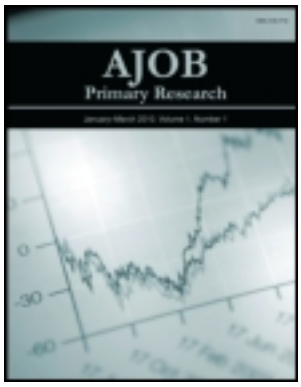

AJOB Primary Research
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uabr20

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Accepted author version posted online: 18 Dec 2012.Published online: 26 Aug 2013.

To cite this article: Lori R. Freedman & Debra B. Stulberg (2013) Conflicts in Care for Obstetric Complications in Catholic Hospitals, AJOB Primary Research, 4:4, 1-10, DOI: 10.1080/21507716.2012.751464

To link to this article: http://dx.doi.org/10.1080/21507716.2012.751464

AJOB Primary Research, 4(4): 1–10, 2013

ISSN: 2150-7716 print / 2150-7724 online
DOI: 10.1080/21507716.2012.751464

Article

Conflicts in Care for Obstetric Complications in Catholic Hospitals

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Background: A recent national survey revealed that over half of obstetrician-gynecologists working in Catholic hospitals have conflicts with religious policies, but the survey did not elucidate the nature of the conflicts. Our qualitative study examines the nature of physician conflicts with religious policies governing obstetrician-gynecologist (ob-gyn) care. Results related to restrictions on the management of obstetric complications are reported here. **Methods:** In-depth interviews lasting about one hour were conducted with obstetrician-gynecologists throughout the United States. Questions focused on physicians' general satisfaction with their hospital work settings and specific experiences with religious doctrine-based ob-gyn policies in the various hospitals where they have worked. **Results:** Conflicts reported here include cases in which Catholic hospital religious policy (*Ethical and Religious Directives for Catholic Health Care Services*) impacted physicians' abilities to offer treatment to women experiencing certain obstetric emergencies, such as pregnancy-related health problems, molar pregnancy, miscarriage, or previable premature rupture of membranes (PPROM), because hospital authorities perceived treatment as equivalent to a prohibited abortion. Physicians were contractually obligated to follow doctrine-based policies while practicing in these Catholic hospitals. **Conclusions:** For some physicians, their hospital's prohibition on abortion initially seemed congruent with their own principles, but when applied to cases in which patients were already losing a desired pregnancy and/or the patient's health was at risk, some physicians found the institutional restrictions on care to be unacceptable.

Keywords: obstetrical emergencies, obstetric complications, abortion, miscarriage, Catholic health care, Catholic bioethics, physicians, qualitative, in-depth interviews

A recent national survey found that 52% of obstetrician-gynecologists (ob-gyns) working in Catholic hospitals experience conflict with religiously based policies about care (Stulberg et al. 2012). These findings have significant implications for care because four of the 10 largest hospital systems in the United States are Catholic (Modern Healthcare 2011), and one in six patients receives care in a Catholic institution (CHA 2012). With some very recent exceptions (Greenhouse 2012; Severson 2011), the depth and breadth of the effect of Catholic doctrine on care have been relatively unclear to the public. People may be aware that abortions are not permitted in Catholic hospitals because of the Catholic Church's well-known opposition to it, but they may not know the extent to which other care is affected by the prohibition. Individuals of all faiths interact with Catholic health entities with regularity—whether as patients, physicians, nurses, and staff at Catholic hospitals or as employees of Catholic agencies or schools with Catholic health insurance.

This article is based on in-depth interviews conducted in 2011 with 31 ob-gyns, most of whom work or have worked in Catholic hospitals. In particular, physicians recounted experiences that demonstrate how Catholic bioethical directives affect their management of complications that can arise during pregnancy. We show how certain treatments can be perceived as morally imperative or neutral and medically necessary care by the ob-gyns interviewed, and as prohibited, illicit acts by Catholic health care authorities. We start by describing the governing Catholic doctrine about pregnancy. Then, using qualitative data, we illustrate what kinds of conflicts emerge for physicians working under Catholic doctrine. In particular, we focus on physicians' and hospital authorities' (clergy, administrators, and ethics committees) conflicting beliefs about care for cases in which patients were already losing a desired pregnancy, the patient's health was at risk, and/or the fetus would never be viable, and treatment to facilitate the end of the pregnancy represented the standard in non-Catholic settings.

CATHOLIC HEALTH CARE IN THE UNITED STATES

The full history of Roman Catholic sponsorship of health care institutions in the United States is beyond the scope of this article and has been described elsewhere (Joyce 1995; McCauley 2005; Mohr 1978; O'Rourke et al. 2001; Reagan 1997; Wall 2011). For the purposes of this article, it is important to know three things about Catholic health care institutions: They are prevalent; they employ and serve diverse individuals; and they are ethically governed by a document called the *Ethical and Religious Directives for Catholic Health Care Services* (henceforth "the Directives"), written by the U.S. Conference of Catholic Bishops (USCCB 2009) and enforced by local Catholic bishops and in some cases the Vatican.

