Referrals for Services Prohibited In Catholic Health Care Facilities

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CONTEXT: *Catholic hospitals control a growing share of health care in the United States and prohibit many common reproductive services, including ones related to sterilization, contraception, abortion and fertility. Professional ethics guidelines recommend that clinicians who deny patients reproductive services for moral or religious reasons provide a timely referral to prevent patient harm. Referral practices in Catholic hospitals, however, have not been explored.*

METHODS: *Twenty-seven obstetrician-gynecologists who were currently working or had worked in Catholic facilities participated in semistructured interviews in 2011–2012. Interviews explored their experiences with and perspectives on referral practices at Catholic hospitals. The sample was religiously and geographically diverse. Referral-related themes were identified in interview transcripts using qualitative analysis.*

RESULTS: *Obstetrician-gynecologists reported a range of practices and attitudes in regard to referrals for prohibited services. In some Catholic hospitals, physicians reported that administrators and ethicists encouraged or tolerated the provision of referrals. In others, hospital authorities actively discouraged referrals, or physicians kept referrals hidden. Patients in need of referrals for abortion were given less support than those seeking referrals for other prohibited services. Physicians received mixed messages when hospital leaders wished to retain services for financial reasons, rather than have staff refer patients elsewhere. Respondents felt referrals were not always sufficient to meet the needs of low-income patients or those with urgent medical conditions.*

CONCLUSIONS: *Some Catholic hospitals make it difficult for obstetrician-gynecologists to provide referrals for comprehensive reproductive services.*

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In the United States, Catholic health care institutions account for 15% of all acute care hospitals, sponsor 17% of hospital beds and, in some regions, are the sole community hospital.[1] (A sole community hospital, as designated by the Centers for Medicare and Medicaid Services, is the only option for patients within at least 35 miles or a 45-minute drive.[2]) Clinicians in Catholic facilities are bound by the *Ethical and Religious Directives for Catholic Health Care Services*, which prohibits common reproductive health care services, such as those pertaining to contraception, sterilization, abortion and assisted reproductive treatments.[3] The directives are enforced by each diocese's bishop, who is charged with ensuring that Catholic hospital ethics committees understand the church's moral teachings and know how to apply them in daily health care practice.[3]

The Committee on Ethics of the American College of Obstetricians and Gynecologists has concluded that a physician who cannot, for reasons of conscience, provide a patient with a requested and medically accepted reproductive health service has a duty to give the patient a timely referral to a provider who can.[4] This committee opinion, first issued in 2007 and reaffirmed in 2013, is concerned primarily with physicians' personal moral objections, but it also speaks to institutional obligations toward patients. It advises health care institutions to ensure that patients have access to safe and legal reproductive care. It emphasizes that patient medical needs—not provider values—should be the leading consideration.

Catholic bioethical writing about referrals is complex and at times conflicted.[5–9] The directives never use the word "referral," and instead repeatedly caution physicians against various forms of "cooperation." For example, directive 70 states, "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide and direct sterilization."[3(p. 37)] Unlike the directives, guidelines from the National Catholic Bioethics Center make a direct link between referrals for prohibited services and cooperation, stating:

"Any form of referral constitutes formal cooperation, and would therefore be immoral. A 'referral' in moral terms is when the person who refuses to do the immoral procedure directs the requesting person to another individual or institution because the other individual or institution is known or believed to be willing to provide the immoral procedure in question."[10]

According to the guidelines, providing information on obtaining the procedure in question is the equivalent of giving a referral, even if the objecting physician does not explicitly request that procedure.

In spite of this guidance, some Catholic theologians advocate openly explaining all existing options to patients, even if they do not support helping the patient to obtain prohibited procedures. Guidelines from the National Catholic Bioethics Center also make a distinction between referral and transfer of care, explaining that transferring the patient's care to a provider who offers the prohibited service is acceptable if the patient finds the provider on her own.

