Reproductive Health Care in Catholic Facilities
A Scoping Review

Nichole B. Thorne, BS, Taylor K. Soderborg, BA, Jacqueline J. Glover, PhD, Lilian Hoffecker, PhD, MLS, and Maryam Guiahi, MD, MS:

OBJECTIVE: Given the rise in Catholic ownership of U.S. health care facilities, we aimed to examine reproductive health care provision and patient outcomes. We performed a scoping review, which maps the literature and considers inclusion of studies that are not specifically quantitative.

DATA SOURCES: We searched five databases (MEDLINE, EMBASE, Web of Science and Cochrane Library, ClinicalTrials.gov) from inception through August 2018 using terms related to reproductive health care and religion.

METHODS OF STUDY SELECTION: We screened 2,906 studies. Articles were included if in English, included primary research data, and referenced U.S.-based Catholic facilities. We reviewed the reference lists of included articles. We excluded articles that addressed the relationship of patient or health care provider religion to provision of reproductive services, described reproductive health care services in non-Catholic facilities, or reported legal cases or concerns. Two independent reviewers screened all citations, a third reviewer resolved differences, and all three reviewers categorized included citations.

TABULATION, INTEGRATION, AND RESULTS: We included 27 studies. Investigators most commonly focused on the provision of emergency contraception (n = 9) or other contraceptive and sterilization methods (n = 7); few focused on a range of family planning methods (n = 3), natural family planning (n = 2), ectopic pregnancy management (n = 2), abortion care (n = 2), miscarriage management (n = 1), and infertility care (n = 1). The most common study designs were cross-sectional (18/27 [67%]) and qualitative investigations (6/27 [22%]). Common data collection approaches included surveys, interviews, and mystery caller designs. Two studies involved authors with Catholic hospital affiliations and one of these reported patient outcomes; no other patient outcome reports were found. Studies cited restrictions to care in comparison with non-Catholic settings and multisite studies demonstrated variable rates of provision of reproductive health services across Catholic sites.

CONCLUSIONS: Despite the significant proportion and recent growth of Catholic health care within the U.S. health care sector, little is known about reproductive health outcomes in these settings and in comparison with other settings.

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Many women receive care within Catholic health care facilities; in 2016, 14.5% of U.S. hospitals were Catholic-owned, accounting for one in six acute hospital beds,1,2 and 349 of the 654 Catholic hospitals had obstetric services, accounting for more than 529,000 deliveries.2 Health care providers at Catholic facilities are expected to adhere to the Ethical and Religious Directives for Catholic Health Care Services (hereafter referred to as “the directives”),3 These directives emphasize the sanctity of marriage between a man and a woman, allude to the moral imperative that intercourse involve both “love-giving” and “life-giving” intentions,4 and state their commitment to...
human life beginning at conception. Thus, family planning methods cannot inhibit the “life-giving” aspect and infertility techniques cannot inhibit the “love-giving” aspect of the marriage or sex act. Reproductive health care provision is acceptable only to treat other medical conditions according to the “double effect principle” (eg, noncontraceptive benefits).

Recent attention has been paid to how religious restrictions affect patient care. In this review, our primary outcome was to understand reproductive health care provision in Catholic facilities. Secondly, we aimed to understand the contexts in which provision occurs and patient outcomes. We conducted a scoping review, rather than a systematic review, because it provides a means to mapping the literature with respect to a broad question. Specifically, it provides the opportunity to include studies that are not specifically quantitative (eg, qualitative) or based on a rigid set of a priori factors, recognizing that any well-designed research studies are potential sources of credible evidence.

**SOURCES**

We used the methodologic framework for scoping reviews as outlined by the Joanna Briggs Institute, Arksey and O’Malley, and Levac et al. Our specific protocol was developed by the research team, which includes three clinicians (N.B.T., T.K.S., M.G.), a research librarian who has experience with systematic reviews (L.H.), and a bioethicist (J.J.G.). The Colorado multiple institutional review board deemed this project to be nonhuman subjects research, because it did not require obtaining information about living individuals.