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Catholic hospitals are financed by Medicaid, Medicare, and private insurance, and provide charity at 2% of their revenues, a rate equal to that of other not-for-profit hospitals (Bazzoli, Clement, and Hsieh 2010; Uttley 2002). Patients who receive care at Catholic hospitals tend to reflect the religious makeup of communities geographically near the hospital, rather than consisting primarily of adherents to the Catholic faith. Some public safety net hospitals are Catholic, and approximately 8% of "Sole Community Hospitals" (a federal designation for hospitals located 35 miles or more from any others) are Catholic owned as well (Stulberg 2012; Uttley 2002).

Regarding physician makeup, a national survey found that ob-gyns who work in Catholic facilities are religiously diverse, with religious and demographic characteristics similar to those who work in non-Catholic facilities (unpublished tabulations from Stulberg 2012). Furthermore, ob-gyns who work in Catholic facilities are no more religious—that is, they do not report religion as a more important motivation in their lives—than other ob-gyns (Yoon, Rasinski, and Curlin 2010).

Health care providers in Catholic hospitals are required to adhere to the Directives. Directive 5 states:

> Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel. (USCCB 2009)

Like most hospitals, Catholic hospitals have ethics committees, and these individuals or committees are responsible for interpreting the Directives and advising medical personnel on how to apply them in specific medical situations. The ethics committee is under the authority of the local bishop and can include clergy, bioethicists, clinicians, hospital administrators, and others (USCCB 2009, Directive 37). The Directives include descriptions of the general principles and motivation behind Catholic health care, as well as specific instructions for clinical care typically pertaining to reproductive and end-of-life care. For example, speaking generally, the introduction states, "The mystery of Christ casts light on every facet of Catholic health care" (USCCB 2009). Speaking more instructively, the document goes on to include 72 directives that concretely advise on matters of clinical, administrative, and ethical relevance, including at least 17 about care related to pregnancy and which particular services or procedures are prohibited.

CATHOLIC BIOETHICS IN PREGNANCY

Observers of the field of bioethics have argued that the field has not succeeded in rising above the so-called culture wars, specifically in reference to debates about care relating to reproduction and the end of life (Evans 2012; Fox and Swazey 2008). This bears directly on the predominant ways in which care in Catholic hospitals differs from care in other American hospitals, which generally follow secular bioethical principles (Bradley 2009; Joyce 2002; O'Rourke, Kopfen-Steiner, and Hamel 2001). While the realm of "secular bioethics" is itself heterogeneous, there is a basic body of Western medical ethics from which Catholic bioethicists have sought to differentiate themselves (Nelson 2009; Smolin 2005; Solomon 2005). From the standpoint of secular obstetric ethics, physicians are obligated to provide care with respect for a woman's autonomy, acting in her best interest at all times, and acting in the best interest of the fetus conditional on the pregnant woman's wishes (ACOG 2005). Some ethicists make conditional exceptions requiring physicians to intervene to save the fetus's life (regardless of the pregnant woman's wishes) after the point at which the fetus could be viable outside the womb (McCullough and Chervenak 1994).

The Catholic bioethical perspective takes a very different starting point on pregnancy. In Catholic theology, the joining of egg and sperm creates a new, complete human being. The developing conceptus is thus treated, in Catholic bioethics, as a patient from the moment of fertilization. The pregnant woman and her embryo (and later fetus) are two people, both with equal claims and independent moral status. The fetus's physiologic dependence on the pregnant woman is seen as merely a matter of geography, with a fetus deserving no less care and protection while inside its mother's body than after it is born. Any act that intentionally harms or kills the fetus is thus prohibited (Diamond 2001, 15–24).

In Catholic ethical reasoning, when complications arise during pregnancy, the pregnant woman and her physicians are obligated to act in the best interests of both the woman herself and the fetus. When these interests conflict, that is, when a treatment or intervention (such as a cesarean section or induction of labor) is available that would improve the well-being of the fetus at the expense of the woman, or vice versa, the right course of action is found through the Principle of Double Effect (Kelly 2004). This holds that when an action is expected to have a good outcome (such as improving fetal survival) and a bad outcome (such as increasing maternal morbidity), the action should be taken if the good outweighs the bad, the good does not come about as a direct result of the bad, the bad effect is not intended even if it is anticipated, and the action in and of itself is not bad. Applying this principle in pregnancy, Catholic bioethicists have determined that *direct abortion* is never allowed because it is, in and of itself, a bad act (Kelly 2004, 112–113). In other words, any medical intervention that directly and intentionally kills a fetus or ends a pregnancy before viability cannot be done no matter how important the proposed good effect (Diamond 2001, 11–24).

On the other hand, *indirect abortion* can be allowed for proportionately good reasons. Directive 47 states:

> Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they

> cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child. (USCCB 2009)

This directive may be interpreted and applied variably in practice. A commonly cited application of this directive in the Catholic bioethics literature is the treatment of a pregnant woman with uterine cancer. Catholic ethics allow a physician to perform a hysterectomy to treat the woman's cancer, even though it is entirely predicted that the fetus inside the uterus will die as a result of the hysterectomy. Because the intended effect is the removal of the uterus in order to cure a proportionately serious condition (uterine cancer) in the woman, and the death of the fetus is both unintended and brought about indirectly, it meets the conditions of the Principle of Double Effect (Kelly 2004, 113).