It is unknown how obstetrician-gynecologists who work in Catholic hospitals handle referrals for prohibited reproductive health care services. We conducted a qualitative study of obstetrician-gynecologists who have worked in Catholic hospitals to assess their perceptions of whether referrals for services prohibited by church doctrine are routinely offered in Catholic facilities, how these referrals are handled and whether patients' needs are met by the process.

METHODS

We conducted qualitative interviews with a subset of respondents to a nationally representative survey of 1,154 practicing obstetrician-gynecologists from around the country.[11] Of the original sample, 237 physicians agreed to be contacted for follow-up interviews, including 30 obstetrician-gynecologists whose primary workplaces were Catholic, 10 who practiced at non-Catholic Christian facilities, four who practiced at Jewish facilities, three who practiced at facilities affiliated with other religions, and 190 who practiced at facilities with no or unknown religious affiliation. Workplace affiliation was determined by a survey question that asked respondents if their primary place of practice was religiously affiliated and, if so, to indicate the religion.

We invited 79 physicians from around the country by phone or e-mail to participate in an interview: all 30 obstetrician-gynecologists whose primary place of practice was Catholic; seven who indicated that they experienced conflict over religious policies or treatment restrictions even though their primary place of practice was not religious; and, to seek a balanced understanding of conflicts common in Catholic and other hospitals,[12] 42 working in non-Catholic religious and secular hospitals. We also sought diversity in the religious self-identity of the obstetrician-gynecologists in our sample, to include perspectives from those who might share the Catholic Church's values and from those whose personal beliefs might differ.

Of the 79 survey respondents we invited to participate, 25 completed interviews (of whom 22 had experience working in Catholic hospitals); five of the remaining invitations bounced back, and 49 yielded no response. We also included a snowball sample to help increase the number of interviewees with experience working in religious hospitals. To recruit this sample, we asked interviewees to forward our e-mail to colleagues they felt would be appropriate for the interview and interested in participating. This resulted in interviews with six additional obstetrician-gynecologists, five of whom had experience in Catholic health care. In total, we interviewed 31 physicians, 27 of whom had experience working in Catholic health care facilities. Those 27 constitute the sample for the analyses presented in this article.

Interviews lasted 45–60 minutes and were conducted by telephone in 2011–2012 by the third author, a qualitatively trained sociologist experienced in physician interviewing. Respondents were asked about their experiences with the health care institutions in which they worked and about how religious hospital policies affected their patient care. Questions were open-ended to allow respondents to partially guide the direction of the interview. Topics included what physicians liked and disliked about their hospitals; how their values meshed with those of their employer and peers; and how they handled clinical services, including abortion, contraception, sterilization and infertility treatment. Respondents were asked about their experiences in their current primary place of practice, as well as in hospitals and clinics in which they had trained or previously worked. Respondents were compensated for participation with a $50 gift card.

Interviews were transcribed verbatim and coded using qualitative data software (ATLAS.ti version 6.2). The first and third authors reviewed early transcripts and identified themes. After a preliminary code list was developed, both authors coded the same three transcripts, discussed the codes, agreed on revisions and repeated this process. The third author then coded the remaining transcripts using the agreed-upon code list. For the current analysis, we reviewed transcripts from respondents who had ever worked in a Catholic facility, and identified content relevant to referrals.

Respondents' demographic and religious characteristics and their values with respect to reproductive health care were drawn from their survey responses. The survey asked if respondents had any ethical or moral objections to various forms of contraception, sterilization, assisted reproductive technology and abortion in specific clinical scenarios (e.g., to terminate a pregnancy caused by failed contraception or resulting from rape). It also asked respondents to identify their religious affiliation and to rate how important their religion was in their own life. Interviewees were less likely than those who did not respond to our invitation for an interview to have reported that religion was very important or the most important thing in their life (36% vs. 62%). For the snowball sample, the interview included discussion of all of these characteristics.

The study was approved by the institutional review boards at authors' home institutions.

