a response to the changing times in order to express the church view on the purpose of marriage. During this time period, there was much concern about population growth and the cost to feed a large family (Pope Paul VI, 1968). Due to scientific advancements, it became possible to limit the size of the family through the birth control pill. This idea seemed like the natural way to fix the problems that society faced, but the Pope urged in his encyclical for natural family planning. In this setup, the size of the family would be regulated by "intelligence and will" rather than other scientific methods (Pope Paul VI, 1968).

One of the factors that influences the view on birth control in the Catholic Church is the view of marriage. Marriage in the church is ordained by God and follows the example of God's love. This sacred aspect of marriage means that it cannot be tainted by outside sources. Marriage also has a holy purpose in the Church. The purpose of marriage is to have more children, bringing in more members to the church. As written in *Humanae Vitae* in a reference to the message from the Second Vatican Council, "Children are really the supreme gift of marriage" (Pope Paul VI, 1968). While children may be viewed as the gift of marriage, it is expected that the urges of those in the marriage may be controlled so that responsible parenthood may be obtained (Pope Paul

VI, 1968). It is important to note that while one of the important purposes of a marriage in the eyes of the church is children, a marriage is not illegitimate due to infertility (Pope Paul VI, 1968).

In the encyclical, Pope Paul VI directly expresses the view of the Church on birth control. Abortion, any form of birth control, and sterilization are strictly forbidden. This is because "human life is sacred… [and] from its very inception it reveals the creating hand of God" (Pope Paul VI, 1968). On sterilization, he says, "Equally to be condemned [with abortion]… is direct sterilization, whether of the man or of the woman, whether permanent or temporary" (Pope Paul VI, 1968). The argument that is invoked is that it is not morally permissible to do something evil in order to promote something good. This means that it is not acceptable to use birth control, an evil to the Church, in order to improve the quality of life for the family. The act of sexual intercourse that is deliberately contraceptive, therefore stopping the natural "generative process," is deemed intrinsically wrong (Pope Paul VI, 1968).

Another important encyclical on the use of birth control was *Evangelium Vitae*, written in 1995 by Pope John Paul II. As the strict moral standards of the church were brought into question through the late 20th century, it became necessary to readdress the reason behind the stance. This starts with the argument about the worth of a human life. Pope John Paul says that humans have value through their connection with God and that the natural law that every believer and non-believer knows is that human life is sacred (Pope John Paul II, 1995).

When *Evangelium Vitae* was written, it had been 30 years since the Second Vatican Council had condemned the attack on human life in the world (Pope John Paul II,

1995). The threat against human life had only increased in that time period. Due to the increase in technology and change in public opinion, abortion became a legal form of birth control (Pope John Paul II, 1995). The Church was also concerned with the willingness of doctors to participate in euthanasia practices. The Pope called for international attention to struggling families who saw abortion or euthanasia as their only options.

Pope John Paul II addressed many current reproductive issues in his letter. When discussing abortion, he also discusses contraception, because the two topics are related. He states that both promote the mentality that a life that could be created might be inconvenient and drastic matters must be taken to prevent it (Pope John Paul II, 1995). Pope John Paul II also discusses artificial reproduction, which is not acceptable in the Catholic Church for multiple reasons. In-vitro fertilization separates the natural human role in the beginning of life and often leads to the death of fertilized embryos, the same thing as killing a fully developed person in the eyes of the Church (Pope John Paul II, 1995). Another topic of concern is prenatal screening due to the intent to terminate the pregnancy if the child has a condition (Pope John Paul II, 1995). In all of these instances, the natural progress of human life has been altered.

In the encyclical letters, the Popes expressed the importance of the sacredness of a human life to the Church. The Pope noted a change in the popular culture towards one of convenience, which favored quick results over valuing human life (Pope John Paul II, 1995). The Church attempted to fight this culture by spreading the reasons for their morals, but the same methods of birth control still remain poplar today.

The Catholic Ethical and Religious Directives

As previously mentioned, the *Ethical and Religious Directives for Catholic Health Care Services* were published in 1971 by the United States Conference of Catholic Bishops (O'Rourke et al., 2001). The stated purpose of the ERDs is to "reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person… [and] to provide authoritative guidance on certain moral issues that face Catholic health care today" (United States Conference of Catholic Bishops, 2009). This important document includes directives on beginning of life and end of life care that should be followed by all Catholics in the medical field or Catholic medical institutions (United States Conference of Catholic Bishops, 2009).

Part four of the 5th edition of the *Ethical and Religious Directives* is called "Issues in Care for the Beginning of Life" (United States Conference of Catholic Bishops, 2009). This chapter of the directives outlines the accepted Catholic view on many beginning of life issues, such as those relevant to this thesis. In this chapter, it affirms that Catholic stance that life is sacred "from the moment of conception until death" (United States Conference of Catholic Bishops, 2009). It also states that while limiting the number of children a couple has is responsible, it must be done in a natural way or the act is disrupting the intended purpose of the conjugal act by God (United States Conference of Catholic Bishops, 2009). The directive on sterilization in this chapter is very relevant to this thesis. The exact wording of this directive states:

> 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 of alleviation of a present and serious pathology and a simpler treatment is not available. (United States Conference of Catholic Bishops, 2009)

These two different situations where sterilization occurs will be discussed further.

Direct sterilization is the deliberate cessation of the reproductive capacity of a person. This procedure is prohibited because it is an unnecessary mutilation of the body and interferes with the natural reproductive purpose of the individual (United States Conference of Catholic Bishops, 2009). According to the Conference of Bishops, this type of procedure should not be permitted in any Catholic health care institution in the United States. The other type of sterilization is termed indirect sterilization. In this situation a person becomes sterile, but sterility was not the intended purpose (United States Conference of Catholic Bishops, 2009). This would be the case if a person had a hysterectomy to treat cancer. This type of reasoning follows a principle called "double effect." By the reasoning of the double effect, an intervention is morally permissible if it was intended for moral purposes and by an unintended consequence has other repercussions (Nelson, 2009). Through the *Ethical and Religious Directives*, it can be determined that indirect sterilizations are morally permissible in Catholic hospitals, but direct sterilizations such as tubal ligations and vasectomies are not.

Sterilization

The methods of sterilization being discussed in this work shall be examined. Tubal ligation surgery is the commonly used method to surgically sterilize women and is over 99 percent effective ("Tubal Ligation," 2004). During this procedure, the fallopian tubes of the woman are cut, tied, clipped, or cauterized, blocking the tube so that eggs may not be released into the uterus ("Tubal Ligation," 2004). This procedure is performed in two different ways, through laparoscopic surgery or a mini-laparotomy. During laparoscopic surgery, the most common technique, an instrument is inserted

through an incision near the umbilicus and is used to cut the tubes. This procedure is often done after filling the abdominal cavity with a gas, carbon dioxide or nitrous oxide, in order to create space between the incision site and the intestine to allow visualization ("Tubal Ligation," 2004). Laparoscopic procedures generally take half an hour under regional or general anesthesia ("Tubal Ligation," 2004). The other method, the mini-laparotomy, is performed much faster and has a shorter recovery. During this procedure an incision is made by the pubic bone. Each fallopian tube is pulled into the incision, pinched, and returned into the body. This procedure takes just a few minutes and is done under regional, local, or general anesthesia ("Tubal Ligation," 2004).

As is the case for the women in this study, many decide to have a tubal ligation directly after childbirth. Immediately following childbirth, the uterus stays enlarged. With this enlargement, no gas is required to access the fallopian tubes. This makes either of the procedures previously mentioned much simpler ("Tubal Ligation," 2004). In the case of a caesarian section, tubal ligations are even easier. While the woman is still open on the table, the same incision site may be used to access the fallopian tubes and cut them ("Tubal Ligation," 2004). Directly after childbirth is therefore a very common time to have a tubal ligation.

Tubal ligations are not always reversible. If a person would like to reverse it, she must undergo another surgery. This surgery is not often covered by health insurance so it is usually expensive ("Tubal Ligation," 2004). A tubal ligation reversal is also not very effective with only about a 50% success rate ("Tubal Ligation," 2004). There is also more risk of an ectopic pregnancy, egg implantation in the tube instead of the uterus, with reversal due to scarring on the fallopian tubes ("Tubal Ligation," 2004). For these reasons

it is recommended that a woman not undergo a tubal ligation if she is not very sure whether or not she would like more children.