We performed the initial search in November 2017 using four online databases: MEDLINE (Ovid), EMBASE (Embase.com), Web of Science (Clarivate), and the Cochrane Library (Wiley). In August 2018, we performed a final update of these databases and also searched ClinicalTrials.gov. With input from study team members, a research librarian (L.H.) devised the search strategy that included applicable text words, terms, and subject headings related to religion and reproductive health care services (see Box 1 for the full Ovid Medline search strategy). No year limits were applied. After identification of articles that met study inclusion, we reviewed all citations to ensure that we did not miss any other relevant articles.

**STUDY SELECTION**

We searched for articles that focused on the provision of any reproductive health care services within Catholic health care facilities and patient outcomes.

We used the following inclusion criteria: 1) articles must reference Catholic hospital or health care facility affiliation; 2) articles must involve evidence of provision or nonprovision of any reproductive health care service, which includes any type of family planning service (eg, natural family planning, contraception, sterilization, or abortion), miscarriage management, ectopic pregnancy management, and infertility management; 3) articles must include

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**Box 1. Ovid MEDLINE Search Strategy**

2. religious.mp.
3. religion.mp.
4. faith-based.mp.
5. Catholicism/
6. Hospitals, Religious/
7. religion/
8. buddhism/
9. exp christianity/
10. hinduism/
11. islam/
12. judaism/
13. exp *religion and medicine* /
14. or/1–13
15. (Reproductive adj3 health*).mp.
16. contracepti*.mp.
17. (medroxyprogesterone adj acetate).mp.
18. DMPA.mp.
19. miscarriage*.mp.
20. sterilization.mp.
22. abortion*.mp.
23. (family adj1 plan*).mp.
24. (reproductive adj3 medicine).mp.
25. ectopic.mp.
26. (calendar adj1 method*).mp.
27. (creighton adj1 method*).mp.
28. (billings adj1 method*).mp.
29. exp Reproductive Health Services/
30. abortion, induced/
31. exp gynecologic surgical procedures/
32. exp sterilization, reproductive/
33. (medical adj1 control).mp.
34. exp "Contraception"/
35. or/24–34
36. 14 and 35
37. Hospital*.mp.
38. (health adj2 services).mp.
39. (healthcare adj1 service*).mp.
40. (healthcare adj1 system*).mp.
41. (healthcare adj1 system*).mp.
42. exp "Delivery of Health Care"/
43. exp Hospitals/
44. "Health Services Accessibility"/
45. or/37–44
46. 14 and 35 and 45
47. remove duplicates from 46
48. limit 47 to english language
primary research findings, as opposed to editorials, commentaries, or news stories; 4) articles must be in relation to U.S.-based facilities; and 5) articles must be published in English. We excluded articles that addressed the relationship of patient or health care provider religion to provision of reproductive services, described reproductive health care services in non-Catholic facilities, or reported legal cases or concerns.

We uploaded the abstracts and titles of identified studies into the online systematic review software Covidence. To reduce biases related to study selection, two researchers (N.B.T., T.K.S.) independently reviewed each abstract and title for study inclusion. If researchers could not determine the relevance of a study based on review of its title or abstract, the full text was obtained and reviewed. Any discrepancies that occurred between the two researchers about relevance of articles were resolved in consultation with a third reviewer (M.G.). After screening completion, these three investigators independently reviewed potentially relevant full-text articles and then met to reach consensus about final inclusion. We extracted the following variables from included articles: authorship, including whether they were affiliated with a Catholic institution, year of publication, study design, type of reproductive service addressed, study participants, respondent rate, sample size, and main finding.

RESULTS

The flow diagram in Figure 1 shows the search retrieval. We identified 3,910 potential titles and abstracts. After removal of duplicates, news pieces, editorials, commentaries, and studies performed outside of the United States, we uploaded the remaining 2,906 records into Covidence. Screening revealed 40 potential records for which we excluded three that we could not locate the full text and an additional five that did not meet inclusion criteria. One record was identified outside of the database search through citation review. We ultimately deemed 27 articles as appropriate for inclusion, which included 24 full-text articles and three abstracts.


