

Original research article

# Tubal ligation in Catholic hospitals: a qualitative study of ob–gyns’ experiences ☆,☆☆

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Received 10 December 2013; revised 22 April 2014; accepted 29 April 2014

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## Abstract

**Objective:** Tubal sterilization remains one of the most commonly requested contraceptive methods in the United States. Catholic hospital policy prohibits all sterilizations, but this ban is not uniformly enforced. We conducted this study to assess obstetrician–gynecologists’ beliefs and experiences with tubal ligation in Catholic hospitals.

**Study design:** We interviewed 31 obstetrician–gynecologists geographically dispersed throughout the US who responded to a national survey and agreed to be contacted for a follow-up interview or who were referred by colleagues from the survey sample. Twenty-seven had experienced working in a Catholic hospital. Interviews were open ended and guided by a semistructured instrument. Transcripts were thematically analyzed.

**Results:** Obstetrician–gynecologists disagreed with strict prohibition of sterilizations, especially when denying a tubal ligation placed the patient at increased medical risk. Cesarean delivery in Catholic hospitals raised frustration for obstetrician–gynecologists when the hospital prohibited a simultaneous tubal ligation and, thus, sent the patient for an unnecessary subsequent surgery. Obstetrician–gynecologists described some hospitals allowing tubal ligations in limited circumstances, but these workarounds were vulnerable to changes in enforcement. Some obstetrician–gynecologists reported that Catholic policy posed greater barriers for low-income patients and those with insurance restrictions.

**Conclusion:** Obstetrician–gynecologists working in Catholic hospitals in this study did not share the Church’s beliefs on sterilization. Research to understand patients’ experiences and knowledge of their sterilization options is warranted in order to promote women’s autonomy and minimize risk of harm.

**Implications statement:** Tubal sterilization, even when medically indicated or in conjunction with cesarean delivery, is severely restricted for women delivering in Catholic hospitals. For women whose only access to hospital care is at a Catholic institution, religious policies can prevent them from receiving a desired sterilization and place them at risk for future undesired pregnancy.

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*Keywords:* Sterilization; Religious hospitals; Qualitative research; Obstetrics; Gynecology

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## 1. Introduction

Female sterilization is the second most common contraceptive method used by women in the United States today [1]. Prevalence of sterilization increases with age; among 40- to 44-year-old women who use contraception, 50% use female sterilization. Approximately 700,000 female sterilizations are performed annually, half within 48 h postpartum [2]. Sterilization is performed following 8–9% of all births [3].

The US Collaborative Review of Sterilization (CREST) study, which followed 10,685 women for up to 14 years

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☆ Funding Support: The Greenwall Foundation, the Eunice Kennedy Shriver National Institute of Child Health and Human Development (1K08 HD060663 to Dr. Stulberg) and the Society of Family Planning (career development grant to Dr. Freedman).

☆☆ Disclosure: The authors have no conflicts of interest.

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following their surgical tubal sterilization procedure, demonstrated that tubal sterilization is highly effective. The cumulative 10-year probability of failure was 1.85% [4]. Complications following tubal ligation are rare and include infection (1% of total cases), minor or major bleeding (0.6%–1%) and anesthesia-related events (1%–2%) [5]. Performing the procedure immediately postpartum is the most effective method according to CREST data and allows the patient to avoid additional anesthesia or additional surgery in the case of cesarean delivery.

Despite its safety and efficacy, tubal sterilization is not always available to women. In a cohort of 429 women requesting a postpartum tubal ligation in a Texas university-based hospital, 31% did not receive the desired procedure. One year later, 47% of those denied a sterilization had experienced a repeat pregnancy [6]. In qualitative interviews with women whose postpartum sterilization requests were unfulfilled, those who faced insurance and institutional barriers expressed frustration with their experience and anxiety about a future unintended pregnancy [7].