PREVIOUS RESEARCH AND UNANSWERED QUESTIONS

This Catholic bioethical perspective on pregnancy has been of interest in the Catholic bioethics literature (deBlois and O'Rourke 1995), and legal advocates and journalists have taken an interest in how Catholic health care restrictions may impact patients generally (Charo 2005; Ginty 2011; Stein 2011). However, there is scant empirical research on the topic. Prior research has identified two pregnancy-related areas in which physicians reported restrictions on standard treatments: ectopic pregnancy (Dickens, Faundes, and Cook 2003; Foster, Dennis, and Smith 2011) and inevitable miscarriage (Freedman, Landy, and Steinauer 2008). These studies generated new questions, such as: Are such standard treatments restricted in a wider range of Catholic hospitals? How are obstetric complications of a wider variety handled in Catholic hospitals? How do physicians interpret and respond to the conflicts with ethics committees around treatment decisions? What are the implications for patients? We aim to shed light on these questions and to elucidate the nature of conflicts reported by the majority of ob-gyns working in Catholic hospitals (Stulberg et al. 2012).

METHODS

The sample of physicians in this study was recruited purposively from a group of 237 physicians who answered a national survey ($n = 1{,}154$) of ob-gyns about physician beliefs and practices related to sexual and reproductive health care and checked a box stating they were willing to be contacted for a follow-up interview by phone (Stulberg et al. 2012). Institutional review board (IRB) approval was obtained for the study at both the University of Chicago and the University of California, San Francisco. The authors first recruited by e-mail and phone those who disclosed in the survey that they worked for a Catholic hospital. We then began to recruit others on the list who worked in other religious and secular hospitals, being mindful of achieving geographic balance; several of these physicians incidentally also had experience working in Catholic hospitals in the past. We pursued a snowball sample from the physicians interviewed from this list, asking at the close of the interview whether subjects would forward our recruitment e-mail to a colleague they deemed appropriate for the study, which yielded a minority of interviews.

Interviews lasted between 45 minutes and 1 hour. The interviewer (LRF) is a qualitatively trained sociologist with previous experience interviewing physicians. Questions were open-ended and fluid, allowing the respondent to guide the conversation to a great degree. Questions inquired about what physicians liked and disliked about where they work, how their values fit with their institutions, and particular clinical issues, with many follow-up questions about the information volunteered. As themes emerged during the interviews, the authors both added questions to new interviews and began to create a tentative list of codes. The analysis and theory emerged from the data somewhat inductively per a grounded theoretical analysis in that we left room for physicians' concerns and perspectives to emerge, rather than placing ours onto them (Corbin and Strauss 2008).

Transcriptions were coded in a qualitative data management program (Atlas.ti Scientific Software Development, GmbH, Berlin, Germany) according to themes decided upon by both investigators through an iterative process. Once a preliminary list was agreed upon, both investigators coded the same three interviews, discussed functionality of the codes, revised the code list, and repeated this process one more time. The remaining interviews were coded by the first author according to the agreed upon themes.

This analysis is part of a larger exploration of how health care institutions—especially their religious affiliations or lack thereof—influence patient care within the practice of obstetrics and gynecology. We do not cover here the full scope of experiences we have gathered from physicians. Here, we focus on a subset of institutions—those sponsored by the Roman Catholic Church—and a subset of clinical scenarios.

RESULTS

Study Subjects

From December 2010 to February 2012, we interviewed 31 ob-gyns geographically scattered throughout the country, five of whom were referred by a colleague in the study (snowball). Their ages ranged from 28 to 60 years, with a mean age of 47 and a median age of 46. Reported religious affiliations were Catholic (3), Hindu (3), non-Catholic Christian (9), Jewish (6), Muslim (1), and none/spiritual (7), with three not reported. For nine respondents religion was described as "very important" or "most important"; for nine more it was "fairly important"; and for 10 it was "not very important" (with three not reported).

Nineteen of the 31 respondents were female, and 12 were male. Some of the physicians ($n = 11$) worked solely in a Catholic hospital setting at the time of the interview, whereas others simultaneously held privileges in Catholic and non-Catholic hospitals. Of the 27 who had worked in

Catholic hospitals, all but one either had been trained or had also worked in a non-Catholic hospital. These experiences allowed respondents to compare and contrast work environments. Four physicians had not worked in Catholic hospitals; in their interviews, they drew upon their familiarity with Catholic health doctrine and experience accepting patient transfers from religious hospitals.

Obstetric Care Conflicts

Many of the physicians in the study reported positive feelings toward their Catholic hospital employer or workplace for a variety of reasons. Nonetheless, conflicts in care arose with regularity in the interviews. Some physicians found themselves surprised by the broad doctrine-based restrictions they faced and the extent to which restrictions impacted their ability to provide care as they judged appropriate for the clinical situations.