The male version of sterilization surgery is called a vasectomy. In a vasectomy, the vas deferens of the man are cut and tied. This may be done normally with a scalpel or in a "no-scalpel" manner with a clamp that perforates the skin (Weiske, 2001). In recent years some vasectomies have also been performed by laparoscopy, but this amount of effort is usually not necessary without other circumstances. This procedure is usually performed under only local anesthesia as an outpatient procedure. (Weiske, 2001) Unlike tubal ligations, which are fully effective immediately, vasectomies are not fully effective immediately following the procedure. It is recommended that a man obtain regular sperm counts for up to a year following the procedure to check its effectiveness. This is due to scar tissue's role in blocking the movement of sperm (Weiske, 2001).

Vasectomies can be reversed through elongation of the vas deferens. This reversal is often very successful, with a 75-95 percent rate of successful reestablishment of flow (Weiske, 2001). The procedure is relatively low in cost, especially when compared to the cost of contraceptives over the length of time that the average man has the vasectomy (Weiske, 2001). This form of sterilization procedure is very popular and often regarded as the safest method of birth control for men (Weiske, 2001). As of 1991, ten percent of men worldwide using some form of birth control had a vasectomy (Weiske, 2001).

The most common reason for surgical sterilization procedures is contraception for consenting adults, but there are other reasons that sterilization is sometimes implemented. In some cases, a person may be surgically sterilized if a pregnancy will endanger the mother's health. It is also performed in some cases without the choice of the individual if

that person is mentally disabled and unable to make good reproductive choices or care for a child (Brake & Millum, 2012). There is also the darker form of forced sterilization in eugenics. This is when people of a certain class, background, mental capacity, or race are sterilized in order to stop their bloodline from continuing in the population (Powderly, 2004).

Tubal ligations and vasectomies are generally accepted by the population of the United States as valid forms of birth control. To most there is no ethical issue associated with these procedures except in the form of racist or prejudiced forced sterilization. The right to use birth control is a part of a person's autonomy to make decisions about his or her own body. (Powderly, 2004) The main group of dissenters against the procedures is religiously conservative Christians. Among this group, "the official teaching of the Roman Catholic church constitutes the strongest and the primary contemporary moral opposition to the use of contraception" (Powderly, 2004).

Other Ethical Views

Secular Bioethics

One of the topics that must be addressed when discussing the ethical virtues of a medical procedure is the topic of secular bioethics. The topic of bioethics began in antiquity with the ancient Greek philosophers. Aristotle and Plato used medicine in their discussions of virtue (Pellegrino, 2008). Hippocrates discussed the virtue in medicine, especially with his concepts of performing medicine for the good of the patient, as doctors profess in the Hippocratic Oath (Pellegrino, 2008). Some sort of moral basis must be formed in order to properly decide the correct action during medical dilemmas.

One way in which to examine bioethics is through the teleological approach that originated with Aristotle. One of the modern philosophers that used this idea was Leon Kass. (Pellegrino, 2008) In his works, Kass states that the end of medicine is health, which he described as "an activity of the human body in accordance with a specific excellence" (Pellegrino, 2008). Within this framework, medicine has an internal morality. Any interaction that the patient has with a physician in order to further his or her health contributes to his or her good and is the whole purpose of medicine (Pellegrino, 2008). Through this type of bioethical reasoning, a procedure may be deemed morally acceptable if it contributes to the health of the patient. The philosopher Alasdair MacIntyre also expanded on the ideas of Aristotle with his discussion of internal and external goods of a practice in his work *After Virtue* (Pellegrino, 2008). Internal goods are those that happen when attempting to achieve excellence in a practice (Pellegrino, 2008). In the practice of medicine, the internal good is excellence in healing (Pellegrino, 2008).

One of the more modern theories that is considered with secular medical ethics is utilitarianism. This concept attempts to optimize utility, the correct balance between things that are valued and things that are not valued (Beauchamp, 1989). This means that in medicine benefits are maximized and harms are minimized (Beauchamp, 1989). The concept of utilitarianism relies on the consequences of the action that is performed. The line of thought that ignores consequences and instead focuses on whether or not the action in itself is right or wrong is called deontology (Beauchamp, 1989). In order to practice this form of bioethics, there must be some way to determine right and wrong. This is difficult to determine concretely. The proposed methods to determine the morality

of an action are intuition and common sense and the appeal to a social contract through complete removal of bias, such as from John Rawls. Rawls promotes the mental removal of social context in order to decide on an action that would promote the good for any person in society (Beauchamp, 1989).

In the predominant modern American culture, ethics are often socially constructed. This means that "moral choices are simply our preferences among the sentiments dominant in our society at a particular time" (Pellegrino, 2008). This causes variability in the moral choices and opinions of the secular population. The end of healing that has generally been decided on by society is the good of patients. This includes the true medical good, what the patient believes is the good, what is good for humans, and the spiritual good (Pellegrino, 2008). Because there is no one philosophy for deciding the ethics of a medical procedure from a secular standpoint, there is not an overall consensus on the medical views that society faces.

Non-Catholic Reproductive Culture

In what is considered the main stream American culture, sterilization is not viewed as an ethical issue. This procedure is a standard form of birth control for those that follow the modern sexual culture (Engelhardt, 2000). Due to the complete disconnect between the two different reproductive cultures, the mainstream liberal culture and the religious conservative culture, there is little possibility for consensus between the two (Engelhardt, 2000).

The rift in the reproductive cultures began with the countercultural movements in the 1960s (Nelson, 2009). During this time period, the advances in contraceptive technology, increased life expectancy, decreased infant mortality, realization of the

population limit, and the changing position of women in society all contributed to the widespread use of birth control (Powderly, 2004). It was during this time period that the Second Vatican Council convened and *Humanae Vitae* was written (Pope Paul VI, 1965, 1968). This popular culture promoted ideas of personal autonomy and freedom of choice (Pope John Paul II, 1995).

At the front of this change in culture was the widespread acceptance of birth control. In the early 1900s, Margaret Sanger led the movement for a legalized form of birth control. Sanger was a social worker in New York City and wanted the poor immigrant families to have access to a method to limit their number of children (McCracken, 2010). After many years of campaigning by the pro-birth control groups, the FDA finally approved the birth control pill in 1960 (McCracken, 2010). The availability of birth control fundamentally changed the sexual culture in America. According to a study by Finn Christensen in the *Journal of Population Economics*, the introduction of birth control increased the rate of cohabitation before marriage in America (Christensen, 2011). The pill also changed the nature of romantic relationships, making cohabitation often a requirement before marriage and sometimes a substitute instead of marriage (Christensen, 2011). With less concern about the possibility of children, marriage was no longer a necessity for a sexual relationship, completely deviating from the previous social norm.

The moral consensus on sexual relationships of the secular culture is very different than that of the traditional Christian culture. According to Dr. H. Tristram Engelhardt, there are seven points to the general consensus of the secular culture. These are privacy of sexual acts with freedom from judgment, moral permissibility of sexual

acts, rejection of moral terms in a sexual context, contraception as a human good, rejection of language that suggests unnatural or deviant behavior, prevention of sexual exploitation, and moral acceptance of embryo and fetus waste (Engelhardt, 2000). The prevalent culture rejects the moral discussions surrounding sexual acts and instead view them as personal lifestyle choices for personal satisfaction (Engelhardt, 2000).

Pope John Paul II references this contrasting dominant social culture in his *Evangelium Vitae*. In the encyclical, John Paul brings about concern that "broad sectors of public opinion justify certain crimes against life in the name of the rights of individual freedom" (Pope John Paul II, 1995). He also mentions how the culture is an extension of personal autonomy, but expresses concern that if individualism is taken too far people will reject each other. This is already seen in the lack of concern for the right to life of others during abortion or euthanasia (Pope John Paul II, 1995). The encyclical states that the current culture has a "perverse idea of freedom" that is caused by selfishness (Pope John Paul II, 1995). These views of the Catholic Church on the current mainstream reproductive culture exemplify the disconnect between the two. No consensus will be able to be reached between the majority of the population and the Roman Catholic Church, creating social tension.

CHAPTER THREE

Data and Significance

Data Collection Process

In order to best determine the current adherence to the Catholic *Ethical and Religious Directives* (ERDs) in our sample population, the Ascension Health hospital system in Texas, data was collected and analyzed. This data was collected from the Texas Inpatient Public Use Data File (PUDF) released from the Texas Department of State Health Services[1]. Texas publically released its hospital discharge data, providing free access to data from 1999-2008 and access up to 2014 for a fee. Using this data, one is able to see the age, gender, and procedural and diagnosis codes for every discharge in the state of Texas from inpatient services in a hospital.

In order to determine procedures performed using this data, one must use ICD-9 codes. ICD stands for the International Classification of Diseases, a coding system used to track diseases worldwide that is distributed by the World Health Organization ("WHO International Classification of Diseases (ICD)," 2015).

