Institutional Religious Policies That Follow Obstetricians and Gynecologists Into Practice

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Dr Smith (name changed) graduated from a maternal-fetal medicine fellowship program in a secular hospital. When she came to work in a rural, sole-provider, Catholic hospital, she looked forward to bringing the best of her field to a relatively poor community. She quickly learned that her hands were tied by religious policies on a few fronts, most commonly for sterilization and previable pregnancy complications.[1] Dr Smith learned that she had to delay miscarriage management until the fetus died or the woman became sick in order to comply with religious policies, and that she had to obtain approval to treat from the Catholic ethics committee. After a distressing case she questioned the quality of care mandated by this doctrine, and said, "If you go to a secular hospital anywhere in the country with the complication of ruptured membranes, but, say, [have] a normal baby at 20 weeks . . . a woman would be offered Pitocin. That would be 1 of her options. In my hospital, I can't do that. So, then, I'm aware that I'm not exactly practicing the standard of care, from a non-Catholic hospital standpoint."

Religious Policies

The *Ethical and Religious Directives for Catholic Health Care Services*[2] were written by the United States Conference of Catholic Bishops to establish religious parameters around care in Catholic facilities. The religious policies prohibit contraception, sterilization, and abortion, and they can limit miscarriage management, pregnancy options counseling, and related referrals.[3] This can produce practices that some physicians believe fall beneath the standard of care they were taught in residency training at non-Catholic institutions.[1]

These distinctions in policies and practice matter. In the United States, 1 in 6 patients is treated and 1 in 14 obstetricians and gynecologists is trained in Catholic hospitals. Catholic facilities have become a significant portion of our health care system. Several studies have documented the experiences of physicians who practice in Catholic hospitals, highlighting the constraints physicians felt on providing comprehensive reproductive health care within this setting.[1,4–8] Few studies to date have documented the experiences of trainees in these institutions.[9,10] The study by Guiahi et al,[11] "Impact of Catholic Hospital Affiliation During Obstetrics and Gynecology Residency on the Provision of Family Planning," in this issue of the *Journal of Graduate Medical Education*, expands our understanding of the effects on trainees and on their patients beyond residency training.

Training

Guiahi et al describe the postresidency effects of limited reproductive health training. They interviewed 15 obstetricians and gynecologists who had completed residency training at Catholic hospitals and now work in secular practices throughout the United States. Their data depict a bleak picture. While these physicians described satisfaction with training overall, they felt unable to meet both their patients' family planning and miscarriage care needs. For example, they described variable but limited contraceptive training, such as inadequate training in contraceptive implant and intrauterine device (IUD) placement. Some had never done a postpartum tubal ligation. Regarding care for women experiencing miscarriages, none of the interviewed physicians had training in outpatient removal of the pregnancy using manual vacuum aspiration, a safe option many women prefer over medical management or an operating room. As residents, some were not allowed to provide counseling to women to support decisions, if the counseling involved abortion. As residents, some could not refer women who chose an abortion. Although the study reported that some programs attempted to supplement training through didactic education and off-site experiences, graduates still felt training was inadequate. As a result, graduates often had to work to make up training deficits in the first year of practice.

Evidence suggests that residents who go to faith-based programs do not differ from residents who go to non–faith-based programs in terms of religious identification and attitudes about abortion.[9] However,

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residents at faith-based programs *are* more likely to be disappointed with their family planning training.[9] This article sheds light on the reasons for their dissatisfaction. First, residents did not choose these residency programs based on the religious policies. They chose programs based on location, other aspects of training, and faculty. Also, while residents were aware of the limitations in abortion training at Catholic hospitals, they were not consistently aware of the inadequacy of training in contraception, sterilization, and miscarriage management.

Opting Out of Training

We expect obstetricians and gynecologists to be competent to meet the reproductive health needs of all women, which include contraceptive counseling and care, management of pregnancy loss, pregnancy decision counseling, and abortion care. Even when obstetricians and gynecologists do not plan to provide abortions due to personal beliefs, the American College of Obstetricians and Gynecologists expects physicians to counsel women about pregnancy options, provide referrals for abortion care if desired, and safely perform an abortion in the case of an emergency if there is no one else available.[12]

The Accreditation Council for Graduate Medical Education (ACGME) requires all obstetrics and gynecology residency programs to include abortion training, to allow for individual residents to opt out of care, and to allow individual institutions to provide training outside of their hospitals.[13] As of 2004, abortion training is routinely scheduled in half of the programs; this rate is up from 12% when the ACGME requirement went into effect in 1996.[14] However, in 40% of programs, residents must seek out training opportunities on their own, and in 10% it is not available at all.[14]

While individual religious affiliation does correlate with intention to perform abortions after residency, choice of faith-based versus non–faith-based training program does not.[15] Furthermore, the majority of those who opt out of abortion training want to be able to provide contraception care, sterilization, and uterine evacuation procedures for miscarriage.[9,16,17] It is important for residents to understand that if they choose a faith-based program with restrictive policies, they may miss out on more than abortion training.

Benefits of Comprehensive Training

Ample evidence indicates that comprehensive family planning training in residency improves skills and patient-centered care. Studies have shown that residents who train at programs with integrated family planning training have greater experience and competence in contraception counseling, pregnancy decision counseling, contraception skills, first trimester and second trimester ultrasound skills, uterine evacuation techniques (applicable to miscarriage as well as abortion), management of analgesia and anesthesia during outpatient surgical procedures, and postabortion care.[16,18,19] Studies have shown that even residents who opt out of abortion training, but spend time in a family planning clinic, benefit in all the ways described here, including learning uterine evacuation skills for management of pregnancy loss; the residents also rate the rotations highly.[16,20,21]

Innovation From Within

As described by Guiahi et al, some obstetrics and gynecology residency programs at Catholic hospitals work to ensure competence in these skills through didactics, experiences with tubal ligation after cesarean section for women with medical problems, and progestin IUD placement for women with noncontraceptive indications. Some programs also offer opportunities for off-site training. As the graduates reported in the study by Guiahi and colleagues, these strategies alone may not be sufficient.

Innovative programs have been created to improve the training quality in faith-based training programs. For example, Teaching Everything About Contraceptive Health, a 1-day educational program that includes simulation, has reported improved knowledge among residents.[22] Additionally, we were excited to see an abstract by Fennimore,[23] presented at the 2017 CREOG & APGO annual meeting, which described a collaboration between St Joseph Hospital (a Catholic hospital–based residency program) and the University of Colorado to provide routine family planning training for St Joseph residents.

We hope that faith-based hospitals with restrictive family planning policies continue to create solutions to guarantee adequate training of graduates. Programs should integrate existing, evidence-based, online resources into training, such as those available from Innovating Education in Reproductive Health (IERH), Training in Early Abortion for Comprehensive Healthcare (TEACH), Physicians for Reproductive Health, and others.[24–26] They might consider using the IERH or TEACH simulation resources for procedural skills training and require didactic curricular content on all sites to ensure competence in medical knowledge. Best practices specific to residency programs at restrictive

religious hospitals should be developed to help program directors meet ACGME requirements while respecting institutional policies.

Additionally, obstetrics and gynecology leaders, faculty, residents, and students in these programs should advocate for high-quality, patient-centered care that respects patients' rights and autonomy. These efforts would ensure not only that women cared for in these hospitals receive high-quality care but also that women for whom their graduates provide care in the future receive the best care.

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