Now, She's Speaking Out

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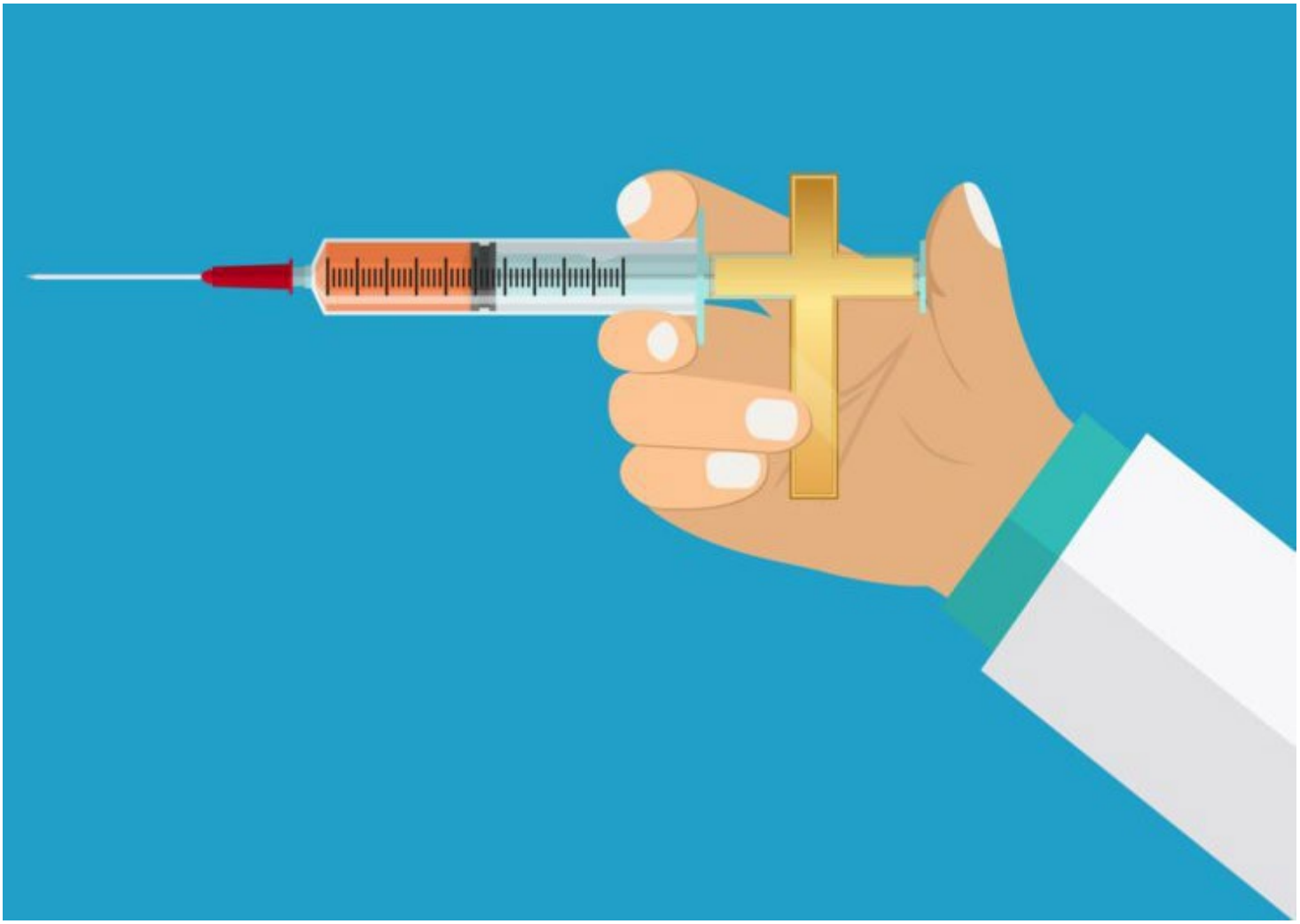

Nationwide, Catholic directives govern one in six acute-care hospital beds; Wisconsin is one of five states where that rate is more than 40 percent.

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Dr. Jessika Ralph was waiting for her patient to get sick.

So Ralph's team trimmed the umbilical cord from the miscarried twin as short as possible to minimize the infection risk, and waited overnight.

