Do women know whether their hospital is Catholic? Results from a national survey

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Original research article

1. Introduction

Catholic health systems account for a significant portion of the United States healthcare market. Since 2001, the number of Catholic-owned or -affiliated hospitals has increased by 22% [1]. As of 2016, 14.5% of acute-care hospitals, 1 in every 6 hospital beds, and 4 of the 10 largest healthcare systems are Catholic owned or affiliated [1]. In 10 states, more than 3 out of 10 acute care hospital beds are located in a Catholic hospital [1].

Catholic hospitals operate according to the Ethical and Religious Directives for Catholic Healthcare Services (ERDs), guidelines for healthcare delivery issued by the United States Conference of Catholic Bishops [2]. The resulting healthcare at these institutions must follow Catholic moral teachings, and the ERDs prohibit access to common reproductive services, including contraception (including sterilization), and abortion [1–14]. Studies have documented a variety of concerns about how religious restrictions affect patient care [4–8, 10–14]. A report from the American Civil Liberties Union highlighted instances when the ERDs conflicted with and precluded standard treatment [3]. Catholic hospitals have refused postpartum tubal ligations, even when this refusal would require the patient to undergo additional surgery, and have delayed...
management of miscarriages [3, 6, 8]. A national survey of obstetrician/ gynecologists (ob/gyns) found that 52% of those working in Catholic hospitals have experienced a conflict with their institution over religious policies for patient care [7].

Whether patients understand the restrictions that may affect their healthcare remains unclear. In 2000, a national survey revealed that women expect comprehensive reproductive healthcare regardless of their hospital’s religious affiliation [15]. A 2014 study by Guiahi and colleagues [16] found that women in the Denver, Colorado, area were unaware of any potential differences in treatment options when surveyed about two fictitious hospitals — St. Ignatius versus Metropolitan Hospital of Denver — and anticipated the ability to receive a full range of reproductive services at each of these centers, regardless of the religious implications of the name St. Ignatius. Furthermore, this information is important to women; Freedman and colleagues found that 81% of women feel that it is important to know about religious restrictions on healthcare [17], with over half feeling it is “very important.”

While in the study of Guiahi and colleagues most women expected comprehensive reproductive care regardless of where they receive treatment, no study has examined whether women are able to correctly identify the religious affiliation of their own hospital. Not knowing a hospital’s religious affiliation can impede a critical step in a woman’s ability to anticipate when religious refusals may impact her care. Our study aimed to determine whether women seeking care at a Catholic hospital are aware of that hospital’s religious affiliation and how characteristics such as education, age, ethnicity, religion, geographic location and the name of the hospital are associated with that awareness.

2. Materials and methods

2.1. Subjects

The results of this study are based on a subset of questions from a larger survey, and our general survey methods have been described in detail in a previous publication [17].

Our study surveyed a nationally representative sample of English-speaking women ages 18 to 45 (n=2857) from the 2015 AmeriSpeak panel [18]. AmeriSpeak is designed and operated by NORC at University of Chicago (formerly the National Opinion Research Center) using their 2010 NORC National Sample Frame. The panel consists of civilian, non-institutionalized adults selected through area-based probability sampling. It provides 97% sample coverage using mail, telephone and in-person recruitment. We selected our sample based on age, race/ ethnicity, education and gender, and we weighted responses to account for differing response rates from each demographic group. The University of Chicago and University of California, San Francisco, Institutional Review Boards deemed the study exempt.

2.2. Panel measures

NORC provided demographic data for each participating panel member. We constructed percent of acute care hospitals in the panel member’s state using state of residence and information from MergerWatch [1].

2.3. Survey measures

We based this analysis on three questions from our larger survey. First, we asked participants the name of the hospital where they would seek reproductive or ob/gyn services (referred to in this paper as their “primary hospital”). Respondents were prompted to write in the name of the hospital, its location (city and state) and the name of any system it was a part of to allow for accurate identification of the hospital following data collection. We then asked participants to identify the hospital as Jewish, Catholic, other Christian, other religion (with a write-in option) or nonreligious. Finally, we asked participants how sure they were of the hospital’s religion with the following options: very sure, somewhat sure, somewhat unsure and very unsure.