A prevalent theme in the data involves conflict related to restrictions on obstetric care for patients experiencing complications while in Catholic hospitals. Physicians interviewed reported reactions ranging from acceptance or mild concern to outright shock about the way the Directives impacted their ability to offer treatment to women experiencing certain obstetric emergencies, such as pregnancy-related health problems, miscarriage, or previable premature rupture of membranes (PPROM). Physicians contested the broad definition of "prohibited abortion" held by their Catholic hospitals and ethics committees. Physicians felt offering treatment to end the pregnancy was justified in certain cases, such as if the pregnancy was dangerous to the woman or the fetus was never going to be viable; these procedures were viewed as more justifiable when the failing pregnancy was deeply wanted. The "wanted-ness" of the pregnancy was referenced in the context of defending the need for treatment and arguing that it was solely for the sake of safety and comfort for the pregnant woman, not because she did not wish to have a child.

In order to explore the ways that such conflicts affect care, we begin by presenting three cases in detail. These cases illustrate a major theme that emerged from the interviews: physician–hospital conflicts that arose due to different definitions of and justifications for abortion. We then discuss a second theme and give illustrative narratives in which respondents frame their concerns in terms of prevention versus cure and the medical risks involved in delaying treatment.

Conflicts Surrounding the Justification for and Definitions of Abortion

The following three cases of care for problem pregnancies demonstrate the kinds of conflicts that can emerge when practicing under the Directives. In the first case, a pregnant woman who was being cared for in a Catholic hospital was found to have cancer that needed immediate treatment. Dr. M[1] recounted, "[She] didn't want to terminate her pregnancy but [her oncologist] told her she needed quite aggressive surgery and chemo." Once the patient decided to go ahead and terminate the pregnancy in order to start cancer treatment, the doctor petitioned the ethics committee to approve the termination. However, his request was denied. The ethics committee told the physician to have the patient schedule her procedure at a local outpatient abortion clinic. Dr. M continued:

> I remember speaking to [the ethics committee], saying . . . "This poor woman is suffering. She's got a malignancy, she doesn't want to terminate, she realizes she has to and you're going to make her go to a clinic?" And they said, "Yes, essentially that's the case."

The physician strongly disagreed with the ethics committee's ruling; his patient was dealing with a medically complex and life-threatening scenario that to him merited an exception to the abortion policy—without the cancer treatment, the pregnant woman would ultimately die, and with the cancer treatment, the fetus would die. He argued that making the woman leave the hospital in order to have her procedure in an outpatient abortion clinic would cause undue suffering. Beyond the logistical and physical challenges of leaving the hospital to get care elsewhere, the doctor subtly insinuated that receiving care in an abortion clinic might be degrading or emotionally uncomfortable for the patient as well. Yet because medically she was stable enough to go, the ethics committee required it.

Physicians tended to evaluate appropriate treatment options for obstetric emergencies based upon their judgment of what the pregnancy and impending loss meant to the patient; their evaluation of what potential remained of the fetal life; and their sense of what the maternal preference was for treatment in each situation. If the pregnant woman truly did not want to lose the pregnancy, but it would be lost nonetheless, physicians often disagreed with the way that medical treatment was morally equated with abortion by their hospital administrations and thus prohibited. Contrary to the Directives, providers made significant distinctions between emergency obstetric care and abortion.

To some extent this position is shaped by a desire to separate emergency obstetric care from the stigma many attach to abortion. Few interviewed identified as abortion providers. But physicians' assertions that a woman with a severely anomalous, miscarrying, or life-threatening pregnancy is different from (their concept of) an abortion patient had relatively more to do with their empathy for the patient as someone who wanted to have this child, as well as the physician's understanding of how the experience of pregnancy loss from that perspective may differ, and how constraints on the management of her care might worsen the experience for her.

In a second case, Dr. P spoke about his patient in a hospital that had been sold three years before to a major

1. All initials are pseudonyms.

Catholic health system. The conflict arose when the patient presented to the emergency room with a molar pregnancy for which the standard care is evacuation of the uterus. Molar pregnancies (or "moles") consist of abnormal cells that multiply rapidly. They can lead to cancer and are therefore considered a threat to the woman's health or life. Patients may require treatment with chemotherapy in order to stop the rapid reproduction of tissue. In rare circumstances, a woman may be pregnant with twins and have one viable fetus and one molar pregnancy. Dr. P described the case:

> This was a twin pregnancy. There was one healthy appearing baby and the other was a typical mole. And generally—I mean, this was diagnosed early in the pregnancy . . . [We told] the patient what her risks are and she didn't want to carry the pregnancy further but by the time she reached that decision, she was about 16 weeks gestation. And she had vaginal bleeding so of course she now goes to the hospital 'cause she has vaginal bleeding . . . And then you can't do anything while she's there [in the Catholic hospital], you can't help her end the pregnancy in a hospital setting that's safer . . . [The ethics committee] refused.

Dr. P transferred the patient out for care, despite her bleeding, and despite the fact that terminating a bleeding molar pregnancy is safer in the hospital setting due to a high risk of hemorrhage.

Dr. L (Dr. P's colleague and witness to the case) discussed her medical concerns about molar pregnancy:

> It's such a dangerous thing that we recommend a woman not get pregnant for a full year after treatment for a molar, because we really want to make sure that there's no residual [molar tissue] in her before she gets pregnant again. So it's pretty dire.