After about 10 hours, the patient's temperature soared to 102 or 103 degrees, Ralph recalled in an interview with *Rewire* in June, a few months after the incident. Ralph and her team gave the patient medication to induce labor. But Ralph could not administer mifepristone, which the American College of Obstetricians and Gynecologists (ACOG) considers part of the most effective drug regimen for such cases. The Catholic hospital didn't carry the drug, which is commonly used for medication abortions—a failure Ralph believes was religiously motivated and needlessly prolonged her patient's labor.

At first, the patient's goals seemed to align with the hospital's rules, Ralph said: She wanted to try to continue her pregnancy to a viable gestation, even though the chances were slim. But as she rapidly sickened, she and her family pleaded with Ralph to speed up the process of ending her pregnancy. Ralph felt powerless. The fastest, safest method for terminating a second-trimester pregnancy—a surgical procedure called dilation and evacuation (D and E)—was not offered at St. Joseph, where no supervising physicians were capable of performing the common abortion

procedure, Ralph said.

For more than 24 hours, the patient labored through painful contractions. She bled heavily, requiring at least one blood transfusion. Her lips and face lost their color. Finally, she delivered a fetus that had no hope of survival.

If the patient had gone to Froedtert Hospital, about five miles away, she would likely have been offered the option of a surgical abortion or induction, without having to get sick first. If she had chosen induction, she could have received mifepristone.

The patient survived her ordeal. Due to medical privacy laws, *Rewire* could not contact her, but we confirmed Ralph's account of the hospital's policies with fellow residents and experts who said such constraints are typical for the growing number of hospitals nationwide that follow directives written by the U.S. Conference of Catholic Bishops. These rules restrict access to contraception, sterilization, abortion, and end-of-life care, although how they apply can vary based on the hospital, doctor, and even the local Catholic bishop who oversees compliance with the directives. Providers have cited these rules to deny transition-related surgery to transgender patients, emergency contraception to rape victims, and abortion care to patients in the potentially life-threatening process of losing their pregnancies, like the woman Ralph treated.

A combination of factors are now giving Catholic hospitals unprecedented power over U.S. health care. Recent decisions by the U.S. Supreme Court and President Donald Trump are poised to hand Catholic hospitals almost unfettered leeway to impose religious doctrine on patients and their own employees. And the reach of these hospitals is expanding. Nationwide, the directives govern one in six acute-care hospital beds; Wisconsin is one of five states where that rate is more than 40 percent.

To get a sense of how profoundly the Catholic directives shape access to reproductive health care, *Rewire* interviewed doctors who rotated through three Milwaukee hospitals as part of a four-year OB-GYN residency at the Medical College of Wisconsin (MCW). Two of the hospitals, St. Joseph and Columbia St. Mary's, are run by Ascension Health, the largest Catholic health system in the world and largest nonprofit health system in the United States. Ascension declined to respond to a detailed list of questions for this article, including the concern that its hospitals' policies put patients at risk.

The third hospital where the residents worked, Froedtert, is not Catholic.

Dr. Jessika Ralph (Amy Littlefield/Rewire)

This situation put doctors like Ralph, who completed her residency in June, on the front lines of one of the most contentious areas of U.S. health care—the role of religion in medicine. Ralph and her colleagues saw firsthand how, even within the same city, a patient's care could vary dramatically depending on whether she happened to wind up in a Catholic hospital or not. And in one of the country's most segregated cities, the residents said, the impact of these religious restrictions often fell most heavily on low-income patients of color. St. Joseph, which is located in a mostly Black neighborhood, and the other Catholic hospital, St. Mary's, both see a higher share of Medicaid patients—and spend a significantly higher percentage of time caring for Medicaid patients—than Froedtert, according to data from Definitive Healthcare.

Ralph and the other residents interviewed by *Rewire* found ways to serve patients as best they could, while staying within religious rules that sometimes forced them to go against accepted medical standards. For Ralph, who trained medical students and fellow residents, an important part of that work was speaking out against the Catholic directives. She admonished her trainees to provide mifepristone when inducing labor at any hospital that allowed it, for example.

"I teach all of my residents, I teach all of the medical students, this is not the standard of care," Ralph told *Rewire*, slamming her hand on the table to punctuate her words. "I tell them, at Froedtert, you better be giving them mifepristone. I will be very disappointed in you if you do not, and anywhere that you go, you better be giving them mifepristone, because we know that it makes this process safer."