There are four unique ICD-9 codes that were used in this study in order to analyze the data pertaining to specific patients. The first is the code V27, the outcome of delivery code. The base code of this class, V27.0, is defined as mother with single live birth (United States, 1991). This code was tabulated without the number after the decimal point in order to encompass all possible outcomes of birth that have varying codes, such

[1] https://www.dshs.state.tx.us/thcic/hospitals/Inpatientpudf.shtm

as still birth or multiples and to find the number of births performed annually in each hospital. This number provided an estimate of the volume of women's services performed in the hospital.

The second code that was used in this study was the procedural code for tubal ligations. Procedures are classified by the Current Procedural Terminology (CPT) code subset of ICD-9. The code for a "other bilateral ligation and division of the fallopian tubes" is 66.32 (American Medical Association, 2013). Using this number allowed for the visualization of all of the female patients receiving sterilization procedures. This code was not only tabulated by itself, but also in conjunction with the code for birth. This is due to the high correlation between patients that recently gave birth and those that underwent a tubal ligation procedure.

The last code that was used in this study was the procedure code for a vasectomy. The proper code for documenting this procedure was also the CPT code describing the procedure. The code indicating "vasectomy and ligation of vas deferens" was 63.7 (American Medical Association, 2013).

The procedure for the use of these codes in analyzing the data is as follows. This method was developed in consultation with the Baylor Statistics department. First, the data files were downloaded from 2005 to 2008, a total of 16 files, one per quarter per year studied. Next, due to the size of the data files, the data was narrowed down to the hospitals of interest. This was done using an egrep code in the terminal of the computer. This code is used to pull multiple pieces of information from the data at the same time. An example of the code used for this experiment is as follows:

(1) egrep "Providence|UTMB|Brackenridge|Dell|Seton|Cedar Park|Central Texas|Childrens Med|Scott & White|Hillcrest|CHRISTUS|Mother Frances|Baptist St| Daughters|Vicente|Nazareth" PUDF_base1q2005.txt> 1q2005.txt

The hospital names were used instead of the official hospital codes due to the error of collecting data that contained that number in any part of the patient coding data. A few extra hospitals were collected in this process that shared similar names with the ones analyzed in this study, but they were easily removed after assembling the data. After the data was narrowed down to the hospitals of interest, the data was counted using a grep –c code. The grep code pulls one code of information from the data and –c counts the number of occurrences of this value. This was done four different times for each data file, once for births alone, once for tubal ligations alone, once for both tubal ligations and births in the same patients, and once for vasectomies. An example of this is shown below, with (2) representing the count of just births and (3) representing both tubal ligations and births:

(2) grep V27 1q2005.txt| cut -c1-30|sort|uniq -c > Q12005birthV27.txt

(3) grep V27 1q2005.txt|grep 6632 | cut -c1-30|sort|uniq -c > Q12005birthstubals.txt

The data was limited to the first 30 characters in order to allow the visualization of just the names of the hospitals. At this point, with just the hospital names and counts listed, the extraneous hospitals were removed.

The data was summed for each hospital by procedure in order to examine the extent of the data. The hospitals analyzed fall into three different categories: Catholic hospitals belonging to Ascension Health, other Catholic Hospitals, and non-Catholic hospitals in similar regions. The Catholic hospitals were also examined by diocese. This is due to the fact that the bishop of each diocese is ultimately the one in charge of

monitoring the activity for a hospital in his diocese. The full list of hospitals studied, organized by category, is listed on Table (1). The non-Catholic hospitals and other Catholic hospitals are in similar regions as the ones in the study for additional comparison. The lists of the hospitals separated by diocese are also outlined in Table (2).

Table 1.

Ascension Health	Other Catholic	Non-Catholic
University Medical Center at Brackenridge (Austin)	Baptist St. Anthony's (Amarillo)	Children's Medical Center (Dallas)
Cedar Park Regional Medical Center (Cedar Park)	St. Catherine Hospital (Katy, CHRISTUS)	Hillcrest Baptist Medical Center (Waco)
Central Texas Rehab (Austin)	Santa Rosa Hospital (San Antonio, CHRISTUS)	Scott and White Hospital (Roudrock)
Centro San Vicente (El Paso)	Mother Frances Hospital (Tyler, Trinity Mother Frances)	Scott and White Memorial Hospital (Temple)
Daughters of Charity Services of San Antonio (San Antonio)		
Dell Children's Medical Center (Austin)		
Nazareth Hall Nursing Center (El Paso)		
Providence Health (Waco)		
Seton Edgar B. Davis Hospital (Luling)		
Seton Medical Center Harker Heights (Austin)		
Seton Medical Center Hays (Kyle)		
Seton Highland Lakes Hospital (Burnet)		
Seton Medical Center (Austin)		
Seton Northwest Hospital (Austin)		
Seton Medical Center Williamson (Roundrock)		
Seton Shoal Creek Hospital (Austin)		
Seton Smithville Regional Hospital (Smithville)		
Seton Southwest Hospital (Austin)		
University of Texas Medical Branch Women's Hospital (Austin)		
Warm Springs Rehabillitation (Kyle)		

Table 2.

Dioceses					
Austin	**Tyler**	**Amarillo**	**Houston**	**San Antonio**	**El Paso**
Univeristy Medical Center at Brackenridge	Mother Frances Hospital	Baptist St. Anthony's	St. Catherine Hospital	Daughters of Charity Services	Centro San Vicente
Cedar Park Regional Medical Center				Santa Rosa Hospital	Nazareth Nursing Center
Central Texas Rehab					
Dell Children's Medical Center					
Providence Health					
Seton Edgar B. Davis Hospital					
Seton Medical Center Harker Heights					
Seton Medical Center Hays					
Seton Highland Lakes Hospital					
Seton Medical Center					
Seton Northwest Hospital					
Seton Medical Center Williamson					
Seton Shoal Creek Hospital					
Seton Smithville Hospital					
Seton Southwest Hospital					
University of Texas Medical Branch Women's Hospital					
Warm Springs Rehabilitation					

The number of tubal ligations, births, combination births and tubal ligations, and vasectomies was compiled for each hospital for each of the four years. This data is shown in detail in the Appendix (Tables A(1)-A(4)). After the data was totaled, it was separated into the relevant groups. Due to the varied nature of the data, it was determined that the best method for analysis would be a graphical comparison of proportions. Other statistical analysis is not possible due to the irregularities in the data, as explained further below. It was decided in conjunction with the Baylor Statistics Department that in order to normalize the data, the number of births in the hospital is divided by the values for

each procedure during the same period. It is assumed that the number of births give an idea of the volume of patients that the hospital admits. The proportions were compiled into bar graphs. This type of graph was used due to the categorical nature of the data. Four graphs were produced. Figures (1) and (2) have the counts for combined post-partum tubal ligation procedures divided by births for diocese then owners respectively for 2005-2008. Figures (3) and (4) display data in the same manner for vasectomies.

Data

Figure 1.

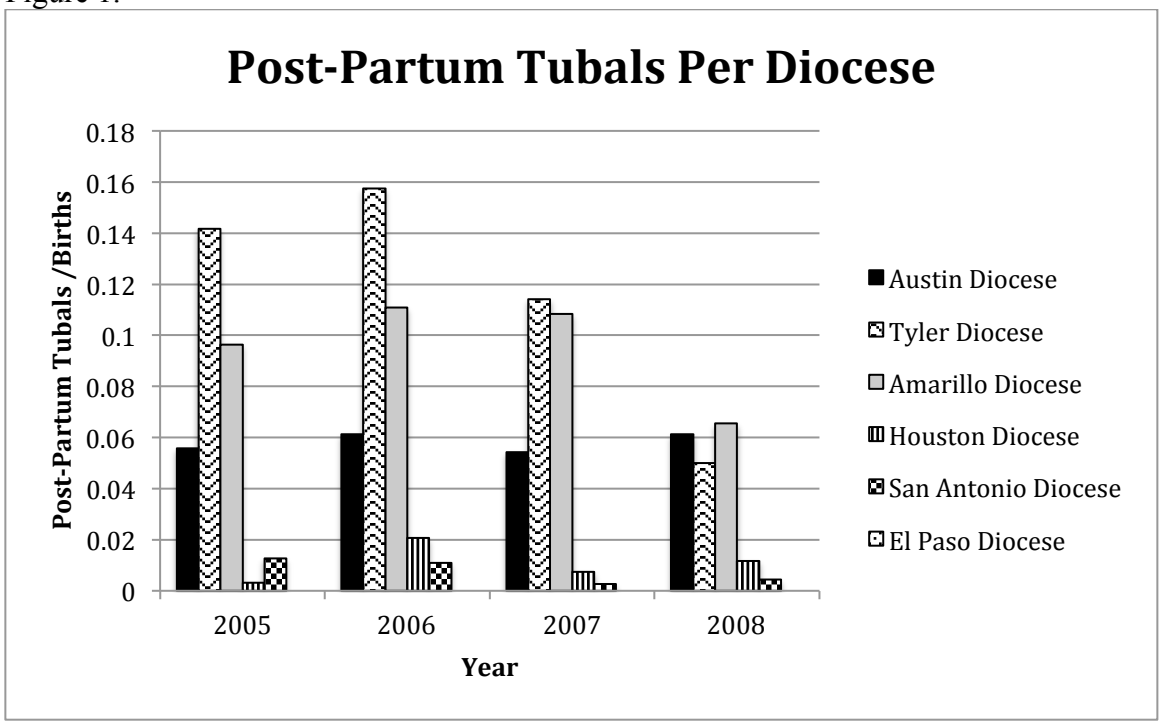


Figure 2.

