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When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals

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As Catholic-owned hospitals merge with or take over other facilities, they impose restrictions on reproductive health services, including abortion and contraceptive services. Our interviews with US obstetrician–gynecologists working in Catholic-owned hospitals revealed that they are also restricted in managing miscarriages.

Catholic-owned hospital ethics committees denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients to non–Catholic-owned facilities. Some physicians intentionally violated protocol because they felt patient safety was compromised.

Although Catholic doctrine officially deems abortion permissible to preserve the life of the woman, Catholic-owned hospital ethics committees differ in their interpretation of how much health risk constitutes a threat to a woman's life and therefore how much risk must be present before they approve the intervention. (*Am J Public Health.* 2008;98: 1774–1778. doi:10.2105/AJPH.2007.126730)

OVER THE PAST DECADE, AS Catholic hospitals have merged with and purchased nonsectarian hospitals around the United States, the lay press and legal journals have featured discussion about the impact of these mergers on patient care, particularly with regard to reproductive health.[1–5] The literature has focused on policies prohibiting tubal ligation, contraceptive services, emergency contraception, and abortion. Although other religiously owned and nonsectarian hospitals may also prohibit or limit some of these services, Catholic-owned hospitals are the largest group of religiously owned nonprofit hospitals, operating 15.2% of the nation's hospital beds,[6] and increasingly they are the only hospitals in certain regions within the United States.[7] The result is that Catholic and non-Catholic patients alike come to depend on these facilities for emergencies, childbirth, and routine procedures without knowing how some of their options are potentially curtailed.

The findings reported here were not the original focus of our research. In the process of conducting a qualitative study about abortion provision in the clinical practice of obstetrician–gynecologists, we interviewed 30 obstetrician–gynecologists around the United States. During the interviews, which were conducted in 2006, 6 physicians working with or within Catholic-owned hospitals revealed that they were constrained by hospital policies in their ability to undertake urgent uterine evacuation. They reported that Catholic doctrine, as interpreted by their hospital administrations, interfered with their medical judgment. For example, some of them were denied permission to perform an abortion when uterine evacuation was medically indicated and fetal heart tones were still present.

Catholic-owned institutions and their employees must adhere

to medical practice guidelines contained in the "Ethical and Religious Directives for Catholic Health Care Services" (hereafter called "the directives") written by the Committee on Doctrine of the National Conference of Catholic Bishops.[8] The directives state that abortion is never permitted. However, regarding emergency care during miscarriage management, the manual used by Catholic-owned hospital ethics committees to interpret the directives states that abortion is acceptable if the purpose is to treat "a life-threatening pathology" in the pregnant woman when the treatment cannot be postponed until the fetus is viable.[9] The experiences of physicians in our study indicate that uterine evacuation may not be approved during miscarriage by the hospital ethics committee if fetal heart tones are present and the pregnant woman is not yet ill, in effect delaying care until fetal heart tones cease, the pregnant woman becomes ill, or the patient is transported to a non–Catholic-owned facility for the procedure.

Although medical journals have featured articles about a physician's right to refuse patients treatment, referral, or information regarding services to which the physician has religious objections,[10–12] few articles in the medical literature published to date have addressed the effect of Catholic-owned hospital policies on patient care and the professional conduct of physicians.[13,14] One recent opinion piece in the *Journal of the American Medical Association* described how a patient was transferred from a religiously owned to a nonsectarian hospital for labor induction to facilitate spontaneous abortion because the religious hospital would not allow the procedure until after she became septic.[15] The following interview excerpts demonstrate how 5 different Catholic-owned hospital ethics committees responded to 6 physician requests to evacuate the uterus during miscarriage and the resulting effects on miscarriage management.

MISCARRIAGE MANAGEMENT

According to the generally accepted standards of care in miscarriage management, abortion is medically indicated under certain circumstances in the presence of fetal heart tones. Such cases include first-trimester septic or inevitable miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman. In each instance, the physician must weigh the health impact to the woman of continuing the pregnancy against the potential viability of the fetus. Ideally, the physician then engages in a sensitive decisionmaking process with the patient. The physician reviews with the patient the risks of continuing the pregnancy and the likelihood of fetal survival, as well as management options that include "expectant management" (i.e., no intervention) and termination of pregnancy, with the physician often recommending a form of management. The patient then chooses how to proceed; when fetal survival is no longer possible or when continuing the pregnancy involves significant risk, she may decide to terminate the pregnancy. For spiritual or psychological reasons, a patient may prefer to delay induction of labor or surgical uterine evacuation until there is no fetal heartbeat, even in cases in which the risk of expectant management to her health is great.