Study participants were primarily physicians (44%)10,11,13,14,16,17,25,26,28–30 (Pereira S. Obstet Gynecol 2017;129:59S) and emergency department staff (26%)12,18–21,23,24. Among the 12 studies that involved physicians, the stated specialties were obstetrics and gynecology (n = 10), family medicine (n = 3), internal medicine (n = 2), and emergency medicine (n = 1). Two of the studies involved investigators that were affiliated with Catholic facilities,13,15 one was of unknown affiliation,14 and the remainder (n = 24 [88.9%]) were investigators affiliated with non-Catholic sites.

Only three studies specifically addressed the provision of natural family planning, the only contraceptive method deemed acceptable by the directives. One survey conducted in 1964 reported that natural family planning was the only method offered at Catholic facilities.26 Another demonstrated that 35.2% of Catholic hospitals provide a natural family planning education program.15 A website review found that 23.1% of Catholic hospitals describe natural family planning as an available method (Kuder M, et al. Obstet Gynecol 2015;125:63S).

Several health care provider reports and surveys demonstrated that many Catholic facilities do not provide family planning methods or are less likely to when compared with non-Catholic facilities, especially with respect to emergency contraception and abortion. A mystery caller survey of 597 Catholic hospitals and 615 non-Catholic hospitals found that
54.9% of Catholic hospitals do not dispense emergency contraception in any cases compared with 42.2% of non-Catholic hospitals. Some highlighted that emergency contraception counseling was permissible in cases of sexual assault; however, this was not always an acceptable exception. Some Catholic institution representatives reported there were policies in place that prohibited discussion of emergency contraception with rape victims.

A national survey demonstrated that less than 2% of Catholic-affiliated obstetrics and gynecology clinics offered abortion. Compared with health care providers in non-Catholic facilities, those in Catholic hospitals were less likely to provide patients with routine abortion referrals than health care providers at non-religiously affiliated hospitals. Health care providers in Catholic facilities also expressed greater difficulty providing referrals for abortion compared with other prohibited services (e.g., tubal ligation); furthermore, some physicians reported hospital authorities actively discouraging referrals and keeping referrals hidden.

Although studies often highlighted that Catholic hospitals did not provide services, many also demonstrated that provision was not completely prohibited. For example, a study conducted in 1975 reported that 60% of U.S. Catholic hospitals offered some form of contraception, most commonly instruction in the rhythm method (38%) followed by the pill (17%).

A more recent study performed between 2014 and 2016 found that 95% of obstetrics and gynecology clinics affiliated with Catholic hospitals offered appointments for birth control and that many were also willing to provide intrauterine device (68%) or tubal ligation (58%) appointments. An analysis of sterilizations using inpatient discharge data demonstrated that 48% of Catholic hospitals had performed this

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**Fig. 1. Flow diagram of study selection.**