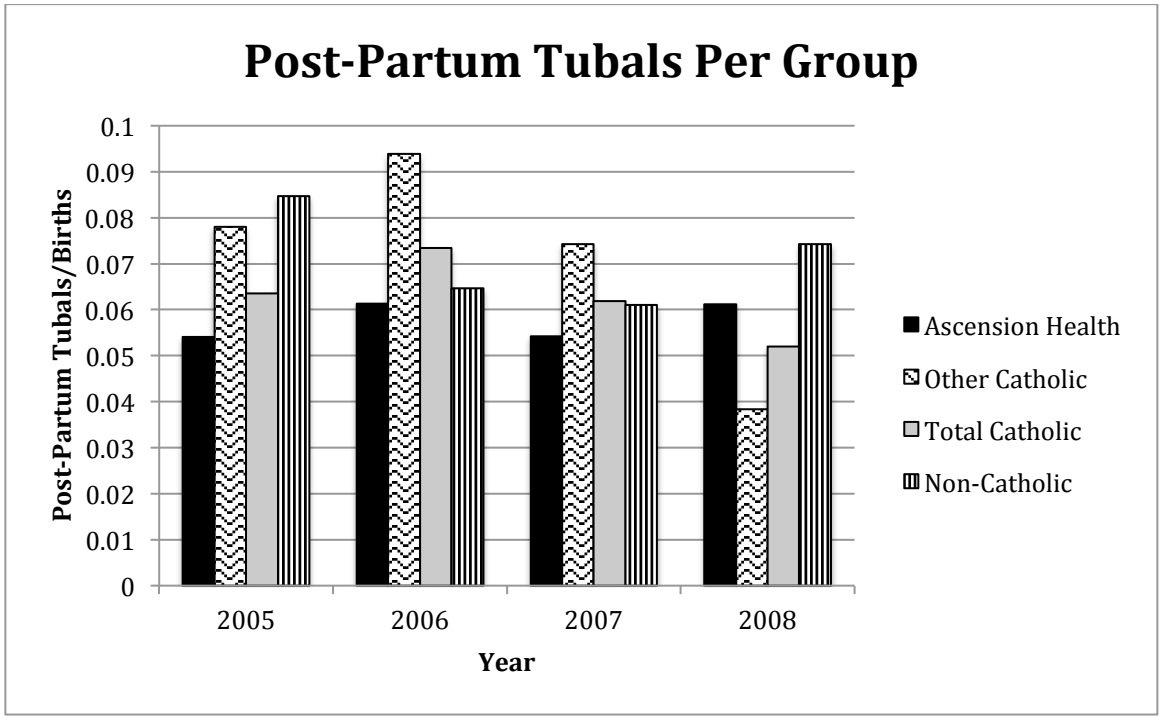


Figure 3.

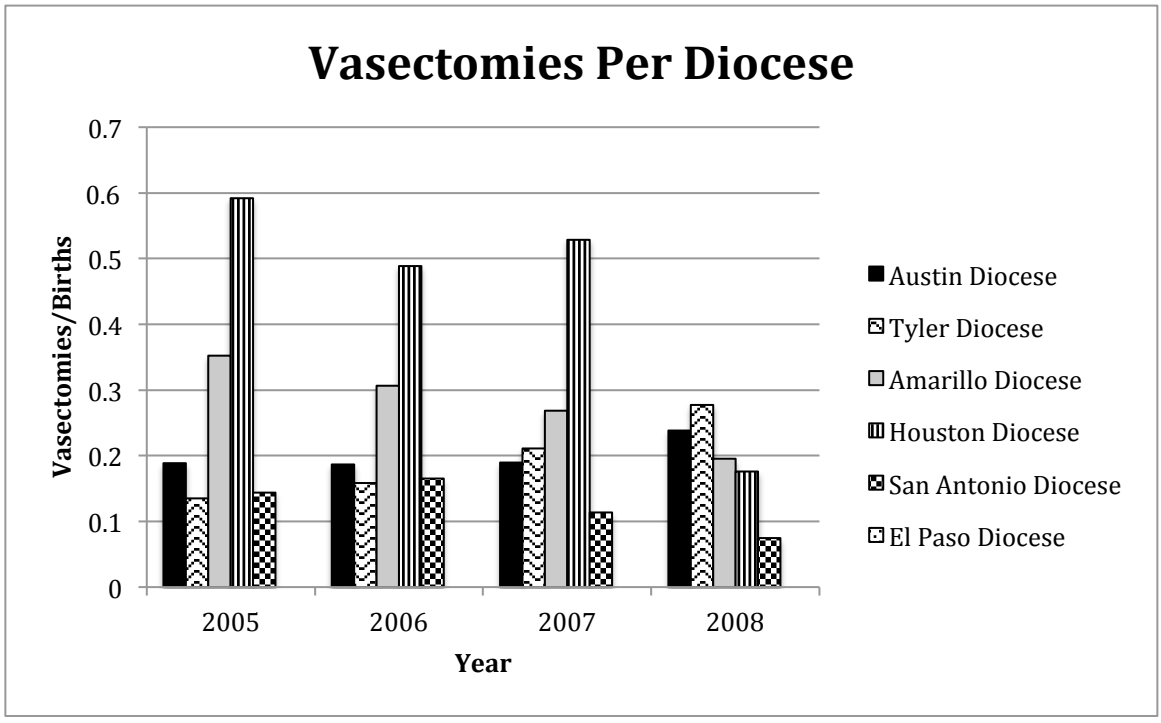
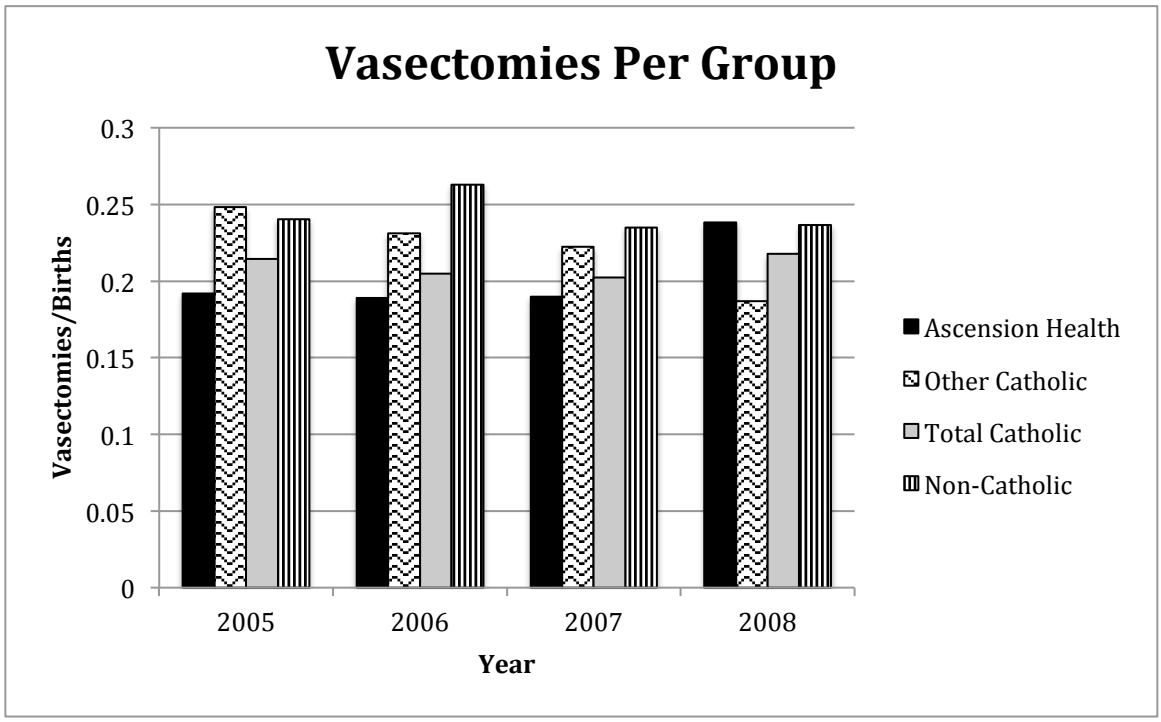


Figure 4.



