Obstetric Complications in Catholic Hospitals

Catholic health care has taken a beating over the past few months, especially the way it supposedly manages obstetric complications due to its adherence to the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs). Articles and editorials have appeared in the *New York Times*, the *Washington Post,* the *Los Angeles Times*, numerous local newspapers, various blogs, the *New Republic* and a good number of other publications. Most of these were reporting the ACLU's lawsuit against the United States Conference of Catholic Bishops (USCCB) as issuers of the ERDs. Then, of course, there was the release of the ACLU's and MergerWatch's report in December 2013, "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care."

Attacks have come not only from the popular media, but also from more professional sources. Mentioned in a number of the popular media accounts was reference to the work of Lori Freedman, a professor at the University of California, San Francisco and Debra Stulberg, a physician in the Department of Family Medicine and the Department of Obstetrics & Gynecology at the University of Chicago. Several of their articles/studies were quoted or alluded to and given considerable credence. Freeman delivered a paper at the October 2013 meeting of the American Society for Bioethics and Humanities where she took Catholic health care to task and Freedman and Stulberg together published an article in the October-December 2013 issue of *AJOB Primary Research.* Because they seem to be fairly influential, their work deserves closer scrutiny.

In 2010, Stulberg published an article in the *Journal of General Internal Medicine* (25, no. 7, pp. 725-30) titled, "Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care." Of the 879 eligible physicians who received the study questionnaire, 445 (51 percent) responded. Of these, 191 (43 percent) had worked in religiously affiliated hospitals and, of these, 36 (19 percent) had experienced conflict over religiously based policies. In the discussion, the author states: "We found that almost half of primary care physicians have worked in a religiously affiliated hospital or practice, and among these physicians, approximately one in five has had conflicts with the institution's religiously based patient care policies" (728). Several observations:

- This wording gives the impression that almost half of *all* primary care physicians in the country have worked in religiously affiliated hospitals or practices, and that one in five of *all* primary care physicians in the country have had a conflict. But, in fact, only 19 percent of the primary care physicians who *responded to the survey* and have worked in religiously affiliated hospitals or practices have had a conflict, for a total of 36. And not all of these

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worked in Catholic health care facilities. Can one legitimately generalize on the basis of the experience of 36 primary care physicians that policy conflicts in religiously based hospitals are a widespread problem?

- The study provides no information about the nature of the conflicts, whether they were actually due to institutional policies or to other factors, or their number or frequency. This would seem to be important information in order to obtain an accurate assessment of the situation and its seriousness. In some instances, it could be that the physician objected to a policy that was more "liberal" than his or her personal views or that the conflict was between the physician's personal views (rather than the standard of care or a medical judgment) and institutional policies. Also, does it matter whether a physician had one such conflict over 20 years or has had 30 conflicts over five years? This is not addressed.

- The study tells us nothing about which religiously based policies were the source of conflict and which were most often the source of conflict.

- As a point of comparison, it would be interesting to know whether primary care physicians in non-religiously based hospitals and practices have had conflicts with institutional policies and which ones.

- In concluding the article, the author writes: "[T]hese results suggest that a significant minority of primary care physicians working in religiously affiliated health care institutions has faced conflict over religious policies for patient care" (730). Can one legitimately make such a generalization on the basis of 36 physicians?

- Based on the study findings, the author concludes: "Policy-makers may find physicians' experiences reported here useful in addressing the role of religious institutions in the delivery of health care" (730). This seems like a significant jump—from a few religiously-based policies that cause conflict to the role of religious institutions in the delivery of health care. It's not clear how one legitimately moves from one to the other.

The article that was most frequently mentioned in newspaper stories and blogs was a 2012 article, "Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies," published by Debra Stulberg and colleagues in the *American Journal of Obstetrics and Gynecology* (207: 73e1-5). This study surveyed 1,128 ob-gyns, described as a nationally representative sample. The purpose of the survey was

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twofold: a) to identify those who practice in religiously affiliated institutions and to

determine the prevalence of physician-institution conflicts over religiously based policies for patient care, and b) to measure the number of obstetrician-gynecologists who said that policies in their institutions limited their options for treatment of ectopic pregnancy (73.e2).

Regarding (a), approximately 241 (22 percent) of the 1,128 physicians surveyed practiced primarily in religiously affiliated institutions. 143 (59 percent) of these practiced in Catholic health care facilities. 90 (37 percent) of the 241 physicians who work primarily in religious institutions have had conflicts with their institution over religiously based policies. 74 (52 percent) of those who work in Catholic institutions have had such conflicts. Regarding (b), the author writes: "With respect to the treatment of an ectopic pregnancy with fetal heart tones present, the great majority of obstetricians-gynecologists would be willing to perform a salpingectomy and/or a salpingostomy. Furthermore, few physicians (n=31; 2.9 percent) reported that policies of their institution limit the options that they have for the treatment of ectopic pregnancy in similar cases: 2.5 percent of those who work in non-Catholic institutions vs. 5.5 percent in Catholic institutions (P=.07)" (73.e4).