RESULTS

Sample Characteristics

Of our 27 interviewees, 18 currently and nine previously worked in Catholic hospitals; 26 had also worked or trained in a non-Catholic hospital. Seventeen of the physicians were women, and 23 were between the ages of 36 and 55 (Table 1).

TABLE 1. Number of obstetrician-gynecologists participating in interviews about referral practices for prohibited reproductive health services at U.S. Catholic health facilities, by selected characteristics, 2011–2012

Characteristic	No.
Total	**27**
Gender	
Male	10
Female	17
Age	
≤35	1
36–45	8
46–55	15
>55	3
Region	
West	9
Midwest	8
South	7
Northeast	3
Religious affiliation	
Jewish	6
Hindu	3
Roman Catholic	2
Protestant	2
Muslim	1
Other*	6
None/metaphysical connection	5
Unknown	2
Importance of religion in respondent's life	
Most important	3
Very important	5
Fairly important	9
Not very important	7
Unknown	3
Moral objection to reproductive services	
Contraception	0
Tubal ligation	0
Assisted reproductive technology	0
Abortion in at least some circumstances†	6

*Includes Eastern Orthodox, Unitarian, Latter-Day Saints, Episcopalian and other Christian. †To terminate a pregnancy caused by contraceptive failure or resulting from rape, or for medical reasons.

Respondents resided in 15 states throughout the country. They were diverse in religious affiliation and in their ratings of the importance of religion in their lives. Attitudes on abortion varied, but no physician expressed personal moral objection to contraception, sterilization or assisted reproductive technology. Some respondents had proactively sought to work in a Catholic hospital, while for the majority, the Catholic affiliation of their hospital was incidental (not shown).

Serving Patients Who Need Prohibited Services

Respondents learned about their hospital's policies and expectations through a variety of means, including formal consultation with the ethics committee on specific cases, instructions or direct feedback from hospital administrators or departmental leaders, and stories or advice from colleagues. For example, one physician recalled being asked to accept a transfer from another hospital of a patient who was having a miscarriage. The physician did not know if the hospital's religious authorities would consider the threat to this patient's health "imminent," which would have allowed treatment that the physician considered standard but that, in some cases, Catholic hospitals consider abortion. The physician said, "I need to make sure I can manage this lady without anyone tying my hands." Before accepting the transfer, the physician called the chair of the hospital's ethics committee, who then "talked to a few other people within the system" before determining that this case "[passed] the litmus test of imminent threat."

Some physicians had two hospital affiliations—one Catholic and one non-Catholic—so they were able to continue to care for their patients who needed prohibited services in the non-Catholic facility. However, many had only their Catholic hospital affiliation and had to choose whether to provide only services allowed in the Catholic setting; to provide prohibited services at their own offices (overtly or covertly), but not in the hospital itself, where enforcement was stricter; or to refer patients out for prohibited services.

Twenty-four of the physicians in our sample reported that when working in Catholic facilities, they referred patients to non-Catholic providers for services they were not allowed to provide. Referrals for prohibited women's reproductive health care services were handled in a variety of ways. Some physicians reported that they handled abortion referrals differently than they did referrals for other prohibited services. For example, hospital and office staff concerns about making referrals for abortions—especially those perceived as elective—arose more often than concerns about making referrals for tubal ligations, contraception or infertility treatment. Respondents mentioned leaving it to patients to seek abortion care on their own more frequently than they mentioned leaving it to them to seek other types of prohibited services. Furthermore, abortion referrals became a source of conflict between providers and their hospitals and, occasionally, office staff.

Referral Process

Three key features of the referral process emerged in physicians' discussions of their Catholic hospital experiences: hospitals' attitudes toward referrals, referral type (direct vs. indirect) and the role of financial incentives.

