Catholic Hospitals, Patient Autonomy, and Sexual and Reproductive Health Care in the United States

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To fully understand the landscape of access to sexual and reproductive health care services in the United States, the context in which religiosity is associated with the delivery of health care must be understood. Drake et al1 provide data on the geographic concentration of Catholic health care systems through the proportionate market share of Catholic hospitals in each county in the United States and the role that health insurance plays in driving access to Catholic and non-Catholic hospital networks within markets.

The authors identified a substantial Catholic hospital market share across counties in the United States (mean, 18.4%); notably, 35.3% of US counties had a Catholic hospital market share greater than 20%.1 Catholic hospital market shares in Marketplace health insurance networks, in contrast, include a lower share of Catholic hospitals compared with the overall county market share, suggesting that Marketplace health insurance networks may be protective of access to reproductive health services.

Future work could benefit from an analysis of market share based on obstetric delivery discharge, which is the most common reason for hospitalization overall and among reproductive-aged women in the United States; it is also a time when women commonly receive sexual and reproductive health services. In addition, it is important to note that the vast majority of sexual and reproductive health care services are provided on an outpatient basis. As such, an understanding of the Catholic hospital market share of services provided outside hospital settings is necessary for drawing a comprehensive picture of access to sexual reproductive health care services in the United States. Drake et al1 provide an important foundation for this work.

Gender equality is widely recognized as a universal human right. It follows that facilitating universal access to sexual and reproductive health care services is a necessary step toward achieving gender equality. The Ethical and Religious Directives for Catholic Health Care Services2 are guidelines created by Catholic church leaders that apply to all health care institutions within Catholic health care facilities. Strict interpretation of these religious directives prohibits the provision of contraception, including sterilization for contraceptive purposes, abortion care, many fertility treatments including in vitro fertilization, and gender-affirming care for transgender individuals. In other words, Catholic hospitals do not facilitate simple access to sexual and reproductive health services.

The association between Catholic religious directives2 and the clinical outcomes of health care provision cannot be understated. The American College of Obstetricians and Gynecologists, the nation’s largest women’s health organization representing over 58,000 obstetricians and gynecologists, has expressed concern over the growing number of health care systems that limit sexual and reproductive health care services.3 The American College of Obstetricians and Gynecologists also firmly asserts that people should have access to scientifically based health care, stating, “Prohibitions on essential care that are based on religious or other non-scientific grounds can jeopardize women’s health and safety.”3 There have been numerous examples of non-evidence-based care resulting in poor health outcomes published in the literature and the general news media, including women denied appropriate counseling and treatment for ectopic pregnancy4 and concerning delays in care for inevitable miscarriage when fetal cardiac activity is present.5

In addition to patient safety concerns, residency training at a Catholic institution has been associated with resident physicians being less likely to report independence in the performance of...
contraceptive, sterilization, and uterine evacuation procedures. Other recent reports highlight an increase in the overall market share of Catholic hospitals in the United States over the last 2 decades, likely due in part to an increase in hospital acquisitions and mergers in the wake of the Patient Protection and Affordable Care Act. Given the increasing market share of Catholic hospitals, the number of graduated obstetricians and gynecologists who feel that they are unable to provide basic sexual and reproductive health care will likely continue to increase.

Ambiguity in hospital policies with respect to which sexual and reproductive health services are provided is rampant across both Catholic and non-Catholic hospitals. A recent study of all hospitals in Washington state found that most hospital reproductive health policies, regardless of Catholic affiliation, provided more confusion than clarity in terms of abortion and contraceptive service provision. These findings suggest that there are concerning restrictions on patient autonomy. Even transfer-of-care guidance is potentially troublesome, because delays in care can place women at risk for unintended pregnancy, increased medical morbidity, and even mortality.

Mandates for standardized, accessible checklists for hospitals to convey contraception, abortion, fertility, and transgender service provision are a possible solution for facilitating access to needed services. In addition, there are limited regulations on health insurance Marketplaces; clarifying the service provision in Marketplace offerings would offer another opportunity for increased transparency. It is critical to note, however, that none of these proposed solutions would solve the disparity in access to unfettered sexual and reproductive health care for those living in a community in which a Catholic institution is their only choice.

Health care provision in the United States is a complex interplay between patient autonomy, evidence-based guidelines, and costs. Ethical provision of health care requires that the guiding principle of this care be allegiance to the patient and their needs. Understanding the way Catholic institutions, which fundamentally provide care differently from non-faith-based institutions, interplay with health care provision on the whole is critical. Drake et al. have provided an important landscape analysis that can inform future policies aimed at improving the public health goal of unhindered access to evidence-based sexual and reproductive health care.

**REFERENCES**