In the Comment section of the paper, the authors write: "Based on obstetrician-gynecologists' experiences, hospital policies frequently do not restrict options for the treatment of ectopic pregnancy. Although physicians at Catholic hospitals were slightly more likely (p=.07) to report institutional restrictions than those at

non-Catholic hospitals, restrictions were uncommon in all institutions. These findings suggest that, although Catholic ethicists debate whether the use of salpingostomy and methotrexate constitute direct abortion, few institutions prohibit these practices. Confusion on this issue …." (73. e4-e5). Again, a few observations:

- While the article title refers to "religious institutions," a great deal of space is devoted to Catholic health care facilities. This doesn't seem to be an even-handed treatment.

- The authors make note of the fact that in the past many Catholic ethicists interpreted Catholic teaching as banning any direct treatment of ectopic pregnancy unless the fallopian tube had ruptured. While this is true, this position has not been held since 1933, yet the authors make it sound like it was held in the not too distant past, thereby, conveying a false impression.

- The authors also refer to the debate among Catholic ethicists about the moral permissibility of salpingostomy and methotrexate (though as evidence of this they cite one article for each position). While there are differing views

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among ethicists today, this is not a pressing debate and the general consensus is that both are morally permissible. The authors' account raises questions about how familiar they are with Catholic moral teaching and with what actually goes on in Catholic health care.

- The authors conclude the article by stating that "[T]his study suggests that conflict over religiously based patient care policies is common among obstetricians-gynecologists who work in religiously affiliated institutions, particularly Catholic institutions" (73.e5). Does 37 percent make it common? 52 percent? And, again, we don't know the frequency of these conflicts. What makes such conflicts "common" is frequency over time for each individual. The fact that 74 obstetrician-gynecologists have experienced a conflict with institutional religiously based patient care policies out of how many ob-gyns who practice in Catholic health care does not make such conflicts "common." The authors seem to be reading their pre-conceived conclusions into the data.

- Finally, despite their findings on ectopic pregnancies (see above), the authors speak in general terms about "confusion on this issue" and, after finding that "restrictions were uncommon," they go to on to encourage leaders of religiously affiliated institutions to inform their physicians regarding which treatments for ectopic pregnancy are prohibited. Confusing.

At the end of 2013, Freedman and Stulberg published an article together in *AJOB Primary Research* (4, no. 4 [2013]: 1-10) titled, "Conflicts in Care for Obstetric Complications in Catholic Hospitals." The article is based on interviews with 31 ob-gyns from around the country "most of whom work or have worked in Catholic hospitals" (1). Four had not worked in Catholic hospitals, but they are said to have drawn upon their familiarity with Catholic health care ethics as well as their experience accepting transfers from religious hospitals. Five physicians were referred by a colleague in the study, which sounds rather questionable.

These 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" (1). They go on to explain: "In particular, we focus on physicians' and hospital authorities' …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

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in non-Catholic settings" (1). While a number of the authors' specific explanations (especially of Catholic health care ethics), interpretations, and inferences could be challenged, I will instead make a few general observations:

- The authors leave the reader with the impression that the situations described by the physicians and in the article are typical of how obstetric complications are handled in all of Catholic health care. This is extremely problematic for a number of reasons. First, the authors' findings are based on interviews with only 31 ob-gyns, four of whom had not actually worked in Catholic health care and five of whom were recommended for inclusion in the study by colleagues who were already in the study. How representative is this of the experience of 1,500 or more ob-gyns practicing in Catholic hospitals? Second, there is no consideration given to how often these situations occurred. Were they isolated instances? Was there a recurrent pattern? This is very significant. Third, there is no context for the authors' discussion, that is, the authors focus on those instances of treatment for obstetric complications that supposedly went wrong, but how do those numbers compare to successful treatment of obstetric complications? If treatment is inappropriate or inadequate in a majority of cases, that is one thing. But if it is appropriate in the vast majority of cases, that is another, and it tells a different story. This information is also critical for a fair assessment of the treatment of obstetric complications in Catholic hospitals. Fourth, we don't know anything about outcomes. Were patients harmed? This after all is the bottom line. There may be somewhat different approaches to some very few obstetric complications in Catholic hospitals, but what is the impact of this on the well-being of mother and fetus?

Two final thoughts. These and other articles and reports have chosen to disparage Catholic health care and Catholic health care's treatment of and care for women with difficult pregnancies on the basis of very limited information and questionable methodologies. They have also chosen not to consider the tens of thousands of women every year who receive excellent prenatal care and who successfully deliver in Catholic hospitals with high degrees of satisfaction. They have chosen not to consider the vast majority of complicated pregnancies that have been successfully treated to the satisfaction of all those involved. And they have chosen not to take into account the

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large numbers of ob-gyns practicing in Catholic hospitals who have not had conflicts with administrators and ethics committees over the *Ethical and Religious Directives*. And yet they are willing to call into question the competency of Catholic hospitals, especially in obstetrics and gynecology, and their role in U. S. health care.

Freedman and Stulberg make several suggestions toward the end of their article that are reasonable and that should be taken seriously. The authors write: "[P]atients 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 … ethics committees should communicate as clearly as possible with physicians about what is and what 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" (9). Not bad advice.

R.H.

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