Divergent practices among Catholic hospitals in provision of direct sterilization

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Background: The Ethical and Religious Directives for Catholic Health Catholic Care Services (ERDs) are designed to promote uniform practice of health care in accordance with human and Catholic values. The aim of this study was to determine whether the ERDs are being uniformly interpreted and applied. Directive 53 prohibits the provision of direct sterilization. Hospital data were reviewed to determine whether direct sterilizations on women are being performed within Catholic hospitals and their frequency. A significant diversity of practice regarding sterilization would indicate that the ERDs are not uniformly interpreted and applied by Catholic hospitals in the United States.

Methods: All Catholic hospitals in seven states—California, Illinois, Indiana, New Jersey, New York, Texas, and Washington—were studied to determine whether diversity of practice existed in the provision of direct female sterilization. Inpatient discharge data were requested from the respective departments of health for each state for three years (2007–2009). Data from 1,734 hospitals, secular and Catholic, within the states were procured and analyzed.

Results: Of the hospitals from the seven states, 239 Catholic hospitals were identified of which 176 provided obstetric services. The patient records of these 176 hospitals were searched for those records containing the diagnostic code from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding system for sterilization for contraceptive management. Eighty-five or 48 percent of these hospitals provided a total of 20,073 direct sterilizations in violation of the ERDs. The entire results of the study are available on the website catholichospitals.org.

Conclusion: There is a significant diversity of practice in the provision of direct female sterilization within Catholic hospitals. Such diversity of practice indicates that there is no uniform interpretation or application of the ERDs by Catholic hospitals. Uniformity could be fostered if the ERDs mandated best practices for accountability and made use of the ICD-9-CM codes where possible to monitor actual practices. In the case of direct sterilizations reference to ICD-9-CM codes in the ERDs would minimize subjective criteria in the implementation of the ERDs.

Keywords: Catholic hospitals, female sterilization, tubal ligation, Ethical and Religious Directives

INTRODUCTION

Scholarly journals, press reports, and statements from Church authorities raise questions about the uniformity with which Catholic healthcare providers interpret and adhere to the Church's teaching.¹ Until

recently, it has been difficult to evaluate actual practices of Catholic hospitals because individual patient records are protected by confidentiality laws. Secure techniques for data collection and processing of hospital data evolved within the last two decades which allow research

without compromising patient confidentiality. As a result of this evolution, many state departments of health began rigorous collection and examination of patient data to ensure accountability among providers in the areas of patient management and fiscal responsibility. The data being collected are made available under certain conditions to insurance providers and medical researchers.

By studying patient-level data of Catholic hospitals, the actual practices of the individual hospitals may be revealed. If the data reveal a significant divergence in interpretation and application of Church teaching among Catholic hospitals, this would indicate that, practically speaking, no uniform Catholic practice exists.

This study seeks to determine the uniformity of practice among Catholic facilities based on official Catholic hospital norms. Patient-level inpatient discharge data for three years were requested from seven states. Although there are many diagnoses and medical procedures within the patient records which could be examined for hospital adherence to the Catholic practice as presented in the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) of the U.S. Conference of Catholic Bishops, this research focuses on procedures for direct female sterilization. Direct sterilization is any procedure that induces sterility when no underlying illness or pathology is present; and it is an explicit violation of official Church teaching. The research examines diagnostic and procedural codes for direct sterilization and the frequency of their reported occurrence.

METHODS

Data collection

The patient records collected by the states usually include specific patient information,

admission and discharge dates, charges, and diagnostic and procedures codes. These data files are generally referred to as 'public use data files' because of their availability to medical researchers. The public use files ensure patient confidentiality by eliminating patient name and address, and providing encryption on other identifying characteristics. In most states this process is managed by the department of health of the respective states; however, in some cases, data collection is controlled by the respective hospital association of the state. Generally, the files must be purchased and the fees may be substantial. The National Center for Health Statistics (NCHS) collects inpatient data nationwide, but their files did not contain enough specificity for this study.

It was not possible to obtain data from all fifty states because some states do not collect such data or collect incomplete data, and others do not have a sufficient number of Catholic hospitals to warrant the expenditures. The criteria used to determine which states to include in the study were the number of Catholic hospitals within the state, the availability of usable data from a state, the cost of the data, and geographic dispersion across the U.S. Illinois, Texas, and California were selected because they are the top three states in number of Catholic hospitals. New York was included because of the number of Catholic hospitals and to provide east coast coverage. The other three states, Indiana, Washington, and New Jersey, were chosen because of the number of hospitals, and availability and cost of data. The total number of Catholic hospitals examined within these states represents approximately 37 percent of all Catholic hospitals in the U.S. Each state from which data were collected required data use agreements specifying how the data were to be used, stored, and disposed of. The agreements restricted the

publication to only summary results such that no individual patient records could be released publicly.