Dr. L, a religious woman, specifically wanted us to know she did not perform "elective" abortions. She also noted that when the hospital where she and Dr. P work was bought by the Catholic system, she was reassured that medical issues would be dealt with according to her medical judgment as long as she consulted first with the Catholic ethics committee. So, she was shocked when her ethics committee denied Dr. P's request to evacuate the uterus of his patient. They rejected his request based on Internet research. She explained, "The clergy who made the decision Googled molar pregnancy." Based upon this search, ethics committee members ruled, "There's a possibility that she could actually have a viable pregnancy [because] there have been cases where a child was born." Thus, the ethics committee identified treatment of this molar pregnancy as equivalent to abortion or "a termination"—a conclusion Dr. L strongly objected to:

> They called it a termination, which is a bogus term 'cause you're not terminating anything but a horrible situation. [They said], "You can't do it here. Take her to another hospital to do it." . . . A molar that bleeds, you can't move her. You've got to take care of her there . . . but regardless of which, he had to transfer her.

Dr. L was quite upset by the judgment of the committee. She did not view the case as an abortion per se because a molar pregnancy is not typically viable and can be dangerous to the woman. The case was likely complicated by the existence of the nonmolar twin. Yet even in this scenario, abortion remains the standard treatment because allowing the pregnancy to continue significantly increases the woman's risk of preeclampsia, hemorrhage, and, at worst, cancer (Cunningham and Williams 2010). Dr. L continued:

> And so that, in my mind, is not adhering to their original commitment to putting the woman's health first. And they said, "If we were the only hospital, maybe we would do it, but we're not. There are other hospitals." They punted, and that's not the way I think medicine should be practiced, and so I think that was egregious.

She explained that before she witnessed this and other such cases, she had felt positively about the hospital merger. She has since lost confidence. She did not realize how broad the ethics committee's definition of a prohibited abortion would be.

The third case is particularly multilayered. It demonstrates how those interpreting and applying the Directives can construe medical treatment as abortion even when the fetus has no chance of life and the woman is miscarrying anyway. Dr. C, a perinatologist (an ob-gyn subspecializing in high-risk pregnancy) in a Catholic hospital, recounted an experience where she clashed with the ethics committee. The patient, whose 19-week fetus had a severe heart defect, showed up with ruptured membranes (broken water) at her hospital, which was the only major care facility within about 2 hours. Thus, this patient both had a previable pregnancy with a lethal anomaly, and was in the process of miscarrying. The pediatric cardiac surgery team consulted; they were pessimistic about any possibility of making successful therapeutic interventions at such an early gestation. They explained to the pregnant patient that the earliest known neonatal survivor of hypoplastic left heart surgery was delivered and operated on at 32 weeks gestation. This patient was 3 months shy of that and now her water was broken. She was at risk for infection. Dr. C recounted that the team of doctors counseled the patient, "'It would be very reasonable for you to say there's just almost a zero percent survival chance here, almost zero.'" At that point, the patient requested and received a drug called Pitocin to induce labor.

The patient opted not to pursue heroic measures to extend the pregnancy, given that there was no evidence that any interventions would work. The physician managing the case did not consult the ethics committee, though she did consult Dr. C, who approved the management. When the ethics committee found out about the case later, both Dr. C and the treating physician were called upon to explain their management of the case. They attended a meeting of the ethics committee that included several physicians, religious personnel, and administrators. Dr. C recalled this as a highly tense and emotional event.

> There were two members of the committee who were very vocally sort of accusing us of carrying out an elective abortion. And I said, you know, "There was nothing elective about this. This woman didn't choose to have her membranes rupture at 19 weeks. She didn't choose to have a baby with the most severe form of congenital heart disease. There was nothing elective about this."

Dr. C took issue with equating the treatment to an elective abortion because this was a deeply desired pregnancy, the fetus had no chance of viability, and treatment (Pitocin) was used to prevent maternal harm (infection). But all of these reasons do not directly answer the concerns of the Catholic ethics committee. Interpreting the Directives strictly, the two members of the ethics committee who were directly challenging their management felt the physicians should have allowed the patient to miscarry without intervention, unless she became infected. They told her, "We allow women with ruptured membranes to stay pregnant all the time at 20 weeks." To which she recalled replying, "Yes, we do, but even that is not completely standard of care."

This tense interaction makes explicit the basic conflict repeatedly articulated by physicians in our interviews. For them, such treatment would not have been equated with abortion and instead was thought of as miscarriage management. They considered it to be a standard practice to offer treatment. Dr. C's challenge that allowing women to stay pregnant after ruptured membranes was not completely "standard of care" hits at the crux of physician conflicts with Catholic approaches to obstetric emergencies.

Preventative Versus Curative Treatment During Miscarriage

The conflicts in Dr. C's case and many cases of miscarriage shared during the interviews generally point to physicians' discomfort with the approach to care during pregnancy loss mandated by Catholic doctrine when a live fetus is involved. Physicians explained that treatment for inevitable miscarriage generally does not draw moral or ethical debate in the non-Catholic hospital settings in which they have trained or worked. While miscarriage is seen as an emotional hardship and loss for the woman, treatment is offered to expedite the sometimes lengthy process, alleviate pain, and prevent infection. Not all women choose to get treatment. Physicians explained that when medically stable, some women prefer to wait to see whether they can pass the pregnancy naturally. But when the waiting is prolonged or discomfort is intense, often women want the treatments offered, such as labor medications (like Pitocin) to help the uterus expel the pregnancy or surgical methods to quickly evacuate the uterus. Dr. C said that labor induction is routine in the non-Catholic contexts of care she has previously worked and trained in. If the fetus is not approaching the line of viability (approximately 24 weeks) and a woman's membranes have definitively ruptured (indicating that miscarriage is inevitable), the prognosis of the fetus is so poor that physicians offer treatment.