2.4. Interpretation of survey responses

We compared the religious affiliations as identified by the participants of the hospitals they named against a comprehensive list of Catholic hospitals provided by MergerWatch, an organization that advocates for medical care guided by scientifically accurate information and patients’ own religious or ethical beliefs in the face of religious healthcare expansion. MergerWatch most recently updated their analysis in 2016 and reviewed all acute-care hospitals in the United States that provide a full range of services. MergerWatch provided the resulting list of Catholic-owned or -affiliated hospitals (i.e., those operating under the ERDs) to this research team upon our request, which has been made available for other research purposes [19]. This list includes some hospitals not on the Catholic Health Association (CHA) directory, a publicly available source that lists Catholic hospitals. This discrepancy is due to MergerWatch identifying hospitals that have been sold to non-Catholic entities under the condition that they continue enforcing Catholic policies for care found in the ERDs [20]. MergerWatch did not include long-term care, critical access, psychiatric or other limited-service hospitals such as pediatrics facilities, so some facilities in the CHA directory are lacking in the MergerWatch list. To account for this, we conducted an independent review of all hospitals named by a survey respondent and not listed by MergerWatch to verify its Catholic/non-Catholic status using publically available information. Using this list as a rubric, we coded participants’ responses as correct or incorrect about their hospital’s religious affiliation.

Two researchers independently coded religiosity of Catholic hospital name on a scale of one (nonreligious; for example, Memorial), two (ambiguous; for example, Mercy) and three (very religious; for example, St. Joseph). Discrepancies existed for six hospital names, and a third researcher settled these discrepancies through a consensus process.

2.5. Statistical analysis

We used descriptive analysis to report demographic and response characteristics of the survey population. Based on MergerWatch’s classification, we compared significant differences between women whose primary hospital is Catholic to those whose primary hospital is non-Catholic using bivariate analysis.

Results from bivariate analyses informed subsequent multivariable regression modeling. We performed logistic regressions to assess factors associated with naming a Catholic facility as one’s primary hospital and with ability to correctly identify that hospital as Catholic. We did not omit any variables included in analysis from the tables. Respondent characteristics included demographic information and religiosity of hospital name. For regression analyses, we collapsed respondent’s religious identification into Catholic and non-Catholic.

We weighted survey responses to reflect nationwide demographics provided by the 2015 CPS March Supplement. Alpha was set at 0.05. We analyzed all data using Stata statistical software, Version 14. All analyses accounted for the complex sampling design.

3. Results

We invited 2857 women to participate and received 1430 responses, for a response rate of 50.1%. We excluded women whose hospital was permanently closed or unidentifiable along with incomplete responses and those who indicated that they did not receive ob/gyn care, leaving an analytic sample of 1279.

Table 1 displays participant demographics according to whether their primary hospital is Catholic or non-Catholic. The sample included 201 Roman Catholic women of 1279 total (15.7% raw percent, 17.0%...
survey-weighted percent; remaining percentages given in the text are survey-weighted to represent estimates of the US population of women ages 18–45. Close to 40% of all participants (441/1279) reported attending weekly or monthly religious services.

Among respondents, 15.6% (n=199) named a Catholic institution as their primary hospital for reproductive and ob/gyn care. Women whose primary hospital was Catholic were almost six times as likely to misidentify the religious affiliation of that hospital compared to women seeking care at non-Catholic hospitals: 62.9% (n=125/199) of women whose primary hospital was Catholic correctly identified their hospital as Catholic [95% confidence interval (CI): 54.5%–70.7%] compared to 93.4% (n=1009/1080) of women who correctly identified their hospital as non-Catholic (95% CI: 91.4%–95.0%) (Fig. 1).

For women whose primary hospitals were Catholic but were incorrect about religious affiliation, 47.9% (35/73) were sure or very sure about the affiliation they reported. Fig. 2 shows how women incorrectly identified their Catholic hospital by the incorrect religious affiliation they named.

Table 2 shows the results of logistic regressions examining factors associated with the respondent naming a Catholic hospital as their primary ob/gyn hospital. Roman Catholic participants were no more likely to name a Catholic hospital as their primary institution [odds ratio (OR) 0.83; 95% CI, 0.48–1.42]. Patients seeking care at Catholic hospitals are religiously and demographically diverse. Lack of insurance [adjusted OR (aOR)=2.07; 95% CI: 1.06–4.07] and geographic location [living in a state with over 40% saturation of Catholic hospital beds (aOR=6.01; 95% CI: 2.80–12.92); living in a metropolitan area (aOR=2.26; 95% CI: 1.16–4.43); and living in the Midwest, south or west] significantly increased the likelihood that participants would report a Catholic facility as their primary hospital.