Table 1. Study Characteristics

<table>
<thead>
<tr>
<th>Title (Year of Publication)</th>
<th>Author(s)</th>
<th>Study Design</th>
<th>Type of Reproductive Service Addressed</th>
<th>Study Participants</th>
<th>Sample Size</th>
<th>Key Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility control in hospitals with residencies in obstetrics and gynecology: an exploratory study (1966)</td>
<td>Eliot JW, Meier G</td>
<td>Qualitative interviews</td>
<td>Natural family planning</td>
<td>Obstetrics–gynecology physicians</td>
<td>20 Catholic and non-Catholic U.S. hospitals with obstetrics–gynecology residencies</td>
<td>Rhythm method was the only family planning method offered in Catholic facilities</td>
</tr>
<tr>
<td>Survey discloses NFP practices, preferences in U.S. Catholic hospitals (1982)*</td>
<td>Martin CM, Walker WR</td>
<td>Cross-sectional (mailed questionnaire)</td>
<td>Natural family planning</td>
<td>Hospital administrators</td>
<td>79.5% of 633 Catholic hospitals contacted</td>
<td>35.2% provide natural family planning education programs Among Catholic hospital websites, 23.1% describe offering natural family planning and 13% describe offering at least one form of contraception</td>
</tr>
<tr>
<td>Do hospital web sites describe available and institutionally restricted family planning options? (2015)</td>
<td>Kuder M, Sheeder J, Guiahi M</td>
<td>Cross-sectional (website review)</td>
<td>Natural family planning, contraception</td>
<td>Hospital websites</td>
<td>39 Catholic hospitals, 39 nonaffiliated hospitals</td>
<td>12-mo repeat pregnancy rates were lower when immediate postpartum injectable contraception was available vs after an institutional restriction was reinforced (OR 0.27, 95% CI 0.10–0.2)</td>
</tr>
<tr>
<td>Changing depot medroxyprogesterone acetate access at a faith-based institution (2011)*</td>
<td>Guiahi M, McNulty M, Garbe G, Edwards S, Kenton K</td>
<td>Historical cohort study</td>
<td>Contraception</td>
<td>Postpartum patients</td>
<td>258 patients within a Catholic hospital</td>
<td>64% prescribed combined hormone pills</td>
</tr>
<tr>
<td>Combined hormone pills: physician practice patterns in two Catholic affiliated community hospitals (2017)</td>
<td>Pereira S</td>
<td>Cross-sectional (mailed questionnaire)</td>
<td>Contraception</td>
<td>Internal medicine, obstetrics–gynecology, family medicine physicians</td>
<td>45 physicians at Catholic-affiliated hospitals</td>
<td>60% offer contraception; rhythm method most common; 20% permit medically indicated sterilization</td>
</tr>
<tr>
<td>Sterilization and contraceptive services in Catholic hospitals (1979)</td>
<td>O’Lane JM</td>
<td>Cross-sectional survey (mailed questionnaire)</td>
<td>Contraception, sterilization</td>
<td>Obstetrics–gynecology physicians</td>
<td>56.7% of 598 Catholic hospitals contacted</td>
<td>60% offer contraception; 38% provide instruction on the rhythm method, 17% provide the pill, 10% provide the diaphragm, 7% provide the IUD, 12% provide all methods, 20% provide sterilizations</td>
</tr>
<tr>
<td>Six in 10 U.S. Catholic hospitals provide family planning: one in five offers medical sterilization (1979)</td>
<td>Anonymous</td>
<td>Cross-sectional (mailed questionnaire)</td>
<td>Contraception, sterilization</td>
<td>Obstetrics–gynecology physicians</td>
<td>57.7% of 589 Catholic hospitals contacted</td>
<td>(continued)</td>
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Table 1. Study Characteristics (continued)

