

[“Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care” \(2013\), by Lois Uttley, Sheila Reynertson, Lorraine Kenny, and Louise Melling](#) ^[1]

By: Cleveland, Claire Keywords: [Catholic Hospitals](#) ^[2] [Reproductive Healthcare](#) ^[3] [ACLU](#) ^[4] [Merger Watch](#) ^[5] [American Civil Liberties Union](#) ^[6]

In 2013, Lois Uttley, Sheila Reynertson, Lorraine Kenny, and Louise Melling published “Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care,” in which they analyzed the growth of Catholic hospitals in the United States from 2001 to 2011 and the impact those hospitals had on reproductive health care. In the US, Catholic hospitals are required to abide by the US Catholic Church’s Ethical Guidelines for Health Care Providers, also called the Directives. The authors of the article argue that the Directives threaten reproductive health because of their limitations on [contraception](#) ^[7], [sterilization](#) ^[8], some [infertility](#) ^[9] treatments, and [abortion](#) ^[10]. The report demonstrated an increase in Catholic hospitals and an associated impact on reproductive health care, which formed the basis for lawsuits the American Civil Liberties Union brought against various Catholic hospitals and health care networks during the early 2000s.

Uttley, Reynertson, Kenny, and Melling coauthored the report in 2013. Uttley and Reynertson worked at Merger Watch, a national consumer health advocacy [organization](#) ^[11], while Kenny and Melling worked at the American Civil Liberties Union, or the ACLU, a nonpartisan nonprofit [organization](#) ^[11] that defends civil liberties in the US. Merger Watch was founded in 1996 in Troy, New York, after secular hospitals merged with religious hospitals in the area. Following the merge, the previously secular hospitals stopped providing contraceptive services at outpatient clinics because the health care policies of the religiously-sponsored partner hospital banned [contraception](#) ^[7]. Uttley was the director of Merger Watch at the time the report was published. Reynertson was Merger Watch’s advocacy coordinator. Kenny worked with Melling and was the associate director for communications and marketing at the ACLU. The American Civil Liberties Union worked in the courts, legislatures, and US communities to defend individual’s constitutional rights and freedoms.

The report is organized into nine sections not including the methodology, appendices, bibliographies and endnotes. The report begins with an introduction section, followed by a section titled “Why We Care” and a “Key Findings” section. The report analyzes the influence, public funding, and services of Catholic hospitals. The final three sections of the report focus on case studies. The authors conclude the report with a “Conclusion and Recommendations” section.

The report begins with an introduction section in which the authors describe the motives for the report and highlight some of their key findings. Uttley, Reynertson, Kenny, and Melling state that hospitals either affiliated with or sponsored by Catholicism are governed by religious restrictions. The Ethical and Religious Directives for Catholic Health Care Services, or the Directives, which the US Conference of Catholic Bishops, or USCCB, issued, is the main governing document. The authors explain that USCCB is a registered corporation based in Washington, DC, composed of both retired and active members of the Catholic hierarchy, and has power in the Catholic community. According to the authors, the Directives prevent health care professionals from providing health care services or allowing patients to choose their care when those treatments conflict with Catholic teaching.

In the next section, titled “Why We Care,” Uttley, Reynertson, Kenny, and Melling further examine the Directives and state that in situations involving reproductive health care, religious doctrine overrides sound medical treatment by prohibiting a range of reproductive health services. Those services include [contraception](#) ^[7], [sterilization](#) ^[8], many [infertility](#) ^[9] treatments, and [abortion](#) ^[10]. The authors then reference twelve Directives and offer them as examples of ways in which women are denied appropriate care. Uttley, Reynertson, Kenny, and Melling illustrate the limitations that the Directives place on reproductive health care. The authors state that some of the Directives prohibit Catholic health institutions from promoting or condoning contraceptives. Other Directives detail that [sterilization](#) ^[8] is not permitted. The authors also state that [infertility](#) ^[9] treatment that uses gametes from at least one donor other than either of the spouses is also banned because it violates the Catholic concept of marriage.

In the section “Key Findings,” the authors analyze the increase in Catholic-affiliated hospitals in the US from 2001 to 2011. The authors focus the report on acute care facilities because they typically have emergency and maternity units. Those units are where Catholic restrictions are more likely to affect patients. The authors explain that the Directives primarily detail appropriate reproductive health care and emergency care. The authors report that in 2016 Catholic acute care hospitals increased by 16 percent, while all other types of non-profit hospitals declined. Similarly, in 2011 about one in nine hospital beds was in a Catholic hospital, and ten of the twenty-five largest health systems in the nation were Catholic-sponsored. In their report, Uttley,

Reynertson, Kenny, and Melling state that the federal government labeled thirty Catholic hospitals as sole community providers, meaning that they were the only health care provider available to the community and thus received higher levels of federal funding. The authors then provide nine key findings which they then break down more thoroughly in the following section.