The main reasons for limited availability of female sterilization are system-level barriers. These include Medicaid consent forms, which were instituted to prevent involuntary sterilization of low-income women but have become a significant barrier to women receiving desired sterilizations because the form is not written in a plain, readable format and many women have difficulty understanding it [8]. Additional barriers include unavailability of physicians or facilities and Catholic hospital policies [8].

The Roman Catholic Church is a large and growing stakeholder in the United States health care system. Between 2001 and 2011, the number of Catholic-sponsored or -affiliated hospitals grew by 16% while public hospitals, secular nonprofits and other (non-Catholic) religious nonprofit hospitals all saw their numbers decline [9]. One in six patients in the United States receives care in a Catholic institution, and nearly 16% of admissions are to Catholic hospitals [10]. Catholic hospitals are funded by Medicaid, Medicare and private insurance. They provide charity care at 2.8% of their revenues, a rate equivalent to other nonprofit hospitals, and their care to Medicaid patients is less (relative to total revenues) than that provided by any other type of hospital — public, nonprofit or for profit [9].

Doctors working in Catholic hospitals are required to adhere to the Ethical and Religious Directives for Catholic Health Care Services, written by the United States Conference of Catholic Bishops [11]. Directive 53 states: “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available” [11]. Catholic hospitals vary in how they interpret this directive [12]. Some provide sterilization in limited circumstances, and in rare instances, Catholic hospitals have agreed to workarounds that allow for the provision of prohibited services [13].

A 2012 national survey found that 52% of obstetrician–gynecologists (ob–gyns) working in Catholic hospitals experienced conflict with religiously-based policies for patient care [14]. Due to limited space in the survey, the nature of these conflicts was not explored. To our knowledge, no prior research has studied physicians’ perspectives on sterilization in Catholic hospitals. Our study used a qualitative approach to assess ob–gyns’ experiences with Catholic hospital authorities when seeking sterilization for their patients and explored their perspectives on how Catholic hospital sterilization policies affect medical practice.

## 2. Methods

We recruited purposively from a sample of ob–gyns ( $n=1154$ ) who answered a national survey about sexual and reproductive health care [14]. Subjects were recruited from the subset ( $n=237$ ) that agreed to be contacted for a follow-up interview. We reached out by phone and email, inviting all ob–gyns who worked in Catholic hospitals. To explore a range of physician experiences with institutional policies, we also invited some ob–gyns who worked in non-Catholic hospitals. Responses to the national survey were used to identify and recruit a geographically and religiously diverse interview sample. Finally, we pursued a snowball sample by asking subjects to forward our recruitment email to colleagues they thought would be appropriate for our study. Subjects were compensated for their time and participation with a US\$50 gift card.

Demographic and religious characteristics of respondents were drawn from their survey responses. For subjects who had not completed the survey (snowball sample), we assessed their age, geographic region, religious affiliation and religious importance during the interview.

Interviews lasted 45–60 min and were conducted by a qualitatively trained sociologist (LRF) with previous experience interviewing physicians. Questions were open ended, allowing respondents to partially guide the conversation. Topics included physicians’ likes and dislikes about their hospitals, how their values fit with those of their employers and peers and specific clinical issues such as abortion, infertility and sterilization. The interview guide was continually shaped by emerging themes. The analysis arose from the data inductively, following a grounded theory approach [15].

Interviews were transcribed verbatim, and transcripts were coded using qualitative data software (ATLAS.ti Version 6.2, Scientific Software Development GmbH, Berlin, Germany). Themes were identified by two investigators (DBS and LRF) through an iterative process. After agreeing on a preliminary code list, both investigators coded the same three interviews. They discussed functionality of the codes, revised the code list and repeated this process again. One author (LRF) then coded the remaining interviews according to the agreed-upon themes. All four authors reviewed the interview transcripts containing

Table 1  
Demographics of obstetrician–gynecologists interviewed (n=31)

Gender	
Male	12
Female	19
Age	
≤35	2
36–45	10
46–55	15
>55	4
Geographic region	
West	10
Midwest	9
South	8
Northeast	4
Religious affiliation	
None/Metaphysical connection	7
Jewish	6
Hindu	3
Roman Catholic	3
Protestant	3
Muslim	1
Other <sup>a</sup>	6
Unknown	2
Importance of religion	
Most important	3
Very important	6
Fairly important	9
Not very important	10
Unknown	3

<sup>a</sup> Includes Eastern Orthodox (1), Unitarian (1), Latter Day Saints (1), Episcopal (1) and other Christian (2).

discussion of sterilization issues and agreed on the themes presented here. Institutional review boards at the University of Chicago and the University of California, San Francisco, approved the study.