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<tbody>
<tr>
<td>Divergent practices among Catholic hospitals in provision of direct sterilization (2013)</td>
<td>Hapenney S</td>
<td>Retrospective review of discharge data</td>
<td>Sterilization</td>
<td>Hospital discharge data</td>
<td>1,734 hospitals, including 239 Catholic hospitals, 176 of which provided obstetrics services</td>
<td>48% of Catholic hospitals provided direct sterilization</td>
</tr>
<tr>
<td>Emergency contraception and Catholic hospitals (1999)</td>
<td>Bucar L, Nolan D</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>589 Catholic hospital emergency departments</td>
<td>482/589 (82%) did not provide emergency contraception, even for rape</td>
</tr>
<tr>
<td>Informed consent for emergency contraception: variability in hospital care of rape victims (2000)</td>
<td>Smugar SS, Spina BJ, Merz JF</td>
<td>Cross-sectional (telephone survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>74% of 58 large urban hospitals contacted; includes 70% of 40 contacted Catholic hospitals</td>
<td>Some Catholic hospitals have policies that prohibit discussion and prescription of emergency contraception in cases of rape</td>
</tr>
<tr>
<td>Contraceptive emergency: Catholic hospitals overwhelmingly refuse to provide emergency contraception (2003)</td>
<td>Nunn A, Miller K, Lapert H, Ellerton C</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>597 Catholic hospitals</td>
<td>5% provide emergency contraception in any circumstance; 23% provide emergency contraception in rape cases</td>
</tr>
<tr>
<td>Under-use of emergency contraception for victims of sexual assault (2004)</td>
<td>Patel A, Simons R, Piotrowski ZH, Shulman L, Petraitis C</td>
<td>Cross-sectional (telephone survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>75.8% of 165 contacted hospitals; 73.9% of 23 contacted Catholic hospitals</td>
<td>Decreased emergency contraception counseling in Catholic vs non-Catholic facilities (5.9% vs 47.2%, P&lt;.003)</td>
</tr>
<tr>
<td>Emergency contraception in emergency departments in Oregon, 2003 (2005)</td>
<td>Rosenberg KD, Demunter JK, Liu J</td>
<td>Cross-sectional (telephone survey)</td>
<td>Emergency contraception</td>
<td>Obstetrics–gynecology physicians in emergency departments</td>
<td>94.7% of 57 emergency departments contacted</td>
<td>Decreased emergency contraception provision in Catholic vs non-Catholic facilities (36.4% vs 63.6%, P=.05); Catholic and non-Catholic hospitals were equally likely to provide emergency contraception in cases of rape</td>
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<tr>
<td>Availability of emergency contraception in Massachusetts emergency departments (2005)</td>
<td>Temin E, Coles T, Feldman JA, Mehta SD</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>86% of 288 nurses contacted, 3.5% of 288 physicians contacted, 10.4% of 288 clerks contacted, within 72 emergency departments, 9 of which are located in Catholic hospitals</td>
<td>Decreased emergency contraception provision for patients in Catholic vs non-Catholic facilities in multiple scenarios (11% vs 83%, P=.001)</td>
</tr>
<tr>
<td>Accessibility of emergency contraception in California’s Catholic hospitals (2005)</td>
<td>Polis C, Schaffer K, Harrison T</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>44 Catholic hospitals</td>
<td>66% did not provide emergency contraception in Catholic facilities less likely to provide emergency contraception for any reason (54.9%) compared to non-Catholic facilities (42.2%), P value not reported.</td>
</tr>
<tr>
<td>Availability of emergency contraception: a survey of hospital emergency department staff (2005)</td>
<td>Harrison T</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Emergency contraception</td>
<td>Emergency department staff</td>
<td>597/597 Catholic hospitals, 615/628 non-Catholic hospitals responded</td>
<td>Decreased emergency contraception provision in Catholic vs non-Catholic facilities in multiple scenarios (10.4% vs 41.7%, P&lt;.05)</td>
</tr>
<tr>
<td>Hospital religious affiliation and emergency contraceptive prescribing practices (2006)</td>
<td>Rubin SE, Grumet S, Prime L</td>
<td>Cross-sectional (written survey)</td>
<td>Emergency contraception</td>
<td>Family medicine physicians</td>