Data Analysis

The data presented included no information about the decisions to perform the procedure. This meant that traditional statistical tests that show statistical differences do not apply. Due to the inability to run complete statistical analysis on the data, it must be analyzed visually for trends. In Figure (1), for the first three years the Tyler and Amarillo diocese have the largest number of tubal ligations, with Tyler being the highest. In 2008 though, there is a drop in the number of procedures performed. This change is equal to about 100 fewer post-partum tubal ligation patients for both hospitals. The number of births was constant during this period. It is possible that this change is due to random chance, such as fewer women wanting sterilization procedures that year, but it may also signify a difference in the policy of the hospitals. In 2008 there was a publication on WikiLeaks that showed the number of tubal ligations being performed in the Catholic

hospitals in Tyler (Carlson, 2010). This information apprised the bishop of the situation, who asked for stricter enforcement of the ERDs (Carlson, 2010). The downward trend may represent the beginning of this enforcement as the hospitals became aware of the impending leak. The Austin Diocese, which includes many more hospitals, has a generally lower number of tubal ligations. This is very interesting due to the fact that Austin is a large city and the Catholic hospitals provide most of the services. This means that while they still offer the services, when normalized for volume they comparatively perform the procedure less. The Houston and San Antonio dioceses perform very few tubal ligations in comparison. The hospitals studied from the El Paso diocese performed no tubal ligations and had no deliveries, discussed further below.

The second set of comparisons, on Figure (2), includes the different administrators in charge of hospitals. All of the groups had relatively similar results, varying up or down slightly depending on the year. The proportion of tubal ligations per births is decreased overall in this comparison due to the large volume of births at each hospital when all combined. The two groups with the highest ratios were Other Catholic and Non Catholic. This was very interesting, as it would be expected that the hospitals with no religious restrictions on women's services would perform many more tubal ligations, but there were very similar proportions between Other Catholic and Non Catholic. In 2008 the Other Catholic hospitals experienced a drop, similar to the drop seen previously when separated by diocese. This once again may be due to random chance or a change in policy. It appears overall that all of the groups of hospitals perform procedures with very similar proportion.

When analyzing vasectomies in Figure (3), the hospital with the overwhelming majority for the first three years is the Houston Diocese. The Tyler Diocese experienced a steady increase over the four-year period while the Amarillo diocese declined. Austin and San Antonio both stayed relatively steady at low frequencies. The El Paso diocese once again had no births or vasectomies. This does not mean necessarily that the El Paso diocese has completely banned vasectomies, but rather that they do not occur in these Catholic owned facilities discussed here during the observed time period. There were multiple anomalies that occurred in the vasectomy data that will be discussed further below.

The last figure, Figure (4), outlines the proportion of vasectomies per group. Each group was relatively similar once again, but as opposed to the tubal ligations the number of vasectomies per birth is much greater. The Non-Catholic group once again had the highest proportions with the other Catholic and Total Catholic close behind. Ascension Health saw a gradual relative increase over the period. It appears that there is no significant difference in the number of vasectomies per birth based on whether or not a hospital is owned by a Catholic group or Non Catholic group.

One difficulty that arose in the data collection process was ensuring that the numbers pulled from the data were actually from the correct part of the data. For example, as previously mentioned, the names of the hospitals were used instead of the hospital codes because one of the hospitals had the code number 001000. This caused any patient data that had the number one to be retrieved mistakenly. An attempt was made to use statistical software to retrieve data from a specific column associated with each procedure, but it was unsuccessful. This was due to the fact that the data is not

standardized. Each patient has a list of procedures and diagnoses that apply to him or her, which varies per patient. This meant that the data had to analyzed as a whole set instead. The vasectomy data would then be more likely to contain inaccuracies because it involved the retrieval of data using just one number. Any patient that had 637 in their file, including parts of their birthday or zip code, would have their file counted in the number of vasectomies. The number of post-partum tubal ligations would be more accurate because it requires two different numbers to appear in the data and the birth code has a "v" attached to it as well.

There were anomalies that appeared in the vasectomy data. The Children's Medical Center in Dallas had a large number of vasectomies. This is an unusual procedure for a Children's Hospital and the procedure is not listed on their website. It was unclear if this was an incorrect result due to errors in the data but it would be unusual that the error would be so frequent. Extra measures were taken after this original anomaly appeared where the Children's hospital data was filtered individually and filtered by gender in order to eliminate some error. Surprisingly there were also vasectomies counted from the women's hospital. There were less than 40 in this category per year so this may be due to error. One interesting problem is that vasectomies are not always performed in hospitals but in outpatient clinics as well. It was noted that depending on how hospitals report their data, outside clinics may have been included as well.

As previously mentioned, the El Paso hospitals had no deliveries, tubal ligations, or vasectomies during the period. Some of these facilities were included because they are owned by Ascension health but are actually not full hospital facilities. The Nursing homes and rehabilitation centers would not be expected to have any births or surgical

procedures to report. Another problem is that not all of the hospitals studied were opened during the examined period. The Centro San Vicente group in El Paso did not open until 2010. The Scott and White Hospital in Roundrock began reporting patient data in 2007. While some of the hospitals did not have data, they did not negatively impact the rest of the study, as they had no births to create a proportion.

In conclusion it was shown that the Ascension health hospitals did perform procedures that are forbidden according to the Catholic *Ethical and Religious Directives*. The proportion of both forbidden procedures were very similar across all governing groups, Catholic and Non Catholic. The diocese that performed the greatest volume of each procedure varied between tubal ligations and vasectomies. In general hospitals in the Tyler and Amarillo dioceses performed the most tubal ligations and those in the Houston diocese performed the most vasectomies. With many Catholic hospitals across a variety of dioceses performing procedures that are forbidden by the United States Conference of Bishops, it is difficult to assert that the Catholic Church and hospitals as a whole oppose these procedures. The implications of this will be further examined in the subsequent chapter.

CHAPTER FOUR

Conclusions and Applications

Significance: Mergers and Religious Standing

The decisions of hospitals to either follow or ignore the Catholic *Ethical and Religious Directives* of course do not occur in a vacuum but have real consequences on their communities and organizations. This impact is often felt during the merging of hospitals or hospital groups. When purchasing secular hospitals, religious hospital chains must make decisions regarding the religious status of that hospital as a member of the group. A purchasing Catholic group often wishes for the new hospital to be Catholic in order to maintain the image of the group. This can become a contentious issue in the surrounding community. The adherence to Catholic directives may mean a sudden lack of women's services that had previously been provided in an area. If Catholic hospitals allow the prohibited procedures to continue, they are sacrificing their Catholic identity and face alienation from the Bishop (Conlin, 2000). Arrangements have become more and more complex in order to appease both non-Catholic and Catholic parties (Nelson, 2009, p. 101). As leaders in the healthcare world, healthcare groups such as Ascension Health participate in many mergers and acquisitions that require extra analysis due to these difficulties.

One example of a situation that faced many such difficulties was the attempt at a merger of the Daughters of Charity hospital Mount St. Mary's and Niagara Falls Memorial Hospital in New York. This merger was widely opposed by pro-abortion

groups such as Planned Parenthood due to the breadth of women's services provided to the area by the Niagara community hospital (Nelson, 2009, p. 123). One of the options proposed was to allow Niagara Falls Memorial to fully continue its sterilization procedures and abortion referrals, but this merger eventually fell through after opposition by the Bishop (Nelson, 2009, p. 124). In 2007 the two hospitals struck an agreement to share some services instead of a full merger to avoid changing the administration of reproductive services (Nelson, 2009, p. 124). One last merger was attempted. The Niagara Falls Memorial side proposed a full merger of management and assets with reproductive services performed on the community hospital campus but not on the Catholic campus (Nelson, 2009, p. 124). Ascension proposed the merging of management and assets but suggested moving reproductive services to a non-related facility (Nelson, 2009, p. 124). No agreement was made due to the differing opinions on how to handle reproductive services (Nelson, 2009, p. 124). The combinations of Catholic and non-Catholic entities are continuously plagued with such difficulties.