> The prognosis is thought to be so grim that she just gets Pitocin. It's a common management of that particular problem, I would say, across the country . . . up until about 23 weeks is probably widely accepted in non-Catholic institutions that that woman would be offered Pitocin.

Because treatment that will induce abortion of a live fetus is prohibited in the Catholic hospital setting, physicians have to demonstrate that the woman's health or life is at risk in order to get a Catholic ethics committee to approve treatment with drugs like Pitocin or surgical means (dilation and evacuation [D&E]), which is consistent with Directive 47. Although interviewees reported that in a non-Catholic setting treatment is generally offered in order to *prevent medical harm,* and the prerequisite to treatment is establishing the inevitability of the miscarriage, in the Catholic hospital setting, the medical harm (infection, fever, excessive blood loss) is the prerequisite to treatment even after the inevitability of the miscarriage is established. And treatment must be, per the Directives, intended specifically to *cure the woman of serious illness*, not to end the life of the fetus. It is allowable because it is considered "proportionate": that is, failing to treat the woman is at least as threatening to her life as the treatment is to the fetus' life. Or in Dr. T's words, "If the mom's sick and if the mom has an infection, then that is a proportionate cause because the mom's life is in danger or could be in danger."

Some physicians took the management mandated by the Directives, which we call the *curative* approach, as a matter of course, a normalized aspect of practice in an institution under Catholic management, whereas others described the policy as nonsensical and unsafe. For example, Dr. E, a physician working in both Catholic and non-Catholic hospitals, compared and contrasted the experiences. He described waiting for infection as a "foolish" practice:

> Say somebody ruptured their membranes, or say somebody had a lethal anomaly, or somebody had no fluid and the prognosis was zero, in the non-Catholic hospital you would just consent them to put in some medicine to put them through labor, or do a D&E. And in the Catholic hospital you had to wait till they get sick, which was kind of foolish when you knew the prognosis was so poor.

Reiterating the reaction that the policy lacked medical common sense, Dr. A said,

> The first time [I had a patient in this situation], I was kind of upset about it and kind of fighting the hospital on it, trying to say, you know, this is kind of an obvious situation. There's nothing that we can do about this baby. But the nurse kind of said to me, "Well, you can't do it here" . . . I just thought that was somewhat ridiculous.

Dr. A followed up with the chief of his department to check whether he truly could not offer treatment and the chief told him, "No, you can't do it here. You better send

them out." In cases like these, other employees, such as this nurse and chief, police the boundaries between miscarriage and abortion and help enforce the Directives' curative approach to care.

Because ambulance care is so expensive, if the woman is medically stable enough, she may be encouraged to check herself out of the hospital and drive to another facility if she wants to prevent infection and pursue medication or surgery to complete the miscarriage. Dr. R explained,

> We often tell patients that we can't do anything in the hospital but watch you get infected, and we often ask them if they would like to be transferred to a hospital that would go ahead and get them delivered before they get infected . . . it's just very difficult for them, they're already in a hard place . . . we actually have the patients discharge themselves . . . drive themselves and then admit themselves to the next institution.

In some cases sending a patient to another hospital represents primarily inconvenience and the emotional and financial costs of prolonging the situation. Some physicians feel that delaying care involves potentially grave medical risks that the patient has little choice about bearing. Dr. M said:

> Obstetricians know that once an infection sets in inside the uterus, you're behind the clock in terms of trying to get the baby out, and if you've got a situation where you don't want the mother to be so infected that it compromises her fertility in the future. And if we wait until they have a high fever and they're really sick, you risk the woman's health and potential fertility.

Other physicians felt that the risk of delaying care until infection could be substantial but saw bad outcomes as rare. For example, Dr. C said:

> Staying pregnant in that situation is definitely an ongoing potential risk to your health and your reproductive health. But . . . any complications are able to be managed the vast majority of the time so that there are no long-term complications. But there are rare cases in which there are maternal deaths. There are rare cases in which a woman has to have a hysterectomy; they're rare.

Physicians who did not find the curative policy to be unacceptably risky for women ultimately shared adaptations they had made to minimize patient risk. Some explained that they find ways to intervene early by slightly stretching the truth in order to get ethics committee approval. Dr. E explained that if they even begin to notice an upward trend in the miscarrying patient's temperature, he and his colleagues would ask the ethics committee for approval to induce labor, even if it technically was not as high as necessary to prove infection.

> So, if the temperature, normal temperature was 98.6, true infection's probably not [until] 100.6—but we would cut corners, and so if they got to 99, we would call it a fever. And we would induce them. Because we were protecting their life and trying to salvage their uterus, so they didn't get a serious infection, that they needed a hysterectomy.

Taking a somewhat different approach, Dr. T explains how he tries to make sure patients are safe and their preferences are respected if they are under his care or the care of his residents. If the miscarrying patient decides she's ready to be done and receive treatment, then Dr. T advised his residents to mention to the ethics committee other signs of infection that are more subjective and less easy to police than a thermometer reading.