Several steps were taken to identify all Catholic hospitals within each state. The first was to use the listing of hospitals belonging to the Catholic Health Association of the United States. Not all Catholic hospitals belong to the association, and therefore *The Official Catholic Directory* editions for 2006, 2009, and 2010 were used to aid in locating additional Catholic hospitals. Also, websites of Catholic healthcare systems were useful in identifying hospitals as were websites of individual hospitals. A total of 239 Catholic hospitals were identified within the seven states.

The study sought to examine three years of data to establish trends. Data were initially obtained for the years 2006 through 2008. When data for 2009 became available, data for that year were also requested. The study focused on the most recent data available (2007–2009). There are two states for which there was an exception. The state of New Jersey completely changed its data formatting in 2008; therefore, only 2008 and 2009 are reviewed. The fees for the state of New York were prohibitive and data were not requested for 2009, so only 2006 through 2008 are reviewed.

Analysis

Each state is unique in the specific data fields collected for each record and the order and layout in which it is stored. Most of the states supplied the files in comma-separated values format; however, fixed-length format was used in two states, and one state, Indiana, extracted the files for the specified hospitals and provided the data in Microsoft Excel. To account for these variances and to allow for

processing of the magnitude of data received (over forty-seven million records), special data mining computer programs were written for importing and analyzing the data. The programs abstracted by hospital those records containing specific diagnostic and procedure codes, and compiled summary tables for each state. To ensure accuracy, the data were reprocessed using a completely different set of programs. Finally, independent analysts from Baylor University reviewed the processes and data outputs, and determined the validity of the findings.

The patient records were coded by the hospitals using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The major diagnostic category labeled V25 is a code defined in the classification as “encounter for contraceptive management.” As a V code, it is not used to indicate any illness. The specific contraceptive management code V25.2 is designated as “sterilization: admission for interruption of fallopian tubes or vas deferens.”² The patient records containing these codes also have a procedural code which indicates the type of procedure used to cause direct sterilization such as 66.32 which indicates “other bilateral ligation and division of fallopian tubes: Pomeroy operation.”³ Additional procedure codes used explicitly to designate bilateral procedures on the fallopian tubes for sterilization are 66.21, 66.22, 66.29, 66.31, and 66.39. The main focus was to capture all records within Catholic hospitals containing the V25.2 code. All of the procedure codes in these records were also captured so that the V25.2 diagnostic codes could be verified by procedure codes as well. It should be noted that it was necessary to eliminate from the study Catholic hospitals that did not offer obstetric services. This was done by selecting only those hospitals which had patient records containing V27 codes which

indicate the outcome of child delivery. The number of women giving birth indicated by V27 was also used to calculate a rate for patients in the hospital for sterilization to women giving birth.

In this study, for each state, a table was constructed presenting by hospital, the name of the hospital, city, and diocese in which it is located, the system to which it is affiliated, the total number of women giving birth, the total number of records with V25.2 codes, and V25.2 codes as a percentage of women giving birth for the period studied. Also, the number of records with V25.2 codes for each year was given. Two additional tables were constructed for each state. One presented the health care systems operating hospitals in the state giving the name of the health system, the number of hospitals included in the study for that system, the number of hospitals reporting sterilization, the religious orders associated with the system, and the diocese of sponsoring religious orders. The last table specified by diocese the number of hospitals included in the study and those reporting V25.2 codes.

RESULTS

This study of 176 Catholic hospitals providing obstetric services located in seven states across the US established and quantified diversity of practice in the performance of inpatient direct sterilization among the hospitals included in the study. Of the 176 hospitals, the study revealed that 48 percent of the hospitals provided sterilization within the time periods studied. A brief summary of the results by state is presented here. All the complete tables by state, system, and diocese may be viewed at catholic hospitals.org.

California had forty-eight acute care, Catholic hospitals whose records contained diagnostic codes for women giving

birth. Thirty-three of the forty-eight hospitals, 69 percent, reported a total of 9,318 direct sterilizations for the three-year period. The largest health system in the state is Catholic Health West which operates twenty-six hospitals with obstetric services. Twenty-one of their hospitals recorded a total of 7,402 direct sterilizations for the three-year period. Illinois has forty-one Catholic, acute care hospitals located in the state. Of these, thirty-seven reported women giving birth. Only five of the hospitals reported incidences of V25.2 codes for a total of 176 sterilizations. While there is diversity of practice among the hospitals, it is noteworthy that only 13.5 percent of the hospitals reported sterilization. Of the hospital systems, the one recording the most sterilizations was the Loyola University Health System operating two hospitals, both of which recorded V25.2 codes.