The merger of Catholic and non-Catholic entities can in some cases involve the creation of loopholes to go around the *ERD*s. One prominent example is in an Ascension Health hospital, University Medical Center at Brackenridge. Brackenridge is the county hospital in Austin and the highest-level trauma facility in the area (Haurwitz & Roser, 2012). While Brackenridge is city owned, the Seton Healthcare Family in Austin, a large part of the Ascension Health group, manages it (Nelson, 2009, p. 128). The purchase of Brackenridge came with many difficulties, as it wished to retain its women's health services while falling under the management of the Catholic group. Originally, the services were allowed to continue as long as a separate company that operated inside the

hospital performed them. In 2000, the local bishop, Bishop Aymond, notified the group that this arrangement was unacceptable. At the time there were 400 sterilizations a year being performed inside Brackenridge. (Nelson, 2009, p. 128) An alternative solution was created to accommodate all parties. The fifth floor of the hospital was renovated to provide a space for a separately licensed hospital within the hospital (Nelson, 2009, p. 128). The floor would perform all of the sterilization, childbirth, and contraceptive services previously performed in the hospital (Nelson, 2009, p. 128). This loophole has allowed the women's services to continue in order to provide for the region, but the profit went directly to the internal hospital instead of Brackenridge. This model ended in 2012 when the inner hospital lost funding and the services were moved to St. David's hospital in Austin (Haurwitz & Roser, 2012).

The debate over the Catholic status of Brackenridge was rekindled in recent years. In 2016 Dell Medical School at the University of Texas at Austin is set to open. The old Brackenridge will be moved to a new building that will serve as the primary teaching hospital for the school (Haurwitz & Roser, 2012). Many were concerned about the idea of a public medical school operating out of a Catholic hospital. This hospital would still not provide abortion or sterilization procedures, which would be part of the students' training (Haurwitz & Roser, 2012). The issue has been mostly resolved due to the current situation with UTMB and UT Southwestern medical students training at Brackenridge in Austin. These students are able to do the majority of their training at Brackenridge, but go to other facilities in order to see the procedures that are not performed there (Haurwitz & Roser, 2012). This arrangement allows students to continue training at the facility regardless of its Catholic standing.

A bishop has the responsibility to ensure that if a hospital is using the designation of Catholic, it is doing so in a responsible manner (Conlin, 2000, p. 172). In the past, it was more common for individual dioceses to own hospitals. With this practice becoming rare, Bishops are often unaware of how to navigate the intricacies of the healthcare system and, therefore, are not fully acquainted with the details of procedures performed in the hospitals (Conlin, 2000, p. 173). This situation creates barriers for the Bishop to perform his role in monitoring the hospitals and, if necessary, participate in the alienation process. In this process, a hospital may lose its ecclesiastical status as the ownership transfers to either a different juridic person or a non-juridic person (Conlin, 2000, p. 160). There are some variances in this definition as "Alienation can be understood strictly (ownership of title is directly transferred to a new owner) or broadly (any act by which the patrimonial condition is jeopardized)" (Conlin, 2000, p. 161). Due to his important role, a bishop must be involved in the sale of religious goods owned by a juridic person and be aware of the religious status of each of the institutions within his own diocese.

One of the important definitions in the discussion of the adherence to Catholic *Ethical and Religious Directives* is the Catholic definition of scandal. The official Vatican statement on scandal is "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (Vatican, n.d.). By allowing other facilities under their care to continue reproductive services, Catholic hospital groups are often accused of committing scandal in the eyes of the church. In order to prevent the accidental incidence of scandal, a publication was released with guidelines for administrators to follow. This publication released by the Congregation for the Doctrine

of Faith was titled “Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services.” These principles instruct an administrator not to cause others to do harm and to ensure full respect of the human body in their facilities (Vatican, n.d.). One of the examples that was previously mentioned that involved a situation of scandal was when an outside researcher proved Trinity Mother Frances Hospital permitted sterilizations.

As mentioned in the previous chapter, some of the Catholic Hospitals in the state of Texas under Ascension Health performed sterilizations during the time period studied, against the requirements stated in the *Catholic Ethical and Religious Directives.* This is due to the desire of these facilities to continue to provide comprehensive services to the women in their area. This practice is able to continue due to lack of enforcement on the part of the local bishops.

Current Events

With differing adherence to the Catholic *Ethical and Religious Directives* across Catholic facilities, even in the same health system, it becomes difficult to argue that there is a unified Catholic approach to healthcare. This causes difficulties in the current political climate. In recent times, the more liberal populous has created laws that have required Catholic hospitals to follow guidelines that go against the directives, which the hospitals have had difficulty fighting. One cannot achieve exemption for Catholic facilities when not all desire or require the exemption. Recent situations involving Catholic facilities will be examined.

In 2014 the Genesys Health System in Michigan suddenly reversed its policy on sterilizations, banning all tubal ligations (Martin, 2014). They were met with outrage

from women's rights groups, and many in that community worry more changes will come as bishops are starting to crack down on the adherence to the religious directives (Martin, 2014). This change came following recent statements from the United States Conference of Bishops about their upcoming revisions to the ERDs in order to prevent future scandal in Catholic facilities (Martin, 2014). Following the sudden cessation of women's services, the ACLU (American Civil Liberties Union) of Michigan filed a complaint stating that the change violates state law and both Medicare and Medicaid protections (Martin, 2014). At the time of the change multiple tubal ligation procedures that were previously scheduled were suddenly canceled, including one for a woman a few months from delivery (Pieklo, 2014). Due to the limited admitting privileges of her doctor she was required to either deliver elsewhere without her doctor in order to receive the procedure or delay the procedure until fully healed from her delivery (Pieklo, 2014). One of the recent cases that incited action again was that of 33-year-old Jessica Mann. Jessica desired to have a tubal ligation when she delivered her child because another pregnancy would be dangerous to her health as she was battling brain cancer (Schuch, 2015). The ACLU has filed many cases against a variety of Catholic hospitals for similar situations (Pieklo, 2014).

One of the recent new items in Catholic healthcare that possibly foreshadows what is to come was the change in identity of Catholic Healthcare West (Martin, 2014). This group in California had been gradually growing by acquiring new secular facilities (Carle, 2013). When the secular hospitals were acquired, they were subject to a set of rules called the "Statement of Common Values" instead of the ERDs (Carle, 2013). This set of guidelines prohibited abortions and euthanasia but allowed hospitals to continue to

perform sterilizations and provide contraceptives (Carle, 2013). By 2011, about one third of the facilities owned by the group were non-Catholic (Carle, 2013). The group decided that the best approach would be to revise the administration practices of the Catholic Healthcare West in order to best provide for the Catholic and non-Catholic participants (Carle, 2013). Multiple options were considered including creating two separate groups or appointing a juridic person. The resolution was restructuring under a new name with continued religious sponsorship, but only for the religious hospitals. (Carle, 2013) Catholic Healthcare West became Dignity Health (Carle, 2013). By dropping Catholic from its name, the group cut some of its connections to the church, with the consent of the bishop, and allowed prohibited reproductive services to continue in its facilities (Martin, 2014).

While not in the United States, a recent change in healthcare requirements in Britain caused some concern for similar situations happening in the United States. In Great Britain, any physician that objects to any form of contraception may be barred from certification from the national Obstetrics and Gynecology association, called the Royal College of Obstetricians and Gynaecologists (Bingham, 2014). The issue involved in this case was the use of the morning after pill. Physicians that refuse to provide the morning after pill as an ethical decision will not receive backing to be an OB/Gyn specialist (Bingham, 2014). This issue is similar to that of conscientious objection of physicians in the United States. Recently the New York Senate proposed a health plan that would change the rules surrounding abortions in the state (Denison, 2013). In the bill, there was no previsions for opt out of religious institutions, as is often included in abortion legislation. This means that it would be possible for government entities to force religious

hospitals and doctors to perform abortions if they receive state funding, as almost all religious hospitals do (Denison, 2013; Kutscher, 2013). There is concern that similar to Britain, doctors in the United States may be required to perform sterilization and abortion procedures, regardless of their religious affiliation.