•***Hospitals' attitudes toward referrals.*** Some obstetrician-gynecologists reported that Catholic hospital ethics authorities encouraged them to make referrals. One respondent explained how a clergyman, who was described as a consultant of the Catholic Church, came from a major metropolitan area to a small Southern town to talk to physicians at the respondent's hospital. The clergyman instructed obstetrician-gynecologists to refer patients out for tubal ligations and other prohibited services, which surprised the respondent:

"He came in and spoke to us about the Catholic ethic.… And one of the things he recommended was that if we have a situation where a patient needs something that can't be provided by the Catholic institution, that we should refer them to…the place where they could get things taken care of…as quickly as possible.… I was really surprised. He

was like…'If…somebody wants a tubal, you know, refer them to a doctor that can do a tubal at another hospital.' I thought that was interesting 'cause usually you would think they would say, 'Well, we don't want them to have a tubal. That's not the right thing to do.'"

Physicians discussed the complexity of referrals when caring for patients who had life-threatening complications during pregnancy. Some felt that in referring these patients out for abortions rather than allowing physicians to administer the prohibited care, the hospital "dumped" or "punted" them. One obstetrician-gynecologist recounted the story of a patient cared for by a colleague at their Catholic hospital. The patient received a diagnosis of brain cancer during her first trimester of pregnancy and needed chemotherapy that would have been harmful to the fetus. According to the respondent, the obstetrician-gynecologist caring for this patient approached the hospital and said, "I've got a woman whose life is threatened by brain cancer. She's pregnant, and I need to do a termination." The respondent then explained:

"And they refused. They said, 'Go take her to another hospital. Take her to another place. Those places are available to you. We don't have to do it here.…' And they said, 'If we were the only hospital, maybe we would do it, but we're not. There are other hospitals.'"

Other respondents recounted scenarios in which referrals, especially for services considered less politically contentious than abortion, were not actively encouraged by their Catholic hospital, but were passively tolerated. One explained:

"I don't think we were really allowed to prescribe contraception under hospital auspices, but generally what we would do is just recommend that they go to the local family planning clinic.… And nobody seemed to care about that. I could just tell people whatever I wanted to. It was just you couldn't write a prescription for birth control pills on a [hospital] prescription pad."

Another physician explained that he was unsure if the administration knew about the contraceptive referrals made in his Catholic residency program:

"We would tell [patients] just pretty directly that we could not provide contraception at that facility and usually would refer them to Planned Parenthood or to the health department. I'm not sure [the hospital administration] knew."

In other circumstances, however, physicians were able to provide some contraceptives (e.g., to treat irregular menstrual cycles), and had to refer for others. One obstetrician-gynecologist explained that physicians had to manage contraceptive counseling and charting discreetly:

"We couldn't provide abortion services there, and we also couldn't provide contraception. Although when the door was closed to the exam room, we did talk about contraception.… And I think the nurses knew that this was going on. I mean, it wasn't that they were policing us.… The given was that they wouldn't get us in trouble for talking about it, but the documentation that went in the chart would be sparse around the contraceptive counseling. You know, there were little euphemisms that went in there about menstrual regulation and things like that."

This physician went on to clarify that pills and IUDs were treated quite differently. While doctors could provide pills "in-house" by fabricating medical justifications, they had to send patients who requested an IUD elsewhere.

Another respondent described working in a Catholic hospital in which providers understood that referring a patient for an abortion would be treated as a violation of professional community norms:

"If you had a patient with a baby…[with] bad chromosomes and the patient elected for a termination, and you were in any way affiliated with the hospital, you were not looked good upon if you…provided [the patient] with the telephone number to someone who does terminations."

•***Referral type.*** Multiple interviewees reported that for most referrals, both the physician and the hospital or office staff are involved in facilitating the patient's transition of care. For abortions, some providers were pressured not to directly facilitate the referral, and especially not to ask nurses or staff to do so. For some, only indirect referrals—in which the provider would tell the patient that she could access the services elsewhere but would not help her do so—were tolerated. For example, one respondent explained that for patients needing abortion referrals, "it wasn't like formal referrals. It was more something that I would say to the patient in the exam room."