### 3. Results

We interviewed 31 ob–gyns drawn from all regions of the country (Table 1). Of the 27 who had worked in Catholic hospitals, all but one had either been trained or had also worked in a non-Catholic hospital at some point during his or her career. These experiences allowed respondents to compare and contrast work environments. Four physicians had not worked in Catholic hospitals; in their interviews, they drew upon their familiarity with Catholic health doctrine and experience accepting patient transfers from religious hospitals. Six subjects were referred by a colleague (snowball).

Ob–gyns in this study were diverse religiously and in their beliefs on abortion. None of the respondents voiced moral objection to sterilization. Two major themes related to sterilization emerged from the interviews, which we summarize as “risk of harm to women” and “when workarounds don’t

Table 2  
Sterilization in Catholic hospitals: themes and illustrative quotations

Themes and subthemes	Illustrative quotations
Theme 1. Risk of harm to women	
Medical indication to prevent pregnancy	You have a patient who has 32 weeks of pregnancy, this is a fourth pregnancy, she has had three previous c-sections and this is going to be a fourth c-section. She has hypertension, she’s got diabetes, she’s got bronchial asthma...and she weighs 332 pounds... So I feel frustrated at times that I can’t give them enough care that I’d like to do. Because for a patient like this, I mean, honestly speaking, it’d be nice if you can avoid pregnancy.
Unnecessary additional surgery	Women who have to have another anesthetic, another operative risk, another- I mean, I think it puts women at more risk...’cause someone who’s had four c-sections before has to have another operation to get her tubes tied, that’s not what’s in her best interest by any stretch of the imagination.
Theme 2. When workarounds do not work	
Partial workarounds	It was her fourth c-section and she wanted her tubes tied... We had her scheduled to be at the other hospital so we could do her c-section and tie her tubes. But when she came in in labor before that time, then she came into the Catholic hospital, which was our primary facility, and she couldn’t get her tubes tied... it felt really stupid.
Change in enforcement	Two months ago having a tubal ligation wasn’t a bioethical issue; it was a decision a patient made after consultation with the physician and it got carried out safely and that was what it was. The hospital was sold and all of a sudden this procedure becomes a bioethical issue and I don’t understand why the procedure, which hasn’t changed, the patients, which haven’t changed... all of a sudden now we have to go to a committee that doesn’t even have a gynecological member on it and ask them for permission to do a tubal ligation. ...It was apparently bishop by bishop, and the bishop in [my city] was fairly liberal...15 years ago...[If a woman was] at risk for having diabetes in her next pregnancy, that’s a reason enough. And they would let them do it. But then the bishop became much more conservative and the diocese became much more conservative and it’s absolutely never allowed.
Insurance or financial barriers	...it comes down to...how motivated the patient is...if their insurance only covers the Catholic hospital but they want a tubal with their c-section, then sometimes they have to jump through a whole lot of hoops... But usually the insurance companies are pretty resistant. When they first stopped doing it I thought it was terrible because our hospital is the main maternity hospital and our patients...tend to be the lower socioeconomic patients... So you had a situation where if you had insurance, had a job or had money, you could go over across the street and get your tubal done. But if you were, you know, getting Medicaid or if you had [state public insurance], then you didn’t have access to that, and I thought it was a terrible double standard.

work.” Major themes and subthemes are described below, with further illustrative quotations in [Table 2](#).