In general, this process of assisted decisionmaking is guided by informed consent or informed choice,[16] which requires that the patient understand all appropriate medical options, as well as the relevant risks and benefits of each, before choosing and consenting to a course of management. Informed choice and consent may be compromised when hospital policies restrict physicians from offering treatment options routinely available in other hospitals.

OVERVIEW OF CATHOLIC POLICY

The standards of medical care put forth in the directives are at variance with those generally recognized in other medical settings, particularly regarding care at the beginning and ending of life. They were codified over 50 years ago to ensure strict obedience to Catholic principles by all employees of Catholic-owned hospitals, without local variation.[17] The directives sanction prenatal care and natural family planning but prohibit nearly all other reproductive services, including all other birth control methods, emergency contraception, infertility treatment, sterilization, and abortion.[8] In Catholic-owned hospitals, physicians must request approval to terminate a pregnancy for any indication from the ethics committee, which interprets and enforces the directives. Such consultations can be done quickly over the phone with an on-call representative of the committee, typically a priest or nun, if the medical situation is urgent. In theory, therefore, consultation with the ethics committee presents only a minor delay to urgent care. If the situation is not urgent, the committee convenes to discuss the matter and then offers its ruling.

An important qualification of the prohibition of abortion is made in Directive 47. Termination of pregnancy is permissible if the health of the mother is at risk:

> 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.[8]

The death of the fetus is therefore acceptable as a secondary consequence of actions intended to preserve the health of the pregnant woman. However, the manual of Catholic hospital ethics committees, used to help them interpret and apply the directives, warns, "The mere rupture of membranes, without infection, is not serious enough to sanction interventions that will lead to the death of the child."[6] By contrast, writing in a leading Catholic health journal, other Catholic health ethicists offer a more liberal

interpretation of Directive 47: uterine evacuation is indicated if abortion is inevitable and delay will harm the pregnant woman.[18] Therefore, the former—and arguably more authoritative—source approves of uterine evacuation only after a woman becomes sick, and the latter approves of it as a measure to prevent sickness. Our data indicate that despite Catholic leaders' desire for strict standardization of Catholic-owned health services, varying interpretations and executions of Directive 47 exist both at the individual (practitioner) and institutional (hospital ethics committee) levels.

STUDY AND METHODS

Our findings arose from a study that was not originally focused on care in Catholic-owned hospitals. In-depth interviews were conducted in person and over the telephone with 30 obstetrician–gynecologists to determine the impact of residency abortion training on their future medical practice. Study participants graduated between 1996 and 2001 from residency programs in the western, midwestern, northeastern, and southern United States that offered routine abortion training, as opposed to elective or "opt-in" training. Most physicians in the study reported that they had participated in such training.

Requests for study participation, contact information, and consent forms were sent to all residents (about 150 in total) of 4 residency programs, one in each of the regions. In this way, we obtained interviews with 30 physicians—at least 5 from each region. Questions were designed to assess the effects of abortion training during residency and obstacles to the subsequent practice of abortion in their various professional environments. Transcripts of the interviews were analyzed with Atlas.ti 5.0 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) for thematic content.

Thirteen of the physicians interviewed had worked in Catholic-owned hospitals regularly or occasionally since their residency. The following reports concerning miscarriage management come from 6 physicians working with and within Catholic-owned health institutions, each of whom reported at least one such event. Five of the 6 physicians participated in abortion training. Two of the 6 physicians currently work in academic medical centers and have continued to perform abortions after residency, and the remaining 4 are prohibited from doing so by their Catholic-owned institutional employers.

In the interview excerpts, the initials of physicians' names are based on pseudonyms. Physicians offered their accounts in the context of questions about their work history and whether they had experienced conflict with colleagues or superiors over the issue of abortion. Although the effect of religious ownership of health care was not initially a focus of our study, we believe it is important to examine and document these cases to highlight miscarriage management in Catholic-owned hospitals and find ways to improve care for pregnant women. For purposes of confidentiality, no identifiers beyond the type of physician and the region and size of the city in which he or she practices are given.

RESULTS

Nontreatment, Delays, and Transport of Patients

Obstetrician–gynecologists working in Catholic-owned hospitals described cases in which abortion was medically indicated according to their medical judgment but, because of the ethics committee's ruling, it was delayed until either fetal heartbeats ceased or the patient could be transported to another facility. Dr P, from a midwestern, mid-sized city, said that at her Catholic-owned hospital, approval for termination of pregnancy was rare if a fetal heartbeat was present (even in "people who are bleeding, they're all the way dilated, and they're only 17 weeks") unless "it looks like she's going to die if we don't do it."