> I make sure that the residents let them know their options and let them know, "Listen, if you're not totally infected and you want to wrap this up, that's okay." But I guess, you know, honestly, what it is, is: If somebody wants to wrap it up, we kind of say, "Gee, you know, the fluid that's draining is a little foul-smelling and you are a little tachycardic and your uterus is tender." I guess that's what we do . . . It has not been difficult for us to do what the patient wants in that situation.

Such adaptations were easier to make for some than others. Some physicians noted significant surveillance from staff and superiors in such obstetric scenarios where others did not.

Another adaptation that arose was not to accept patient transfers. After her experience with her ethics committee (described earlier), Dr. C decided it was better to preventatively divert a miscarrying patient from coming to her sole-provider hospital for care. Because she anticipated problems based upon her experience with her ethics committee, she told the referring physician to send the patient instead to a large university hospital a few hours away. She told the physician, "The last thing I want is for her to get here and not get the care she needs."

DISCUSSION

The ob-gyns we interviewed were surprised to find themselves in conflict with Catholic hospital ethics committees (or other hospital authorities citing Catholic ethical principles) over whether or not they could provide what the physician considered to be standard and morally acceptable treatment for women with these pregnancy complications. These physicians generally did not consider themselves abortion providers or even necessarily abortion rights supporters. In some cases, physicians expected to get along well within the values of Catholic hospitals because they shared what they believed was a similar moral opposition to or discomfort with abortion. Yet even the providers most opposed to abortion in the sample draw a moral distinction between emergency obstetric care and abortion that the Catholic doctrine does not. In the context of desired pregnancies complicated by maternal health risks such as cancer or infection, or of serious fetal anomalies that would threaten either the fetus's viability or the likely quality of life of the child should the pregnancy continue, these physicians were trained to offer or even recommend treatments that help bring about the end of pregnancy. They do not use

the word "abortion" for these treatments. The treatments they describe are "inducing labor," or "expediting delivery," or in some cases "evacuating the uterus." They use phrases like "there's nothing elective about this" and "the only thing we were terminating was a horrible situation."

A common feature of obstetric emergencies and complications that physicians recount in the data is that the fetus was determined to be either too early in gestation to survive (previable) or severely impaired and unlikely to survive. Whether acknowledged or not, these scenarios were characterized by conflicting interpretations of abortion between a physician working in a Catholic hospital and the hospital authorities.

These different definitions of or justifications for abortion can have direct implications for patients. Some physicians were highly critical of the religion-based policies, but overall they varied in their beliefs about the degree to which the institutional restrictions compromised the standard of patient care and how to adapt or work around restrictions. According to the respondents, in some cases the patients had their care delayed, had to travel to other providers (some near, some quite distant), or did not receive standard-of-care treatment; in other cases physicians adapted or slightly stretched the truth in order to get approval to treat according to their training and judgment. Such truth stretching, which appeared to be not only an individual coping strategy of the physicians interviewed but a routine shared by colleagues they practice with, further points to the mismatch between Catholic doctrine and standards of care for obstetric complications. We believe more research is needed to assess whether Catholic hospitals routinely deliver substandard care in cases of obstetric complications like the ones featured in this study.

We did not interview the individuals on the other side of these conflicts—hospital administrators, clergy, or other members of ethics committees who interpret the Catholic Directives and apply them to specific clinical scenarios. But the explicit language of the Directives and other Catholic bioethics sources supports respondents' reports that Catholic hospitals and their ethics committees sometimes do not allow the treatments that physicians recommend for these pregnancy complications. While the Directives were written as an effort to codify these differences and standardize treatment in Catholic hospitals throughout the country, in our data we saw institutional variability, both in governance and workarounds.

Today, virtually all hospitals in the United States have an ethics committee or similar mechanism for addressing ethical issues and they generally serve in a role of consultants to help deliberate the ethical complexities of different courses of care with clinicians, to inform clinicians of relevant and helpful literature, and to facilitate discussion with patients and families (Aulisio and Arnold 2008). Yet physicians in this study painted a picture of ethics committees in the role of permission-granting bodies or authorities over care. More research about the roles of ethics committees in hospitals is warranted to assess which hospitals tend to rely upon them as consultants and which tend to rely upon them as gatekeeping authorities, in which circumstances, and why.

We also did not interview patients for this study. They are the people who have the most at stake in these scenarios. From the standpoint of Catholic ethics, a pregnant woman's preferences, what the pregnancy means to her, what course of care she prefers, and how she weighs those concerns against the realistic prognosis for the baby are all irrelevant in deciding how to treat when the fetus is threatened (Diamond 2001). Even a fetus with no chance of survival to viability is seen as a living patient of moral status equal to the pregnant woman. This ethic does not fit well with the way ob-gyns are trained in secular medicine: that is, to elevate the autonomy of the pregnant patient and privilege her choices regarding what level of risk and discomfort she will endure.