"I Was So Worried That She Would Never Trust a Doctor Again"

In less than 1 percent of pregnancies, a patient's water breaks before the fetus is viable. When this happens, ACOG recommends patients be counseled about the risks of trying to continue the pregnancy versus ending it immediately.

"Immediate delivery should be offered," the ACOG bulletin states.

That's what happens at Froedtert Hospital, where patients are counseled about the risks and benefits of all options, including remaining pregnant, according to Dr. Kate Dielentheis, an OB-GYN who works there.

"My strong medical recommendation is that in a previable, preterm rupture of membranes, or premature rupture of membranes, it is not safe to stay pregnant, because of the infection risk and the risk that mom can get very, very, very sick," Dielentheis, an assistant professor at MCW, told *Rewire* in a phone interview.

But patients at Catholic hospitals often have no choice but to run that risk if the fetus has a heartbeat.

In rare instances, the consequences of maintaining a pregnancy under these circumstances can be fatal, as in the case of Savita Halappanavar, who died of septicemia in 2012. Halappanavar had sought care while in the process of losing her pregnancy at a hospital in Ireland, where abortion is illegal in most cases. The hospital denied her an abortion; one practitioner told her Ireland was a "Catholic country."

In the United States in 2010, a Catholic hospital in Michigan sent Tamesha Means home twice after her water broke at 18 weeks. When she returned a third time with an infection, the hospital prepared to send her home again, treating her only after she began to deliver, according to the American Civil Liberties Union, which sued the hospital and the U.S. Conference of Catholic Bishops on her behalf. Means survived.

Residents like Ralph may face less extreme versions of this scenario a few times a year.

"You're in this limbo of knowing that the right thing to do is to induce her labor because she is going to get sick. And when we say sick, I mean, it's not common but they can die, they can become septic and die from something that we could treat and prevent and never have them get ill," Ralph said. "How do you tell this patient, in good conscience, 'I'm waiting for you to get sick?'"

The Catholic directives forbid abortion, but allow procedures aimed at alleviating a serious risk to the pregnant person, even if they also happen to end the pregnancy.

But how this rule applies in practice—how sick a patient must get before she can be treated, and what that treatment entails—can vary, even within the same hospital.

In a case from a few years ago that still troubles her, Ralph was ordered to send a young patient home from St. Joseph after her water broke at 18 or 19 weeks. Typically, doctors would keep patients like her under observation for 24 hours, but the attending physician overseeing Ralph was concerned about the financial cost of keeping her, particularly since little could be done to help the patient due to the directives. So the attending told Ralph to discharge her after several hours.

The patient, still reeling from the news that she was likely to lose her pregnancy, was furious and frightened. She couldn't understand why the hospital was sending her home if she was at risk of infection, Ralph recalled.

"I had to be the one to go in and say, 'I have to send you home,' even though it's not what I wanted to do … and explain to her, essentially, come back when you're really sick, and then we can take care of you," Ralph said. "I was so worried that she would never trust a doctor again."

Before sending her home, Ralph told the patient she would have more treatment options at Froedtert Hospital. She was careful not to document that advice in the patient's medical record, for fear of ruffling feathers at St. Joseph. The patient checked into Froedtert the next day, Ralph learned.

Sometimes, the residents would help patients get care at Froedtert if they were in the process of losing their pregnancies and wanted a D and E or a prompt induction. If a patient was under the care of certain attending physicians who opposed abortion, residents knew such referrals were off limits.

Even at Froedtert, terminating a pregnancy was not always seamless. Some doctors and staff who opposed abortion refused to take part in D and Es, which could stall surgeries. Froedtert does not perform abortions unless two doctors attest that there is a lethal fetal anomaly or significant risk to the patient. Unlike the Catholic hospitals, however, Froedtert deems it a sufficient risk if a patient's water breaks before viability, even without an infection.

Spokespeople for Froedtert and MCW declined to comment for this story. Dielentheis, the OB-GYN who works there, confirmed the hospital's policies on abortion and said that in her

experience, enough doctors there are willing to perform D and Es that moral objections by other physicians do not delay care.

At the Catholic hospitals, residents felt they were forced to place an implicit moral condemnation on patients.