In another case, Dr H, from the same Catholic-owned hospital in the Midwest, sent her patient by ambulance 90 miles to the nearest institution where the patient could have an abortion because the ethics committee refused to approve her case.

> She was very early, 14 weeks. She came in . . . and there was a hand sticking out of the cervix. Clearly the membranes had ruptured and she was trying to deliver. . . . There was a heart rate, and [we called] the ethics committee, and they [said], "Nope, can't do anything." So we had to send her to [the university hospital]. . . . You know, these things don't happen that often, but from what I understand it, it's pretty clear. Even if mom is very sick, you know, potentially life threatening, can't do anything.

In residency, Dr P and Dr H had been taught to perform uterine evacuation or labor induction on patients during inevitable miscarriage whether fetal heart tones were present or not. In their new Catholic-owned hospital environment, such treatment was considered a prohibited abortion by the governing ethics committee because the fetus is still alive and the patient is not yet experiencing "a life-threatening pathology" such as sepsis. Physicians such as Dr H found that in some cases, transporting the patient to another hospital for dilation and curettage (D&C) was quicker and safer than waiting for the fetal heartbeat to stop while trying to stave off infection and excessive blood loss.

Dr B, an obstetrician–gynecologist working in an academic medical center, described how a Catholic-owned hospital in her western urban area asked her to accept a patient who was already septic. When she received the request, she recommended that the physician from the Catholic-owned hospital perform a uterine aspiration there and not further risk the health of the woman by delaying her care with the transport.

> Because the fetus was still alive, they wouldn't intervene. And she was hemorrhaging, and they called me and wanted to transport her, and I said, "It sounds like she's unstable, and it sounds like you need to take care of her there." And I was on a recorded line, I reported them as an EMTALA [Emergency Medical Treatment and Active Labor Act]

violation. And the physician [said], "This isn't something that we can take care of." And I [said], "Well, if I don't accept her, what are you going to do with her?" [He answered], "We'll put her on a floor [i.e., admit her to a bed in the hospital instead of keeping her in the emergency room]; we'll transfuse her as much as we can, and we'll just wait till the fetus dies."

Ultimately, Dr B chose to accept the patient to spare her unnecessary suffering and harm, but she saw this case as a form of "patient dumping," because the patient was denied treatment and transported while unstable.

Circumventing the Ethics Committee

Some doctors have decided to take matters into their own hands. In the following case, the refusal of the hospital ethics committee to approve uterine evacuation not only caused significant harm to the patient but compelled a perinatologist, Dr S, now practicing in a nonsectarian academic medical center, to violate protocol and resign from his position in an urban northeastern Catholic-owned hospital.

> I'll never forget this; it was awful—I had one of my partners accept this patient at 19 weeks. The pregnancy was in the vagina. It was over. . . . And so he takes this patient and transferred her to [our] tertiary medical center, which I was just livid about, and, you know, "we're going to save the pregnancy." So of course, I'm on call when she gets septic, and she's septic to the point that I'm pushing pressors on labor and delivery trying to keep her blood pressure up, and I have her on a cooling blanket because she's 106 degrees. And I needed to get everything out. And so I put the ultrasound machine on and there was still a heartbeat, and [the ethics committee] wouldn't let me because there was still a heartbeat. This woman is dying before our eyes. I went in to examine her, and I was able to find the umbilical cord through the membranes and just snapped the umbilical cord and so that I could put the ultrasound—"Oh look. No heartbeat. Let's go." She was so sick she was in the [intensive care unit] for about 10 days and very nearly died. . . . She was in DIC [disseminated intravascular coagulopathy]. . . . Her bleeding was so bad that the sclera, the white of her eyes, were red, filled with blood. . . . And I said, "I just can't do this. I can't put myself behind this. This is not worth it to me." That's why I left.

From Dr S's perspective, the chances for fetal life were nonexistent given the septic maternal environment. For the ethics committee, however, the present yet waning fetal heart tones were evidence of fetal life that precluded intervention. Rather than struggle longer to convince his committee to make an exception and grant approval for termination of pregnancy, Dr S chose to covertly sever the patient's umbilical cord so that the fetal heartbeat would cease and evacuation of the uterus could "legitimately" proceed.

Dr G also circumvented the ethics committee in her southern Catholic-owned hospital. She opted not to check fetal heart tones or seek ethics committee approval when caring for a miscarrying woman for fear that documentation of fetal heart tones would have caused unnecessary delays. This led to conflict with the nurse assisting her.