In the next section titled “In-Depth Look,” the authors evaluate the influence of health systems sponsored by Catholicism based on the data and findings from the previous section. In this section, the authors argue that the growth in Catholic-sponsored systems had a medical impact in local, regional, and national markets. The authors describe the history of Catholic and secular hospital mergers since the 1990s, and focus on the histories of three of the largest Catholic-sponsored systems. Those include Ascension Health, Catholic Health Initiatives, and Catholic Health East, otherwise known as Trinity Health. The authors note that most Catholic hospitals used to be stand-alone facilities but started merging for economic advantages. The financial advantages included enabling facilities to control a greater share of the local market so they could negotiate prices with insurers, saving money through joint purchasing, sharing administrative and billing services, and gaining financial shelter during challenging years. According to the authors, Catholic sponsored and affiliated hospitals also receive billions of taxpayer dollars. Uttley, Reynertson, Kenny, and Melling also report that, in 2011, Catholic hospitals billed the federal government \$115 billion for Medicaid and Medicare, which resulted in a \$27 billion net revenue. To receive federal funds, hospitals must meet conditions set by the government. The authors argue that Catholic hospitals should be investigated to ensure that those conditions are being met.

Uttley, Reynertson, Kenny, and Melling critique one common defense of Catholic hospital health restrictions, which is an emphasis of the hospitals’ mission to serve the poor and provide charity care. They report that, when compared to other types of hospitals, Catholic hospitals provided disproportionately less charity care than public and other religious non-profit hospitals. Another common measure of service to the poor, according to the authors, is the amount of care a hospital provides to low-income patients who have insurance through Medicaid. Medicaid is the US government-subsidized insurance for low-income citizens. Catholic hospitals had the lowest percentage of patient revenue from Medicaid, when compared with other hospital types, meaning that Catholic hospitals were serving less low-income patients than other hospitals.

The “Case Studies” and “A Cautionary Tale” sections, near the end of the report, describe multiple examples and case studies to highlight and contextualize the authors’ findings. The authors illustrate the impact of Catholic health care restrictions in two reports of women that received inadequate care at Catholic hospitals in Arizona and Michigan. The authors describe how in Muskegon, Michigan, in 2010, a pregnant woman named Tamesha Means was not informed of all options for terminating a pregnancy^[12], the likelihood that her fetus^[13] would not survive, or the risks of delaying treatment. Means arrived at a Mercy Health Partners hospital after her water broke and she began having contractions at eighteen weeks of pregnancy^[12]. The hospital staff sent Means home and she returned multiple times over the next two days. On the night of the second day, Means delivered a premature son, who died within hours. She also had infections that developed after her water broke. The authors claim that the hospital unnecessarily put Means’s health at grave risk as a result of the Directives the hospital had to follow. In the following section, “A Cautionary Tale,” Uttley, Reynertson, Kenny, and Melling describe the marketplace advantage of Catholic hospitals in Washington, where twenty-eight percent of acute care hospitals are affiliated with the Catholic church. The percentage was almost three times higher than the national average in 2011. According to the authors, patients served by these hospitals had reduced access to comprehensive reproductive health care.

Uttley, Reynertson, Kenny, and Melling end the report with a “Conclusion and Recommendations” section that contains eight steps that federal and state governments, advocates, health professionals, and patients should take to ameliorate the problems with Catholic hospitals. Overall, the authors outline a mandate stating that medical standards and community needs must be prioritized over religious Directives. The authors go on to say that patients need more protection of their rights and access to necessary reproductive health care that aligns with established protocols for divulging full information about treatment options and the federal Emergency Medical Treatment and Active Labor Act. The authors say that achieving enhanced protections will happen through broad policy reform in which women’s health and rights are respected. The final sections of the report include the methodology, three appendices, bibliography, and endnotes.

The authors wrote “Miscarriage of Medicine” when the number of private for-profit and Catholic non-profit hospitals was growing quickly in the US while the number of all other types of hospitals was decreasing. The ACLU and Merger Watch analyzed the trends in Catholic hospital increases and noted ethically problematic situations for patients. In 2014, the ACLU filed several lawsuits against multiple Catholic hospitals and health care systems that were not providing adequate reproductive health care to patients. The ACLU also advocated to require hospitals to make their policies public, especially those concerning reproductive health care. As of 2018, many of those cases were still in early stages of litigation.

Sources

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