Since the institution of the *Patient Protection and Affordable Care Act*, commonly referred to as ObamaCare, multiple cases have reached the Supreme Court over how a religious entity should be affected when a requirement conflicts with their ethical values. Part of the new national healthcare system included a set of basic requirements that a private health insurance company must cover. One of these new requirements, that was not previously covered on all plans, was the birth control pill (Internal Revenue Service, 2013). The birth control pill, sterilization, and abortion are all women's services that are banned by the Catholic Church due to the church's ethical position on the purpose of procreation, the body, and sanctity of life (Pope Paul VI, 1968). Religious entities, such as churches, had the ability to sign a waiver and opt out of such coverage, but this was not an option for other religious companies. Multiple groups went to the courts to fight for this privilege. One of the cases that made headlines was the Hobby Lobby Supreme Court case, fighting for a religious exemption of contraceptive coverage for for-profit institutions (Cohen, Lynch, & Curfman, 2014). This case ended with a win for closely held for-profit institutions, allowing them to have the same opt-out privileges as religious institutions (Cohen et al., 2014). This opt-out allows religious institutions to file official documentation stating that due to their religious affiliation they will not cover contraception for their employees. When this document is filed, contraceptive coverage is transferred to an outside institution (US News and World

Report, 2014).

As previously mentioned, a Catholic entity is considered in scandal if it influences others to commit wrong. Some religious institutions believe that by signing the form, forcing others to provide the contraceptives to their employees, they are committing scandal (US News and World Report, 2014). Another case currently making its way through the courts, that is more directly related to this thesis, is to clarify the protection for non-profit institutions. While churches easily receive religious exemption, some other non-profit religious entities do not, such as universities, nursing homes, and hospitals (The Becket Fund, 2015). The group currently leading the fight with a Supreme Court Case is the Little Sisters of the Poor, a group of nuns that manages nursing homes in Colorado and Maryland (The Becket Fund, 2015). In this case, it has been called into question "how religious" the groups involved are and whether or not they should receive any exemption, let alone to the degree to which they are requesting (The Becket Fund, 2015; US News and World Report, 2014). The Little Sisters group has stated that they are not satisfied with signing the exemption paperwork because by allowing another group to go against their ethics they would be causing scandal. The refusal to sign this paperwork has caused the Little Sisters to receive many IRS fines (The Becket Fund, 2015).

The Little Sisters of the Poor case is currently making its way through the legal system. Justice Sotomayor provided the Little Sisters a temporary exemption in December 2013 when the mandates first went into effect. The case was then heard by the Tenth Circuit court, which ruled against the Sisters, taking away their exemption. This was appealed to the Supreme Court, which agreed to take their case on November 6th, 2015 (The Becket Fund, 2015). This case will be heard in 2016. The legal group

representing the nuns is hopeful that it will see success in the Supreme Court due to recent success in cases such as the Hobby Lobby case, regardless of the questions concerning the devoutness of Catholic healthcare facilities (The Becket Fund, 2015).

Future of Catholic Healthcare

The conflict between the Catholic Church and the reproductive culture will lead to changes in the future of Catholic healthcare. There are currently many opinions present on how the structure of the current systems must change in order to accommodate the current society. It is clear that due to the dissonance between the American culture and the Catholic Church, especially concerning reproductive rights, Catholic healthcare systems will have to be smart and adaptive to continue to run successful businesses.

One of the changes that is already occurring in Catholic healthcare is the shift to for-profit systems (Nelson, 2009). With the shift to a for-profit status, there is concern that Catholic hospitals will lose their identity (Popovici, 2012). These hospitals have always been known for their benevolence towards the poor and support for their communities (Kauffman, 1995). With a focus on profit instead of charity, it is possible that the groups may lose sight of their original goals. The hospital groups that have already made this transition insist that they are still essentially the same hospitals and operate with the same goals; the change in their tax status as a public company simply allows them to be more stable financially as they work to achieve these goals (Popovici, 2012). As time progresses, more Catholic facilities will navigate what it means for them to follow their Catholic mission.

As it currently stands, some see the Catholic hospital system as a dying breed (Brown, 2010). An obvious trend in the data collected was that Catholic hospitals are

currently performing procedures that they deem evil by their own ethical guidelines (United States Conference of Catholic Bishops, 2009). This is being done in facilities under pressure by not only the reproductively opposing American culture but also influence from government funding (Brown, 2010). This problem will only continue as requirements from legislation, such as the contraception mandate in ObamaCare, force hospitals to provide such services. These hospitals are then potentially unable to make a case for opt out from these requirements due to lack of adherence nationally to their own ethical guidelines (Nelson, 2009). The solution that has been proposed to counter this growing problem is the creation of a more unified Catholic identity (Nelson, 2009). Institutions that wish to continue to retain affiliations with the Catholic Church must completely follow the *Catholic Ethical and Religious Directives* and prevent incidence of scandal. This change would necessitate involvement from throughout the hierarchy of the church, starting with the bishops of the dioceses containing Catholic hospitals. These bishops would be required to be intimately involved with their local hospitals in order to enforce the *ERD*s much more strictly than they were before. Without complete embracement of the Catholic identity, truly Catholic hospital systems may cease to exist.

A prominent trend in Catholic healthcare is the merging of systems (Conlin, 2000). The systems that are able to navigate the intricacies of our current healthcare system and the ethical requirements of a Catholic hospital thrive, while the smaller groups that retain their non-profit status more often fail and are purchased by the successful systems. (Conlin, 2000) In this "survival of the fittest" scenario, only the large systems survive. This means that the actual number of Catholic healthcare systems in the United States is shrinking (Conlin, 2000). This natural progression in the marketplace

may be the solution that is needed to sustain Catholic healthcare. When a system is large, as is the case with Ascension Health, it is more stable and sustainable in the market. This size and stability is necessary if they were to fight societal ethical norms. In order to retain a strong Catholic identity, as previously mentioned, it will be necessary to strictly follow the *ERD*s. It is possible that in the future procedures that are prohibited by Catholic bioethics will be required by all facilities receiving government funding with no opt out options. If this becomes the case, it may be necessary for Catholic groups to either cease to receive government funding or stop being Catholic. It is also possible that the government may no longer fund Catholic groups at all if they are viewed as too religious to be supported by the secular government (Nelson, 2009). If this becomes the case, a large hospital system with a strong monetary foundation will be necessary for the survival of the system. A large unified system also has the benefit of common leadership, making it simpler to attempt to create national unified adherence to the religious directives in Catholic hospitals.

Catholic healthcare is a very unique system in the United States. It has a rich history that started out of religious organizations and has transformed into some of the largest healthcare providers in the country. With the religious background also comes a longstanding tradition of religious bioethics, making procedures commonly accepted by the secular public forbidden in such entities. This has created conflict that has continued to compound in the face of mergers with non-Catholic facilities and the changing legislation of healthcare. Through this study, it was evident that Catholic facilities operating under the Ascension Health name in Texas, across a variety of dioceses, are performing post-partum tubal ligation and vasectomy procedures, both forbidden under

the *Catholic Ethical and Religious Directives.* As evidenced by current mandates and cases in review by the Supreme Court, it will become necessary for Catholic healthcare entities to create a unified front in their adherence to such directives. Without a unified voice, more and more facilities will continue to allow procedures and truly Catholic hospitals, that completely follows mandates required by the Catholic faith, will cease to exist.

Appendix

Table A1.

Total 2005	Births	Tubals	Birth and Tubal	Vasectomies
Baptist St. Anthony's (Amarillo)	2200	254	212	774
University Medical Center at Brackenridge (Austin)	2096	33	11	570
Cedar Park Regional Medical Center (Cedar Park)	0	0	0	0
Central Texas Rehab (Austin)	0	0	0	0
Centro San Vicente (El Paso)	0	0	0	0
Children's Medical Center (Dallas)	0	27	0	264
St. Catherine Hospital (Katy, CHRISTUS)	923	18	3	546
Santa Rosa Hospital (San Antonio, CHRISTUS)	2118	61	28	276
Daughters of Charity Services of San Antonio (San Antonio)	0	0	0	44
Dell Children's Medical Center (Austin)	0	0	0	0
Hillcrest Baptist Medical Center (Waco)	2438	159	87	387
Nazareth Hall Nursing Center (El Paso)		0	0	0
Providence Health (Waco)	1401	218	112	701
Scott and White Hospital (Roudrock)	0	0	0	0
Scott and White Memorial Hospital (Temple)	2483	575	330	532
Seton Edgar B. Davis Hospital (Luling)	0	11	0	9
Seton Medical Center Harker Heights (Austin)	0	0	0	0
Seton Medical Center Hays (Kyle)	0	0	0	0
Seton Highland Lakes Hospital (Burnet)	0	3	0	11
Seton Medical Center (Austin)	4284	135	62	773
Seton Northwest Hospital (Austin)	1882	26	8	159
Seton Medical Center Williamson (Roundrock)	0	0	0	0
Seton Shoal Creek Hospital (Austin)	0	0	0	0
Seton Smithville Regional Hospital (Smithville)	0	0	0	0
Seton Southwest Hospital (Austin)	689	8	7	18
Mother Frances Hospital (Tyler, Trinity Mother Frances)	2613	548	370	354
University of Texas Medical Branch Women's Hospital (Austin)	1571	446	444	15
Warm Springs Rehabillitation (Kyle)	0	0	0	0

Table A2.