Another respondent described a case in which the patient's genetic testing showed that her fetus was affected by Down syndrome, and the patient opted to terminate the pregnancy:

"I gave my secretary all the clinical paperwork and test results and whatnot that she needed to forward on to the facility that we were referring the patient to, and had her call and make the appointment, 'cause we make the appointments for everybody that we're referring, not just for terminations. If we're making appointments for mammograms or bone densities or second opinions, whatever—we make all those appointments for the patient in our office."

In this case, however, the secretary objected to facilitating the abortion referral. The respondent continued:

"So she did send them, but then when I got back, we had a discussion over whether that was appropriate or is she breaking the rules, so to speak, by making the appointment for the patient as opposed to just giving the patient the number and saying, 'Here, you call and make the appointment.'"

The respondent recounted that the nurse in this office shared the concerns of the secretary about facilitating the abortion referral, and argued that giving the patient a phone number was sufficient.

In another case, a physician related that an indirect referral handout was seen as too informative. The local bishop learned that tubal ligations and other prohibited services were being provided at the respondent's hospital, and the bishop decided to tighten enforcement on many aspects of reproductive care. As the physician described the situation:

"We used to hand out a form also that did list places in town they could get contraception, through Planned Parenthood or the health department and things like that, and that actually also went away. They didn't want us… even providing information to the patients."

•***The role of financial incentives.*** Some interviewees raised the issue of their hospital's financial incentive not to lose patients—especially for lucrative services—when Catholic doctrine prompted them to refer patients elsewhere. When the hospital's business interest and its moral teaching were in conflict, physicians reported that they received mixed messages from hospital authorities. For example, some respondents described infertility treatment as a service that hospitals wanted to hold on to, even if they had to make creative arrangements for the aspects prohibited by Catholic doctrine. Catholicism teaches that procreation should not be separated from intercourse within the context of heterosexual marriage. Thus, procedures to extract eggs or sperm, or to fertilize an egg in vitro, are prohibited in a Catholic facility. But provision of fertility drugs is permitted, as are medical visits that do not involve handling eggs, sperm or embryos. Noting that no one at her Catholic facility was allowed to provide fertility services, one respondent explained:

"Now, they're getting a little crafty with how they get around it, and they go off-campus [to provide such services]. So we actually do now have…an infertility specialist, who is starting up an in vitro fertilization clinic off-campus.… We had somewhere to send them anyway before—it was just out of the system—but now the system wants the business."

Similarly, one perinatologist explained that her Catholic hospital objected when she suggested that she stop accepting obstetric patient transfers during the previable period because she could not provide a full range of care to those patients. This respondent had cared for a pregnant patient whose fetus had a severe heart defect, and the patient's membranes had ruptured at 19 weeks. The respondent had approved an induction of labor, and had then been accused by her Catholic ethics committee of performing an illicit abortion. The respondent recounted her response and subsequent interaction with the ethics committee:

"[I asked the committee,] 'So am I to understand that if I receive a patient in transfer, who's 20 weeks and has a number of other complicating factors, that, you know, I can't offer [labor induction]? Because if that's the case, then I am going to turn away all patients between 18 and 24 weeks, because we can't manage them in what I believe to be, and what I'm quite certain is, standard of care.'"

After the meeting, the respondent noted that once the opposition had left the room, "several people came up to me and said, 'No, no, no, don't stop accepting those patients.' [The] nurse vice president, the chairman of the ethics committee, kind of quietly afterwards…[came] up to me and [said], 'You know, we don't disagree with what you did, and we don't want you to not accept those referrals…because we're a referral hospital, and you start losing referrals for one thing, and you'll lose referrals for all kinds of things.'"

Addressing Patients' Medical Needs

Given the potential tension that physicians who do not share the Catholic Church's values may feel between providing quality care and following hospital rules, it is not surprising that respondents varied in whether they felt the referral process adequately addressed their patients' medical needs. For the most part, obstetrician-gynecologists expressed acceptance that for outpatient services perceived as nonurgent or elective, their patients could get care at nearby non-Catholic providers. Respondents mentioned being happy that a local Planned Parenthood, women's clinic or public health department could provide services that they wanted their patients to have but that they could not provide. One physician mentioned, "We give them the phone number for Planned Parenthood or one of the women's centers that are local." Another said, "Oftentimes I'll just end up sending them to Planned Parenthood, and they can get [oral contraceptives] really cheap there."