Some Catholic hospitals rely on transfers of care as an ethical escape valve. While the Directives forbid association with, cooperation in, and recommendations for abortion services (Directives 36 and 45), physicians we interviewed described cases in which Catholic hospital ethics committees advised their physicians to transfer patients to another provider for the specific purpose of obtaining an abortion. In these cases, the woman's health or life was threatened by her pregnancy, and the Catholic ethics committees did not want to allow her to experience irreversible harm. Yet they refused to allow their physician to end the pregnancy—they wanted someone else to take care of the woman. This brings up serious questions about the role of Catholic hospitals in our health system. Is it appropriate to have such a large provider of U.S. health care prohibit certain services that they expect others will provide? Is their existence, in fact, sustained by providers of abortion and other prohibited services who fill in the gaps by caring for women who might otherwise be harmed by the denials of care? Even when Catholic institutions comply with the professional duty to refer, the referral may be of little use to the patient if the objecting (i.e., referring) hospital is located very far from the prohibited services and patients of limited means cannot realistically access care (ACOG 2007; Annas 1987). Similarly, what happens to women with Catholic health insurance that does not cover prohibited services?

Conscience-based denials of care are complex and rife with ethical questions. In the case of Catholic hospitals and health care networks, the conscientious objector is the institution and not the clinician. As demonstrated by our interview subjects, discord between what physicians deem appropriate and what the institution will allow them to do can cause distress for both physicians and patients. Physician distress occurs when the institution prohibits standard treatments that physicians are trained to provide during obstetric emergencies.

Given how readily, even eagerly, physicians brought up these conflicts in the interviews, and given how much of American health care Catholic facilities provide, lack of available information surrounding the problem is

surprising. It is unknown how much patients know about these restrictions or what opinions they would have if informed about them. Future research should address patient knowledge of institutional doctrine-based restrictions and the role of patients in decisions about restricted care in religious health care settings.

Regardless of patient awareness, many of the poorest and most rurally located patients may have little choice about where they receive care. Drawing on the principle of informed consent, patients should have a right to know about how care for obstetric emergencies may be different in Catholic versus non-Catholic hospitals before selecting a Catholic provider for obstetric care. Furthermore, physicians should look carefully into the Directives (and other hospital ethics policies) and how they're applied before accepting a job or applying for staff privileges. And as indicated by the data, ethics committees should communicate as clearly as possible with physicians about what is and is not allowed, to avoid confusion in emergencies. This may help those involved understand and anticipate conflicts, and may even allow physicians and patients to avoid crises before they arise.

This was a small qualitative study, and therefore we cannot generalize these findings to the larger population. Furthermore, those most supportive of the Catholic health care policies may have been less likely to respond to requests to participate in our study, and therefore their views may not be as well represented here. While none of the 31 physicians we interviewed agreed with everything the Directives advised, there was a range of feelings about Catholic hospitals generally represented in our interviews. The cases described here illustrate a specific type of conflict that we observed recurring in the data, and our goal was to describe and characterize the conflict and explain why we think it occurs. This research confirms previous findings (Freedman, Landy, and Steinauer 2008) and adds perspectives from a larger number of hospitals with more geographic variety, indicating the practices may be widespread. The clinical scenarios discussed here also demonstrate a greater diversity of obstetric clinical and ethical conflicts than previously reported regarding Catholic health care.

CONCLUSION

We recounted cases in which physicians believed a woman who was experiencing a pregnancy complication or miscarriage should be offered a specific intervention in order to prevent infection or preserve her health or fertility, but hospital authorities, citing religious ethics principles that physicians were contractually obligated to practice by, prohibited the treatment. The data show that patients may receive different treatment of the same medical scenario depending upon the institutional affiliation (non-Catholic vs. Catholic) due to the Catholic Directives. With the Catholic bioethical approach, women bear risk in ways that conflict with the training of the physicians we interviewed. Physicians had the tools to solve a medical problem for the patient, but not the authority to use them. For some, the prohibition on abortion initially seemed congruent with their own principles in the abstract, but when applied to cases in which patients were already losing a desired pregnancy, the patient's health was at risk, and/or the fetus would never be viable, physicians found the restrictions imposed by Catholic bioethics to be unacceptable. More research about patient knowledge of religious restrictions is needed in order to understand how to better ensure informed consent for pregnant women seeking ob-gyn care in Catholic hospitals.

ACKNOWLEDGMENTS

We would like to thank Tracy Weitz, Katrina Kimport, John H. Evans, and Elena Gates for their helpful comments on earlier drafts of the article; Irma Dahlquist for assistance with data management and analysis; and Farr Curlin for guidance at the start of the project.

AUTHOR CONTRIBUTIONS

Drs. Freedman and Stulberg collaboratively developed the research concept and study design. Dr. Stulberg provided the research sample, and Dr. Freedman recruited subjects and conducted the interviews. Drs. Freedman and Stulberg collaboratively conducted the analysis and wrote the manuscript.

FUNDING

This project was funded in part by the Greenwall Foundation. Dr. Freedman's time was also supported by the University of California San Francisco's Research Evaluation and Allocation Committee, the Mary Wohlford Foundation, the David & Lucille Packard Foundation, and a career development award from the Society for Family Planning.

COMPETING INTERESTS

None declared.

ETHICAL APPROVAL

This study was approved by the institutional review boards at the University of California San Francisco and the University of Chicago. ■

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