Total 2006	Births	Tubals	Birth and Tubal	Vasectomies
Baptist St. Anthony's (Amarillo)	2320	324	257	711
University Medical Center at Brackenridge (Austin)	2504	58	21	661
Cedar Park Regional Medical Center (Cedar Park)	0	0	0	0
Central Texas Rehab (Austin)	0	0	0	0
Centro San Vicente (El Paso)	0	0	0	0
Children's Medical Center (Dallas)	0	10	0	333
St. Catherine Hospital (Katy, CHRISTUS)	680	32	14	332
Santa Rosa Hospital (San Antonio, CHRISTUS)	1924	49	21	291
Daughters of Charity Services of San Antonio (San Antonio)	0	0	0	27
Dell Children's Medical Center (Austin)	0	0	0	0
Hillcrest Baptist Medical Center (Waco)	2305	131	53	622
Nazareth Hall Nursing Center (El Paso)	0	0	0	0
Providence Health (Waco)	1527	230	130	654
Scott and White Hospital (Roudrock)	0	0	0	0
Scott and White Memorial Hospital (Temple)	2628	484	266	342
Seton Edgar B. Davis Hospital (Luling)	0	17	0	9
Seton Medical Center Harker Heights (Austin)	0	0	0	0
Seton Medical Center Hays (Kyle)	0	0	0	0
Seton Highland Lakes Hospital (Burnet)	0	5	0	12
Seton Medical Center (Austin)	4366	141	73	836
Seton Northwest Hospital (Austin)	1948	47	25	156
Seton Medical Center Williamson (Roundrock)	0	0	0	0
Seton Shoal Creek Hospital (Austin)	0	0	0	0
Seton Smithville Regional Hospital (Smithville)	0	0	0	0
Seton Southwest Hospital (Austin)	750	12	10	36
Mother Frances Hospital (Tyler, Trinity Mother Frances)	2682	618	422	425
University of Texas Medical Branch Women's Hospital (Austin)	1646	525	522	18
Warm Springs Rehabillitation (Kyle)	0	0	0	0

Table A3.

Total 2007	Birth	Tubal	Birth and Tubal	Vasectomies
Baptist St. Anthony's (Amarillo)	2549	335	276	684
University Medical Center at Brackenridge (Austin)	2771	91	51	733
Cedar Park Regional Medical Center (Cedar Park)	0	0	0	0
Central Texas Rehab (Austin)	0	0	0	0
Centro San Vicente (El Paso)	0	0	0	0
Children's Medical Center (Dallas)	0	157	0	308
St. Catherine Hospital (Katy, CHRISTUS)	535	25	4	283
Santa Rosa Hospital (San Antonio, CHRISTUS)	2291	40	6	260
Daughters of Charity Services of San Antonio (San Antonio)	0	0	0	0
Dell Children's Medical Center (Austin)	0	4	0	90
Hillcrest Baptist Medical Center (Waco)	2202	109	42	444
Nazareth Hall Nursing Center (El Paso)	0	0	0	0
Providence Health (Waco)	1482	172	76	562
Scott and White Hospital (Roudrock)	115	15	7	8
Scott and White Memorial Hospital (Temple)	2871	463	268	459
Seton Edgar B. Davis Hospital (Luling)	0	10	0	11
Seton Medical Center Harker Heights (Austin)	0	0	0	0
Seton Medical Center Hays (Kyle)	0	0	0	0
Seton Highland Lakes Hospital (Burnet)	0	7	0	20
Seton Medical Center (Austin)	4750	126	64	808
Seton Northwest Hospital (Austin)	1845	153	19	226
Seton Medical Center Williamson (Roundrock)	0	0	0	0
Seton Shoal Creek Hospital (Austin)	0	0	0	10
Seton Smithville Regional Hospital (Smithville)	0	0	0	0
Seton Southwest Hospital (Austin)	768	3	1	24
Mother Frances Hospital (Tyler, Trinity Mother Frances)	2848	553	325	600
University of Texas Medical Branch Women's Hospital (Austin)	1645	518	508	32
Warm Springs Rehabillitation (Kyle)	0	0	0	0

Table A4.

Total 2008	Birth	Tubal	Birth and Tubal	Vasectomies
Baptist St. Anthony's (Amarillo)	2549	233	167	497
University Medical Center at Brackenridge (Austin)	2377	107	73	569
Cedar Park Regional Medical Center (Cedar Park)	191	6	0	70
Central Texas Rehab (Austin)	0	0	0	4
Centro San Vicente (El Paso)	0	0	0	0
Children's Medical Center (Dallas)	0	29	0	460
St. Catherine Hospital (Katy, CHRISTUS)	851	33	10	150
Santa Rosa Hospital (San Antonio, CHRISTUS)	2317	34	10	172
Daughters of Charity Services of San Antonio (San Antonio)	0	0	0	0
Dell Children's Medical Center (Austin)	0	7	0	189
Hillcrest Baptist Medical Center (Waco)	2366	153	97	307
Nazareth Hall Nursing Center (El Paso)	0	0	0	0
Providence Health (Waco)	1600	202	105	690
Scott and White Hospital (Roudrock)	410	48	32	61
Scott and White Memorial Hospital (Temple)	2730	413	280	474
Seton Edgar B. Davis Hospital (Luling)	0	12	0	13
Seton Medical Center Harker Heights (Austin)	0	0	0	0
Seton Medical Center Hays (Kyle)	0	0	0	0
Seton Highland Lakes Hospital (Burnet)	0	6	0	16
Seton Medical Center (Austin)	4351	129	72	880
Seton Northwest Hospital (Austin)	1606	32	16	320
Seton Medical Center Williamson (Roundrock)	150	10	3	133
Seton Shoal Creek Hospital (Austin)	0	1	0	2
Seton Smithville Regional Hospital (Smithville)	0	0	0	0
Seton Southwest Hospital (Austin)	726	7	7	115
Mother Frances Hospital (Tyler, Trinity Mother Frances)	2775	269	139	768
University of Texas Medical Branch Women's Hospital (Austin)	1629	509	497	9
Warm Springs Rehabillitation (Kyle)	0	0	0	0

Table A5.

Total 2005				
Group	Birth	Tubal	Birth and Tubal	Vasectomies
Austin Diocese	11923	880	664	2246
Tyler Diocese	2613	548	370	354
Amarillo Diocese	2200	254	212	774
Houston Diocese	923	18	3	546
San Antonio Diocese	2218	61	28	320
El Paso Diocese	0	0	0	0
Ascension Health	11923	880	644	2290
Other Catholic	7854	881	613	1950
Total Catholic	19777	1761	1257	4240
Non-Catholic	4921	760	417	1183

Table A6.

Total 2006				
Group	Birth	Tubal	Birth and Tubal	Vasectomies
Austin Diocese	12741	1035	781	2382
Tyler Diocese	2682	618	422	425
Amarillo Diocese	2320	324	257	711
Houston Diocese	680	32	14	332
San Antonio Diocese	1924	49	21	318
El Paso Diocese	0	0	0	0
Ascension Health	12741	1035	781	2409
Other Catholic	7606	1023	714	1759
Total Catholic	20347	2058	1495	4168
Non-Catholic	4933	625	319	1297

Table A7.

Total 2007				
Group	Birth	Tubal	Birth and Tubal	Vasectomies
Austin Diocese	13261	1084	719	2516
Tyler Diocese	2848	553	325	600
Amarillo Diocese	2549	335	276	684
Houston Diocese	535	25	4	283
San Antonio Diocese	2291	40	6	260
El Paso Diocese	0	0	0	0
Ascension Health	13261	1084	719	2516
Other Catholic	8223	953	611	1827
Total Catholic	21484	2037	1330	4343
Non-Catholic	5188	744	317	1219

Table A8.

Total 2008				
Group	Birth	Tubal	Birth and Tubal	Vasectomies
Austin Diocese	12630	1028	773	3010
Tyler Diocese	2775	269	139	768
Amarillo Diocese	2549	233	167	497
Houston Diocese	851	33	10	150
San Antonio Diocese	2317	34	10	172
El Paso Diocese	0	0	0	0
Ascension Health	12630	1028	773	3010
Other Catholic	8492	569	326	1587
Total Catholic	21122	1597	1099	4597
Non-Catholic	5506	643	409	1302

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