> She was 14 weeks and the membranes were literally out of the cervix and hanging in the vagina. And so with her I could just take care of it in the [emergency room] but her cervix wasn't open enough . . . so we went to the operating room and the nurse kept asking me, "Was there heart tones, was there heart tones?" I said "I don't know. I don't know." Which I kind of knew there would be. But she said, "Well, did you check?" . . . I said, "I don't need an ultrasound to tell me that it's inevitable . . . you can just put, 'The heart tones weren't documented,' and then they can interpret that however they want to interpret that." . . . I said, "Throw it back at me . . . I'm not going to order an ultrasound. It's silly." Because then that's the thing; it would have muddied the water in this case.

Dr G's main concern was sparing the patient extended suffering during loss of pregnancy. She disregarded the authority and protocol of the hospital ethics committee by not checking for fetal heart tones, which, she believed, would have led to significant delay in the inevitable treatment.

Strategic Communication With Ethics Committees

Dr J, an obstetrician–gynecologist working in a small town in the West, had success navigating his ethics committee by presenting patients to them in the language of the directives themselves. A nun advised him that terminology such as "inevitable abortion" and "maternal complications" should be highlighted.

> I [received] a good bit of advice actually . . . from the sister that sits on the ethics committee the first time I tried to have one of these conversations with her. She said, "Well, what are you concerned about with the mom?" . . . [T]hat's just the way that the conversation gets started. . . . I don't know if she was trying to give me a hint or whether she was . . . just interested in doing what she really considers to be the right thing, the moral thing . . . but it certainly helped me out.

Dr J described how he applied this advice in another case. The patient, at 20 weeks, was dilated with a placental abruption and fetal heart tones present, and she preferred to expedite uterine evacuation. He presented her case to the ethics committee in this fashion: "If we continue to watch this placental abruption, it could end up being dangerous, [leading to] transfusions or potentially even maternal death, if left untreated." This was the only case of approval by a Catholic-owned institution's ethics committee for urgent uterine evacuation with fetal heart tones present that was mentioned in the interviews.

DISCUSSION

Physicians working in Catholic-owned hospitals in all 4 US regions of our study disclosed experiences of being barred from completing emergency uterine evacuation while fetal heart tones were present, even when medically indicated. As a result, they had to delay care or transfer patients to non–Catholic-owned facilities. Some physicians violated the authority and protocol of the ethics committee to deliver what they considered safe medical care that reflected the standard of care learned in residency. The extent to which this might occur needs to be researched further but may be difficult to assess, because most physicians are not likely to discuss

such behavior even in a confidential interview.

Contradictory interpretations of Directive 47 in the Catholic health literature and in practice indicate that ethics committees are either uncertain or in disagreement about how to manage miscarriage when fetal heart tones are present and what exact circumstances allow for termination of pregnancy in Catholic-owned hospitals. In cases in which physicians judge their patients' health or comfort to be compromised by delay, they may, like Dr J, obtain safer and more-expeditious patient care by emphasizing to the ethics committee the inevitability of fetal death and the risk of maternal complications. When physicians are unable to persuade the committee to approve pregnancy termination in emergency cases, however, it appears that patients may receive treatment that is riskier and less comfortable than the care provided in non-Catholic medical settings.

Given the prevalence of Catholic-owned health care today, these issues bring to light important policy questions about standards of medical practice and a patient's right to information. Patients entering a Catholic-owned hospital may be aware that abortion services are not available there, but few prenatal patients conceive of themselves as potential abortion patients and therefore they are not aware of the risks involved in being treated there; these include delays in care and in being transported to another hospital during miscarriage, which may adversely affect the patient's physical and psychological well-being.

For women to make informed decisions about care, physicians must be able to communicate clearly with them about the chances of fetal survival, all management options, and their recommendations. After such counseling, which also includes a discussion of the patient's personal beliefs, she will give informed consent to a specific management option of her choice. As with other examples of medical decisionmaking, the physician's recommendation is not always the chosen course. When a physician has recommended termination because waiting until the fetus is dead carries a high risk, a woman might decline intervention because of her personal beliefs. When possible, the course of treatment must be the patient's decision, but it is important that the physician is able to offer patients pregnancy termination when he or she considers it a necessary treatment without having to defy hospital policy or risk job loss.

Our findings bring into question the ethics of an institution's right to refuse care as granted by "conscience clauses."[12,19] Should a religiously owned institution have a right to a legally protected "conscience" in the same way an individual physician does? These are questions that members of the medical profession, ethicists, and lawmakers must continue to grapple with. The case histories we described indicate that, in some Catholic-owned hospitals, the private patient–physician relationship, patient safety, and patient comfort are compromised by religious mandates that require physicians to act contrary to the current standard of care in miscarriage management. ■

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Contributors

L. R. Freedman conducted the research, did preliminary analysis, and led the writing. U. Landy and J. Steinauer conceptualized and supervised the study, contributed to analysis, and assisted in the writing.

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