However, respondents described clinical scenarios in which they felt that referring a patient to an outside provider put the patient's health at risk. For example, obstetrician-gynecologists routinely treat acute bleeding with hormonal contraceptives, but physicians noted that not having these medicines in stock delayed or disrupted a patient's urgent medical care. One obstetrician-gynecologist explained:

"Say you have…a 45-year-old who comes in [at three in the morning] with heavy bleeding and irregular periods. The most common approach to stopping her bleeding is to give her high-dose birth control pills for a short period of time. So, that became very difficult…'cause they didn't have them in stock. I won't say it's impossible to get them, because like the head pharmacist knows where there's three secret packs, and if you happen to manage to find the head pharmacist at [that hour], you can. But it's nearly impossible to get birth control pills to treat heavy bleeding."

Respondents also felt frustrated over their inability to perform tubal ligations at the time of a cesarean or immediately after a vaginal birth. They believed that requiring an unnecessary additional hospitalization or procedure for a patient who wanted a postpartum tubal ligation was not in her best interest. One respondent explained that a decent second choice for such patients is long-acting contraceptives, but Catholic hospitals do not allow provision of these, so he gave referrals to other hospitals:

"A lot of these Catholic institutions, they don't even… dispense those things, unfortunately. So finally I had to kind of tell [patients] that, 'Look, I'm going to give you a prescription. Please go to another hospital [that] is nearby, which is non-Catholic, and please take care of it that way.'"

Another frustration physicians mentioned repeatedly was that the shortage of abortion providers in their communities, especially for procedures at later gestations, limited referral options. Although this issue is not unique to Catholic hospitals, physicians in Catholic hospitals do

not have the option of providing abortions for their own patients the way others would. One respondent explained that at one time, patients seeking abortions at Catholic hospitals could be referred to nearby non-Catholic hospitals, but this type of referral had become more challenging with the dwindling numbers of abortion providers. The physician recalled a local provider, now retired, who "would take all comers." With that provider's presence, the respondent related, "We always had avenues where we could send patients. But those avenues are getting harder to find as it's getting harder to find providers."

Finally, financial barriers—especially for patients from lower socioeconomic groups—were reported as a reason that referrals were not always an adequate solution. A physician explained how, at one Catholic hospital with a large indigent population, providers would prescribe birth control under the guise of treating menstrual irregularity because there was no other way the patients could get contraception. Prescribing pills to treat menstrual irregularity, this physician commented, "was just the right thing to do."

DISCUSSION

Obstetrician-gynecologists working in Catholic facilities commonly reported referring patients to other providers for reproductive services not permitted under Catholic religious directives. While some reported that their employers openly encouraged them to make such referrals, others had to hide these referrals or make them outside of normal institutional channels. Physicians experienced the greatest difficulty offering abortion referrals—these often had to be kept hidden from employers, and so patients received little assistance. Some physicians noted that financial incentives prompted their Catholic hospitals to keep more lucrative procedures, such as infertility treatment, and refer out only for a small portion of the service, to adhere to the letter of Catholic law.

Referrals allowed some of these obstetrician-gynecologists to feel their patients' medical needs were met, with three commonly cited exceptions. First, patients delivering in a Catholic hospital who wanted a tubal ligation postpartum or accompanying a cesarean were not well served by referrals, because this meant an unnecessary additional hospitalization or procedure. Second, patients with limited financial resources faced barriers in accessing referrals. Third, patients who needed emergent treatment were not always able to get necessary services at the hospital to which they presented. These differences in care raise issues about whether Catholic hospitals are providing a different standard of care to women than non-Catholic hospitals. Furthermore, the limited number of abortion providers in some areas made referral an inadequate strategy to meet patients' needs, according to some respondents. Although this problem highlights the shortage of abortion providers that exists in many areas,[13] it may be especially great for Catholic hospital patients because these facilities have a stricter definition of prohibited abortion than others.[14] This problem would likely be further compounded in Catholic facilities that serve as sole community hospitals, where getting to another hospital for urgent treatment may be especially difficult.