"Even if you're not personally putting a judgment on them, that kind of comes with an inherent judgment. You know, like, I'm not saying what you're doing is wrong, but I can't do it here, because it violates the Bible," Dr. Sarah Krueger, who finished her MCW residency alongside Ralph, told *Rewire*. "Even if you don't feel that same way, your patients kind of feel like you're judging them."

"It Feels Like I'm Letting Them Down"

Dr. Molly Isola, who is due to finish her MCW residency next year, grew frustrated with a note she saw repeatedly in her patients' medical records.

"I've seen more than one patient who, in her notes, it will say, 'wanted a tubal ligation last time but couldn't get it where she delivered,' and now she's pregnant again," Isola told *Rewire* in a phone interview.

These were patients who delivered babies via cesarean section and wanted to have their "tubes tied" at the same time, a common practice that obviates the risk and cost of a second surgery. But under the Catholic directives, Columbia St. Mary's hospital forbids tubal ligations under any circumstances.

"I just don't feel that it's ethical to require someone to have a second surgery that isn't necessary," Isola said. "It could all be done at once."

Isola would offer to refer her patients to another hospital that allowed tubal ligations, but some chose to deliver at St. Mary's anyway, either because they had done so before, or because, like many patients at the hospital, they spoke Spanish, and wanted a midwife from the bilingual clinic that partners with St. Mary's.

At St. Joseph, tubal ligations were allowed only during a c-section, following approval by an ethics committee that considered factors like prior c-sections and medical conditions that could make pregnancy dangerous. Krueger, for example, applied for a tubal ligation for a patient who

was pregnant with twins and had more than five children, but because all of the patient's previous deliveries were vaginal and she was relatively healthy, the request was denied. Some fear the policy could become even stricter after Ascension, which already owned St. Mary's, acquired St. Joseph, and other Wheaton Franciscan hospitals in the area, last year.

Krueger also found herself frustrated with the contraceptive policies at St. Joseph, where the residents' clinic didn't stock long-acting reversible contraceptives like intra-uterine devices (IUDs). In yet another sign of the inconsistency of such restrictions, the residents' clinic at St. Mary's did stock some of these methods.

In segregated Milwaukee, St. Joseph sits in a low-income, predominantly Black area. It wasn't uncommon for Krueger's patients to take three buses or walk dozens of blocks to reach St. Joseph for medical care. Often, their pregnancies were complicated by consequences of poverty and racism—poor access to nutritional foods, which can fuel health conditions like diabetes; exploitative jobs that didn't afford time off for medical appointments; or unstable housing.

For these patients, adding an additional barrier, like sending them elsewhere for another medical appointment, often meant they just never got the care they wanted.

One patient became pregnant again only to lose her fetus in the second trimester, an ordeal that Krueger believes could have been avoided if the patient had been able to get an IUD at her postpartum visit.

"It feels like I'm letting them down," Krueger told *Rewire*. "These patients have had negative interactions with health-care providers before and so they come in jaded and guarded and not trusting and you build this really awesome, awesome relationship with them, but then at the end, that's something that they really need … it impacts their life forever. And I can't give that to them."

While Krueger and her colleagues received relatively comprehensive reproductive health-care training at Froedtert, some residents aren't so lucky. About 13 percent of OB-GYN residency programs in the United States are at faith-based institutions with restrictive policies on family planning, according to Maryam Guiahi, an assistant professor at the University of Colorado School of Medicine.

Graduates of these programs often report being unable to provide basic services like IUD insertions and tubal ligations, instead relying on colleagues or even watching YouTube videos to

compensate for their lack of training, Guiahi wrote in a recent article for the *Journal of Graduate Medical Education*.

Ultimately, that means patients can suffer from delays and inadequate counseling, even in secular facilities, if their doctor was trained in a Catholic institution.

As for the residents *Rewire* interviewed, an important lesson they learned was to avoid institutions with religious restrictions on health care. Both Ralph and Krueger have accepted positions where they can provide care without these barriers, and Isola said she asks potential employers about them.

"I haven't just ruled out [working for] Catholic hospitals as a rule, but the things that I want don't seem compatible with most if not all" of these hospitals, Isola said.

"But they're everywhere," she added resignedly.

Tell us your story. Have religious restrictions affected your ability to access health care? Email stories@rewire.news

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