### 3.1. Risk of harm to women

Physicians expressed that their inability to provide tubal sterilization to women, due to the Catholic Directives, sometimes posed a risk of harm to those patients. They discussed instances in which future pregnancy was medically contraindicated, and instances in which patients were undergoing a medically indicated cesarean section and the physician felt that denying a concurrent tubal ligation would expose the patient to unnecessary risk with a second surgery.

#### 3.1.1. Medical indication to prevent pregnancy

Subjects expressed frustration at not being able to provide what they considered to be the standard of care for patients wanting sterilization. One said: “I mean, we had patients that were very sick, who were pregnant and really needed to not ever get pregnant again.”

#### 3.1.2. Unnecessary additional surgery

Doctors also disliked when patients had to undergo surgeries separate from the cesarean sections they were already having just to have tubal ligations done outside of the Catholic hospital. For example, one physician explained her own conflict of conscience between doing what is best for the patient and doing what is best for her professional security:

“You know, if you’re doing a c-section on somebody that wants a tubal and has had six other previous c-sections and, you know, if I tie her tubes I’m going to get kicked off the staff. And I just don’t think that’s right, but, you know, instead of benefitting my patients, I benefit myself and don’t do the tubal and stay on staff. So that’s difficult sometimes.”

Two ob–gyns described how colleagues would perform unnecessary hysterectomies to avoid being identified as performing a prohibited sterilization. One said:

“I’ll tell you one thing they used to do. They used to - the old private doctors - instead of doing tubal ligations, they would do cesarean hysterectomies, believe it or not ... And a cesarean hysterectomy is a pretty dangerous operation.”

In one case, Dr. S<sup>1</sup> told her obstetrical patient whose labor had stalled that she would be unable to provide tubal sterilization during her imminent cesarean section. The patient became very angry and upset; she was particularly

<sup>1</sup> We have assigned initials to the ob–gyns interviewed about this case for the sake of clarity and continuity as the narrative unfolds. The initials given for the ob–gyns and their hospital are pseudonyms to protect their identities.

fearful of surgical complications related to her obesity. The ob–gyn stated:

“That’s when I heard the expletives of, ‘You’ve got to blanking be kidding me. This is my health and if you’re going to open me up and now, you know, what am I going to have to go through another procedure? Look at me. I can’t go through another procedure. My sister had a c-section. She had a wound complication. Her wound opened up. That’s going to happen to me. I can’t go through another procedure. Look at me.’ And I...couldn’t have agreed with her more and I told her that. And I just kept apologizing.”

As the above quotations illustrate, ob–gyns were uncomfortable complying with hospital policy to deny sterilizations to women who had a high risk of complications in a future pregnancy or when the patient was undergoing medically necessary cesarean section and desired an intraoperative tubal ligation to avoid the need for future (interval) surgery.

### 3.2. When workarounds do not work

Although the ob–gyns we interviewed told us that they were sometimes able to employ strategies to circumvent Catholic hospital bans on sterilization (“workarounds”), they identified three kinds of scenarios in which workarounds were insufficient: partial workarounds that did not apply to all women; workarounds that were narrowed due to changes in enforcement and workarounds subject to a patient’s insurance or ability to pay.

#### 3.2.1. Partial workarounds

Dr. A worked with Dr. S, described above in the case of the patient whose sister had a wound complication. Dr. A discussed the insufficient workaround in their Catholic hospital, Saint P’s, in which one particular operating room was sold to another clinic — a nonreligious entity. In that particular room, the clinic staff — not employed by Saint P’s — were allowed to work outside the scope of the Catholic Directives to assist in the performance of sterilizations only. Dr. A explained:

“...it’s vastly complicated, but I’ll keep it only stupidly complicated. All c-sections between 7:00a.m. and 5:00p.m. are staffed by clinic ambulatory surgery personnel, whether they need a tubal or not. And after 5:00p.m., we try and maintain a call team of ambulatory surgery personnel that will come in from outside the hospital to cover the c-sections that require tubals... We have not been able to maintain a call team for every night, and weekend. So, at this point, we have maybe 60% of the nights and weekends covered. So... if you want your tubes tied, you’re basically playing, you know, Russian Roulette as to whether you’ll get your operation done.”