<td>81% of 93 nonreligiously affiliated physicians, 95% of 80 religiously affiliated physicians</td>
<td>Decreased emergency contraception provision in Catholic vs non-Catholic facilities due to affiliations between Catholic and non-Catholic institutions; provision of abortion was most likely to be discontinued after mergers</td>
</tr>
<tr>
<td>The implications of affiliations between Catholic and non-Catholic health care organizations for availability of reproductive health services (1999)</td>
<td>Weisman CS, Khoury AL, Cassirer C, Sharpe VA, Morlock LL</td>
<td>Retrospective review of case studies</td>
<td>Variety of family planning methods</td>
<td>Case studies</td>
<td>4 case studies</td>
<td>Contraception availability, sterilization, and fertility treatment did not change as a result of affiliations between Catholic and non-Catholic institutions; provision of abortion was most likely to be discontinued after mergers</td>
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<td>Title (Year of Publication)</td>
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<tr>
<td>Impact of Catholic hospital affiliation during obstetrics and gynecology residency on the provision of family planning (2017)</td>
<td>Guiahi M, Hoover J, Swartz M, Teal S</td>
<td>Qualitative interviews</td>
<td>Variety of family planning methods</td>
<td>Obstetrics-gynecology physicians</td>
<td>48.3% of 31 physicians who trained at Catholic-affiliated residency programs</td>
<td>Former resident physicians reported dissatisfaction with family planning training and delayed competency in this area</td>
</tr>
<tr>
<td>What are women told when requesting family planning services at clinics associated with Catholic hospitals? A mystery caller study (2017)</td>
<td>Guiahi M, Teal SB, Swartz M, Huynh S, Schiller G, Sheeder J</td>
<td>Cross-sectional (mystery caller survey)</td>
<td>Variety of family planning methods</td>
<td>Obstetrics-gynecology patient care coordinators</td>
<td>144 Catholic-affiliated clinics</td>
<td>95% offered appointments for birth control; 68% for copper IUD, 58% for tubal ligation; 2% for abortion</td>
</tr>
<tr>
<td>Do religious restrictions influence ectopic pregnancy management? A national qualitative study (2011)</td>
<td>Foster AM, Dennis A, Smith F</td>
<td>Qualitative interviews</td>
<td>Ectopic pregnancy</td>
<td>Obstetrics-gynecology and emergency physicians</td>
<td>24 physicians including 18 physicians from 13 Catholic sites</td>
<td>Three Catholic facilities do not offer methotrexate; unnecessary testing was required to document nonviability before treating ectopic pregnancies</td>
</tr>
<tr>
<td>Obstetrician–gynecologists, religious institutions, and conflicts regarding patient-care policies (2012)</td>
<td>Stulberg DB, Dude AM, Dahlquist I, Curlin FA</td>
<td>Cross-sectional (mailed questionnaire)</td>
<td>Ectopic pregnancy</td>
<td>Obstetrics-gynecology physicians</td>
<td>66% of 1,800 surveys sent; 13% from Catholic-affiliated institutions, 9% from other religiously affiliated institutions, 78% from nonreligiously affiliated institutions</td>
<td>52% of physicians at Catholic institutions report conflicts with their institutions based on religiously based policies (aOR 8.7, 95% CI 1.7–46.2)</td>
</tr>
<tr>
<td>Referrals for services prohibited in Catholic health care facilities (2016)</td>
<td>Stulberg DB, Jackson RA, Freedman LR</td>
<td>Qualitative interviews</td>
<td>Abortion</td>
<td>Obstetrics-gynecology physicians</td>
<td>27 physicians who currently work or previously worked in Catholic facilities</td>
<td>Within Catholic facilities, hospital authorities actively discouraged abortion referrals, referrals were sometimes hidden by health care providers</td>
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(continued)
service with variable rates across institutions.\textsuperscript{32} Several qualitative investigations highlighted the use of “workarounds” or other strategies to provide services that were generally otherwise prohibited.\textsuperscript{25,27,29} With respect to mergers between Catholic institutions and nonreligiously affiliated institutions, a 1999 report cited that abortion services were usually limited after mergers, but that continued access to other reproductive services generally occurred.\textsuperscript{33}