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Table 3 shows logistic regressions examining factors associated with respondents correctly identifying their primary hospital as Catholic. Roman Catholic participants were no more likely to correctly identify their hospital as Catholic (OR 1.98; 95% CI, 0.62–6.33) compared to non-Catholics. Participants whose primary hospital had a very religious name were almost three times more likely to identify that hospital as Catholic than those whose primary hospital had a non-religious name (aOR 3.77; 95% CI, 1.35–10.56). Women residing in a metropolitan area were more than three times as likely as women in nonmetropolitan areas to correctly identify their hospital as Catholic (aOR 3.35; 95% CI, 1.01–11.10). Annual income over $100,000 was also associated with ability to correctly identify one’s hospital as Catholic compared to those with household income less than $25,000 (OR 4.95; 95% CI, 1.35–18.17). Higher saturation of Catholic hospitals was not associated with being able to identify that hospital as Catholic (aOR 1.53; 95% CI, 0.52–4.45).

4. Discussion

While many women need further education on how religious affiliation can influence reproductive healthcare, awareness of a hospital’s religious affiliation is an important step in making an informed decision about where to seek care. The potential harms of misunderstanding the religious affiliation of one’s hospital include not getting timely and patient-centered miscarriage management resulting in infection, excessive blood loss, unnecessary distress or being denied a postpartum sterilization or contraception and remaining at risk for unintended pregnancy. Such denials can be financially, logistically, physically and emotionally challenging for some patients.

Among women whose primary hospital is Catholic, over a third were unaware of that hospital’s religious affiliation. The majority of these women identified their hospital as nonreligious, suggesting little understanding of how religious affiliation may impact their healthcare. Half of the women who incorrectly identified their Catholic hospital as non-Catholic were sure or very sure that they were correct. These results illustrate the information gap that may obscure how hospital religious affiliation may impede access to appropriate care.

Catholic women in our study were no more or less likely to report a Catholic hospital as their primary hospital compared to other participants, indicating that many patients seeking care at Catholic hospitals likely do not hold the same religious values that dictate what services are available. Even among Catholic women, reports from the Guttmacher Institute show that the vast majority use a contraceptive method other than natural family planning, suggesting that the values upheld by the ERDs do not necessarily represent those of Catholic patients [21].

While Catholic hospital market saturation increased the likelihood that a woman would anticipate going to a Catholic hospital, it was not significantly associated with being able to identify that hospital as Catholic. Given the growth of Catholic healthcare, especially in certain states and regions, this disconnect demonstrates a tension in how patients are able to identify and subsequently understand potential limitations on the care available to them in their primary hospital. Adding weight to recent findings that women of color in some states...
could then further educate women by counseling patients in the full range of reproductive services and elucidating when patients may need to seek care at other hospitals for these services.

A particular strength of our study is that it tests women's ability to identify their own hospital as Catholic, applying our research question to real-world conditions. By collecting information about respondents' own hospitals and back-checking these hospitals' religious affiliations, we are able to identify and integrate local healthcare patterns to illustrate how trends in the healthcare landscape filter down to individual women's reproductive healthcare. The main limitation of our study is the use of a panel-based sample rather than random sampling from the general population. However, our sampling method is diverse and weighted according to current US census data, resulting in a nationally representative sample. Another limitation of our study is that correctly identifying the religious affiliation of a hospital does not imply that our participants are aware of religious restrictions or that those restrictions are implemented uniformly at all Catholic hospitals. Finally, while MergerWatch updated its list of Catholic hospitals in 2016, mergers and acquisitions among hospitals are constantly developing, and our identification of hospital affiliations may not perfectly reflect women's experiences seeking care in these hospitals.

At Catholic hospitals, the ERDs prohibit common reproductive services that are critical to women's lives, such as contraception, sterilization and abortion procedures. Building upon the finding of Guiahi et al. finding that few women can discern if or how religion affects care, our results add further evidence that many US women are unable to identify the religious affiliation of their hospital in the first place [16].

These findings have important implications for a woman's ability to make an informed decision about where to seek reproductive and ob/gyn healthcare. Increased transparency surrounding religious affiliations and the resulting restrictions on healthcare services is necessary to aid women in determining where their health needs will be met. Further research is necessary to investigate how to increase awareness about these restrictions, particularly with regards to how women choose their primary hospital, what resources women use to find information about that hospital and how efforts to increase transparency of religious affiliations and restrictions might better equip women to make these choices in the future.

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References