Strengths and Limitations

One of the strengths of this study was that it included a diverse group of obstetrician-gynecologists who have worked in Catholic hospitals around the United States. Our open-ended interviews allowed themes about referral processes and barriers to emerge naturally in the respondents' own words and from their personal experiences. Most of the physicians we interviewed were drawn from a nationally representative survey sample, but the interview sample itself was not representative, so we cannot generalize respondents' experiences and perspectives to the entire population of U.S. obstetrician-gynecologists.

It is also important to note that the hospital policies described here are filtered through the experiences and perspectives of the physicians interviewed. We did not directly speak to hospital administrators, ethicists or others in position to enforce the Catholic directives. In the survey from which this sample was derived, 48% of obstetrician-gynecologists who described religion as "not very important" in their lives experienced a conflict with their religious hospital, compared with 20% of those for whom religion was "most important."[11] Physicians' own beliefs and attitudes may therefore affect their reporting of hospital referral policies.

Conclusion

Little research has been done on referrals for reproductive health services. In a nationally representative survey, primary care physicians were asked what doctors should do when they felt a service was clinically indicated but was prohibited by their hospital's religious policies. Some 86% responded that the right course of action was to refer the patient to a different facility.[15] But this belief may not readily translate into patients' getting timely information and referrals, and barriers other than Catholic hospital policy may also play a role. In a 2010–2011 study of reproductive health facilities (not specifically religious ones) that did not provide abortion but were located fairly near an abortion provider, callers posing as patients received a direct abortion referral in only 46% of instances.[16] In a separate study, in Nebraska, only 52% of family medicine providers and obstetrician-gynecologists believed that clinicians have a professional obligation to refer patients for abortion services, and 17% said they would in no way participate in an abortion referral.[17] The nonprofit organization Provide reviewed both published literature and expert guidance on abortion referrals, and found a need for research evaluating the effectiveness of abortion referrals and the role of the referral process in women's access to care.[18]

Prominent bioethicists and obstetrician-gynecologists have debated whether physicians who hold a personal moral objection to abortion should be required to refer patients to a physician who will safely provide it.[19,20] However, they have not addressed the behavior of institutions (or the

physicians within them) when the objection comes from the religious denomination sponsoring the institution, rather than from individual physicians. The wide range of referral patterns in Catholic hospitals described by the obstetrician-gynecologists we interviewed is probably attributable, at least in part, to the lack of clear guidance from professional norms. Furthermore, individuals charged with enforcing doctrine in Catholic hospitals, such as ethics committee members, clergy and hospital administrators, may be responding to conflicting messages and may be passing this confusion on to the physicians in their facilities.

Our study shows how these complex teachings translate into daily practice in Catholic hospitals, and the findings hold important implications for patient care and public policy. Physicians are important points of entry for patients, yet hospitals and health systems inherently enter into the patient-doctor relationship. Given the prevalence of Catholic health care in the United States, it is highly likely that these hospitals serve patients needing comprehensive health care.

For patients to access the full range of legal reproductive health services in a timely fashion, we recommend that obstetrician-gynecologists and the practices and hospitals in which they work put in place referral practices that help patients access services not provided on-site. As recommended by the American College of Obstetricians and Gynecologists,[4] patients' wishes and well-being, not provider moral judgment or institutional religious policy, should be the primary driver of health care decisions. When religious entities participate in health care service provision for the broad public, policymakers should require them to offer such referrals and to ensure that patients are well informed about the limitations to the care available in their facilities. Further research is needed to better understand opportunities for physicians, bioethicists, professional societies and patient advocacy organizations to work together to improve care for women, in light of the boundaries that exist.

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