#### 3.2.2. Change in enforcement

Some doctors described the change in policy at their hospitals when they were sold to Catholic entities; for others,

a new bishop or greater scrutiny by the local archdiocese led to stricter enforcement of sterilization prohibition.

Returning to the hospital of Drs. A and S (above), which was already Catholic, the local bishop became involved after being informed that medically indicated sterilizations were happening in the hospital. He resolved to put a stop to it. Dr. S. said:

“I think what happened was that someone from the archdiocese that encompasses this area was in contact with the hospital administration and, basically, said, ‘I think we have a problem, and this needs to stop.’ And so, what was a very easy sort of step, being able to just go forward and do the tubal ligation at the time of the c-section, changed gradually. At first, the change involved... that during the surgery, the c-section, the staff of the hospital could continue to assist me, but then, the moment I began the process of the tubal ligation, they had to... disengage... They had to step back from the table, and I had to get my own instruments...”

Dr. S continued explaining that the bishop felt that more separation was needed between the hospital and the practice of sterilization. The room ownership was entirely transferred to the clinic:

“Even though it was within the confines of Saint P’s Hospital, the room became the clinic delivery OR... And then there were two consent forms: one consent form for the cesarean section on Saint P’s Hospital paper, and then a separate consent form which was the clinic paper for the tubal ligation. And then the biggest step...was that [hospital] staff cannot be, in any way, shape, or form, involved in the case. They can’t be at the OR table, they can’t start the case, they can’t participate in the c-section – in any way, at all – if there will be a tubal ligation.”

Another ob–gyn described her hospital’s tightening of its enforcement of the directives:

“...there were times when we’ve had patients that ... should never get pregnant, because if they did, it would be risking a life. And if we recommended that a tubal be done at the time of c-section or time of delivery, we would have to petition the hospital’s Ethics Committee to see if they would allow us to do that. I think probably about ten years ago, the Ethics Committee was much more amenable to sitting down and listening to us and would grant us permission to do it in those special circumstances. Interestingly, I think over the last ten years, after the new pope [Benedict] came out, the rules of the Church started to be more heavily enforced. And so that option was taken off the table.”

Thus in some hospitals, physicians who had come to rely on workarounds, or who had been told they would be able to bypass the sterilization ban in specific scenarios, found these options no longer available for their patients.

### 3.2.3. *Insurance or financial barriers*

Physicians explained that patients whose insurance only covered the Catholic hospital where tubal sterilization is

prohibited could not receive tubal sterilization unless the insurance company agreed to cover it at another hospital.

One physician’s patient switched from her husband’s insurance plan to her own, which only covered the local Catholic hospital. When she informed her doctor that she wanted her tubes tied immediately after delivery, she was told that this would be impossible. The physician recalled: “And so then she had to wait a whole year until she could switch insurance plans back to her husband’s plan and do a tubal ligation then.” The Catholic hospital’s ban on sterilization meant that this patient had to undergo a second surgical procedure a year later.

As described by these ob–gyns, workarounds or alternatives were at times least available to women with restrictive insurance policies or government-sponsored insurance (see [Table 2](#)).

## 4. Discussion

The ob–gyns we interviewed disagreed with strict Catholic hospital prohibitions on sterilization, especially when the patient faced increased medical risk from a future pregnancy or when she was undergoing cesarean delivery. Hospitals that were initially lax in enforcement sometimes had sudden changes that directly impacted patients’ access to sterilization procedures. Some physicians reported that Catholic hospital sterilization policy had a more restrictive effect on women with insurance or financial barriers.