Surveys and qualitative studies demonstrated that physicians often reported conflict with their hospitals’ policies.\textsuperscript{16,25,27–30} Many voiced concerns over how restrictions limited effective care in relation to ectopic pregnancy management,\textsuperscript{16,28} provision of tubal ligations for medically complicated patients,\textsuperscript{25} and miscarriage management.\textsuperscript{30} Obstetrics and gynecology graduates from residency programs at Catholic hospitals reported dissatisfaction with their family planning training based on restrictions to service provision and cited the inability to perform several family planning procedures on graduation despite expectations to achieve competency.\textsuperscript{27}

**DISCUSSION**

We set out to elucidate whether reproductive health care services are provided in Catholic settings and, if so, in what contexts. Most studies highlighted limited provision of reproductive services, reflecting adherence to the directives. Multisite studies also highlighted that rates of provision varied, especially by type of service, reflecting nonadherence to the directives. A limited number compared access to non-Catholic settings and often found that access to reproductive services at non-Catholic facilities was not ubiquitous. Because additional barriers to reproductive health care service provision exist, future studies should provide direct comparisons to elicit confounding factors.
The most common study designs included cross-sectional and qualitative investigations often using surveys, interviews, and "mystery caller" approaches. These approaches provide insights about actual implementation of reproductive provision rather than echoing stated policies. A comprehensive understanding of service provision, however, is lacking. Few studies commented on the provision of contraceptive methods that require onsite administration (eg, intrauterine devices), which is a potential barrier to provision in Catholic-owned facilities.22,31 One historical cohort study from a Catholic hospital found that after a restriction to the provision of injectable contraception during the immediate postpartum period occurred, 12-month rates of short interval pregnancies increased, particularly for young minority women.31 More research is needed to understand whether religious restrictions disproportionately affect marginalized groups, particularly those in conflict with the views of the Church (eg, same-sex couples, transgendered individuals, gestational surrogates).

Despite the significant contributions that Catholic facilities play within the U.S. health care system, we found a relatively low number of studies relevant to our broad topic (n=27). A minority of researchers (n=2) were from within Catholic health care settings,15,31 used data derived from Catholic health care settings (n=2),31,32 and reported patient outcomes (n=1).31 Many reasons may exist for this paucity of data. First, some may agree with the restrictions and find any comparison with care within non-Catholic settings to be morally irrelevant. Researchers within these institutions may experience or worry about employment violations if their research exposes any forms of nonadherence to the directives or demonstrates poor health outcomes compared with non-Catholic settings. Investigators from both within and outside of these institutions may have trouble gaining approvals based on institutional priorities; a prior study related to Catholic health care reported that the investigators were unable to gain approval for survey dissemination within a Catholic hospital.34 Such concerns or rejections highlight an ethical conundrum; how can the effect of religious restrictions on health care be understood if barriers to studying these implications exist?

This scoping review provides insight about reproductive health care provision within Catholic health care institutions and identifies knowledge and research gaps. Our review did not include individual physician characteristics and behaviors, which may be a contributing factor to who works or chooses to work in a Catholic facility and their associated practices. It is also possible that the available literature is biased in nature based on the small number of reports, that most of the empirical findings were based on subjective measures (eg, interviews) susceptible to several biases (eg, respondent), and that 10 of the reports (37%) were authored by one of three authors (Freedman, Guiahi, Stulberg). There also are potential biases with respect to articles we were unable to locate. Because we wanted to focus on provision of reproductive health care and related outcomes, we intentionally did not include reports of legal cases or concerns. We recognize that this omission leaves out concerns that have been expressed by both proponents and opponents of religious institutional health care.

Reproductive services are integral to the emotional and physical well-being of women and have vast effects on a woman’s physical and economic well-being.35,36 As Catholic health care services continue and expand within the U.S. health care market, so does the need for a better understanding of patient outcomes. Although many may assume that institutional restrictions cause harm, our current understanding demonstrates that the landscape of provision is wide-ranging and complex in nature. A better understanding of how specific medical restrictions affect patients will provide a clearer understanding of how the medical community should consider these institutional religious restrictions and satisfy the majority of U.S. women who want information about religious health care restrictions.37 A deeper understanding of the ethical implications on the patient–physician relationship can also inform whether protections are needed for patients and health care providers. In providing a more nuanced understanding of this intersection of medicine and religion, stakeholders charged with informing and enforcing the directives may better understand the implications of these restrictions and ensure ethical medical care.

REFERENCES


10. Six in 10 U.S. Catholic hospitals provide family planning; one in five offers medical sterilization. Fam Plann Perspect 1979;11:308–9.


PEER REVIEW HISTORY

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