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Research shows how providers in Catholic health systems use workarounds to provide contraception

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Secular and Protestant hospital providers report fewer limitations on contraceptive care versus providers working in Catholic systems, according to recent research from the University of Chicago.

In a new study, researchers from UChicago's Center for Interdisciplinary Inquiry and Innovation in Sexual and Reproductive Health (Ci3) and the Department of Family Medicine found that providers working in Catholic health care systems reported multiple barriers to contraception provision, including direct discouragement from supervisors and peers, restrictive language in employment contracts, and lease agreements prohibiting contraception on Catholic-owned land. However, the study also found that patient needs motivated many providers to develop and use workarounds to provide contraception in Catholic systems, some of which were endorsed by administrators and other hospital leaders.

Providers within Catholic hospitals are expected to follow the Ethical and Religious Directives for Catholic Health Care Services (ERDs), which prohibit contraception, sterilization, abortion, most fertility treatments, and other services. As religious health care systems grow nationally, an increasing number of patients within these systems may unknowingly encounter restrictions to reproductive healthcare. Though previous research has shown restrictions on contraceptive care in Catholic hospitals and systems, less is known about reproductive health care services in non-Catholic Christian hospitals.

'Am I Going to Be in Trouble for What I'm Doing?'

The study, conducted from 2016 to 2018, explored contraceptive access in these settings. During the study, in-depth interviews were conducted in Illinois with 28 key informants who had experience in secular, Protestant or Catholic health care systems. The interviews were made up of a variety of medical providers including obstetrician-gynecologists, other physicians, nurse-midwives and nonclinical professionals such as ethicists, administrators, and chaplains.

During the interviews, some providers described pressure or direct instruction from colleagues or administrators within the institution to falsely document medical conditions or omit contraceptive provision. Though previous research has documented individual provider workarounds, this direct instruction from superiors to provide contraception using alternative diagnoses is unusual.

Providers reported feeling dishonest about applying these workarounds, as many found themselves having to purposely misdiagnose a patient, document a menstrual condition (e.g. dysmenorrhea, menorrhagia, metrorrhagia), or ask leading questions during patient conversations and counseling to reach an acceptable diagnosis. Other providers chose to omit any documentation of contraception provision, while some providers described carving out a room or space in a Catholic-owned facility that was separately managed and paid for in order to offer contraception.

"I understand why providers felt that making up a false diagnosis was better than not providing contraception at all, but it can be harmful to patients to have that false diagnosis in their chart," said Debra Stulberg, MD, Director of Research at UChicago's Department of Family Medicine and senior author of the study. "This could affect future insurance coverage, create confusion or concern for the patient, and it

also sends the message that contraceptive care has to be secretive or lied about. This further stigmatizes reproductive health care and may discourage patients from talking about their health needs in the future."

Many providers in Catholic systems relied on referrals to their other non-restricted affiliations or secular family planning sites for patients who desired contraception, though patients were often only informed of this option during a visit when seeking contraception. Some providers acknowledged the obstacles these workarounds created for patients while others cited the availability of non-Catholic family planning providers to suggest care was not significantly affected.

"Given the current effort to expand protections for conscientious objections at the federal level, it's also important to consider the flip side—ensuring that policies protect the conscientious provision of reproductive health care," said Lee Hasselbacher, JD, Senior Policy Researcher at Ci3 and an author of the study. "This helps clinicians avoid ethical dilemmas such as making a false diagnosis or having to withhold care the provider believes the patient should receive. Policies should also recognize the burden on patients who may already be facing greater obstacles to care."

The study was published on December 4, 2019, in *Perspectives on Sexual and Reproductive Health*.

More information: Yuan Liu et al. "Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Care Systems, *Perspectives on Sexual and Reproductive Health* (2019). DOI: 10.1363/psrh.12125

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