This was a qualitative study designed to explore themes from ob–gyns who have professional experience with Catholic hospitals. This study did not intend to capture opinions representative of all ob–gyns, and our conclusions may be limited by who we interviewed. It is possible that ob–gyns most supportive of Catholic health care policies may have been less likely to participate in our study. Furthermore, most interviews for this study were coded by one author. However, strengths of our approach included drawing from a large national sample and using rigorous interview and coding methods. Our efforts to recruit a religiously and geographically diverse sample and to ask questions openly yielded a range of expression about Catholic hospitals. Many physicians we interviewed (including several non-Catholic physicians) expected, because of their own values, to agree with their Catholic hospital in many aspects of care, but found themselves frustrated and in conflict about sterilization.

To our knowledge, no previous research has directly addressed ob–gyn experiences and perspectives on tubal ligation in Catholic hospitals. Previous studies have demonstrated ob–gyns’ conflicts with Catholic hospitals over miscarriage management and other obstetric complications [16–18]. The findings of this study have implications for physicians and other health care personnel. For example, we found repeated examples of tightening enforcement under new hospital management or a new bishop. We therefore advise

doctors and others seeking employment or privileges at a Catholic hospital to approach with caution any upfront assurance that sterilization can be allowed under some circumstances. Furthermore, Catholic health care has demonstrated significant growth through hospital mergers and affiliations [9]. Our findings suggest that administrators and physicians at non-Catholic hospitals considering a new Catholic affiliation should carefully consider the impact on women's health, including access to sterilization.

This study also has important implications for public health and adds to the literature on systemic barriers that women face in obtaining a desired postpartum sterilization. Other investigators have found that Medicaid policy and lack of physician or facility availability pose important barriers in non-Catholic settings [7]. In Catholic hospitals, these factors may still come into play and compound the religious restriction on care. Future research should examine how these different factors interact. Quantitative research is warranted to confirm the sense expressed in our qualitative interviews that low-income women and those with restrictive insurance are most affected by Catholic hospital sterilization policy. Populations at elevated risk for unintended pregnancy and adverse birth outcomes may be further disadvantaged if they face a disproportionate risk of being denied a desired family planning method due to Catholic hospital restrictions.

Finally, we believe that our findings have important implications for patient autonomy and outcomes. Physician conflicts with Catholic hospitals emerged precisely because physicians knew that they would have been allowed to provide different — in many cases medically preferable — options to patients if not restricted by the hospital's doctrine. Women often do not have the ability to make an informed choice about whether to seek care in a Catholic hospital [9,19,20]. A survey in 2000 found that the majority of American women were unaware that going to a Catholic hospital meant that they would be unable to access medical services contrary to Catholic teaching [21]. There is little evidence to suggest that patients choose their hospital based upon its religious affiliation [22,23]. They are likely to go to a hospital because their physician practices there, which may be more a matter of geography than an informed choice. Yet, even when patients seek to be informed consumers doing research about which hospital to choose, to our knowledge, hospitals do not advertise the services they do not provide, and insurance policies sometimes restrict where their members are treated. In the case of Catholic hospitals, these omissions and restrictions effectively inhibit women's reproductive autonomy.

Some argue that with the advent of sterilization procedures such as Essure® that can be done in an office setting, women no longer need access to hospital-based tubal ligation. But these procedures do not remove the need for surgical sterilization in the operating room for some women. Patients undergoing a cesarean delivery who want to have a concurrent tubal ligation to avoid the need for a future procedure were most frequently mentioned in this study. Furthermore, women who receive care at a Catholic hospital

may also receive care at associated clinics where office-based sterilization and contraception can be prohibited by religious policy.

Future research on sterilization in Catholic hospitals should elicit the perspectives of those most directly affected by hospital policies: the patients. In the meantime, women should be encouraged to ask questions in advance to maximize their opportunities for receiving desired sterilization. And in the face of a growing Catholic health care sector in the United States, policymakers should address whether public funding of medical care should be subject to religious directives that may not be in the patient's best interest.

## Acknowledgments

This project was funded in part by the Greenwall Foundation. Dr. Freedman's time was also supported by a career development award from the Society of Family Planning. Dr. Stulberg's time was also supported by a career development award from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (1K08 HD060663).

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