Of the thirty-four Catholic hospitals in Indiana, twenty-two reported births. Only three of the twenty-two hospitals reported records with V25.2 codes with a total of 166 such codes. All three are affiliated with Ascension Health.

In New Jersey, for the two years examined (2008–2009), eight of the fifteen Catholic hospitals offered obstetric services. Seven of these hospitals (87.5%) had records with the V25.2 codes indicating 867 sterilizations. The two hospital systems operating in New Jersey, Catholic Health East and Catholic Health Initiatives both reported sterilizations as did four independent hospitals. It is noteworthy that the only hospital that did not provide sterilizations is Saint Peter's University Hospital owned by the Diocese of Metuchen.

In New York, twenty-seven Catholic hospitals were identified of which twenty-one provided obstetric services. Of the twenty-one, five (28%) reported a total of 318 sterilizations for the three-year period

of 2006–2008. Catholic Health Services of Long Island, owned by the Diocese of Rockville Centre, has five hospitals of which one reported V25.2 codes. Ascension Health is responsible for four of the hospitals and reported one hospital with V25.2 codes.

In Texas, there were forty-seven Catholic hospitals reporting data, of which twenty-five provided obstetric services. Seventeen of the twenty-five reported V25.2 codes representing 68 percent of the hospitals. There were a total of 5,560 sterilizations for the three-year period. All of the Catholic hospitals in Texas belong to health systems. Two healthcare systems own the majority of the hospitals, CHRISTUS Health with fourteen hospitals and Ascension Health with six hospitals. Nine CHRISTUS hospitals reported sterilizations, and three Ascension Health hospitals reported sterilizations.

In Washington State, seventeen Catholic hospitals were identified, fifteen of which offered obstetric services. All fifteen hospitals (100%) reported V25.2 codes for a total of 3,668 sterilizations. The fifteen Catholic hospitals all belong to Catholic healthcare systems. The largest Catholic system operating in the state is Providence Health and Services with eight hospitals. Catholic Health Initiatives and PeaceHealth have three hospitals each and Ascension Health operates one hospital.

The study demonstrated that diversity of practice exists among Catholic hospitals. This diversity can also be seen within hospitals belonging to common healthcare systems or located within a common diocese. This limited study did not evaluate other medical procedures that violate Catholic ethics, nor did it address outpatient procedures for sterilizations. Both of these areas could be investigated further, and would contribute to a more in depth analysis of diversity of practice in Catholic hospitals.

DISCUSSION

Diversity of practice in the provision of direct sterilizations exists to a great degree as indicated by 48 percent of hospitals investigated which reported providing sterilizations coded as V25.2. Such diversity of practice demonstrates that the ERDs are not consistently interpreted and applied by Catholic hospitals in the US. From its original publication by the US bishops in 1971, the ERDs were updated four times with the latest edition in 2009. They are explicit in their definition and prohibition of direct sterilization.

According to directive 53:

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. (USCCB 2009)

Directive 53 references a document by the Congregation for the Doctrine of the Faith Entitled *Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters* (Sacred Congregation for the Doctrine of the Faith 1975) which explains that if a medical procedure has a directly therapeutic character to curtail a serious present danger to a woman then it may be permitted even if it indirectly results in sterilization. The resulting sterilization is often referred to as an indirect sterilization. In the ICD-9-CM coding system, an existing pathology would be signified by a diagnostic code for the underlying illness and the V25.2 code would not therefore be present in the record. For example, if a woman is admitted for an ectopic pregnancy in the fallopian tube, it might require the removal of the fallopian tube. In this case,

the diagnostic code would be 633.1 and V25.2 would not be present in the record. The V25.2 code always indicates a non-pathology-based request for direct sterilization for contraceptive purposes.

The diversity in the practice of providing direct sterilizations in some Catholic hospitals seems to be due to divergent interpretations of directive 53 since all hospitals assert that they are abiding by the ERDs. Repeated attempts on the part of the US bishops and the Vatican over a period of forty years to bring an end to alternate interpretations points to a broader problem. The ERDs do not establish transparent and accountable mechanisms for oversight (Carey 2011).⁴

Currently, ethics committees are not required to report violations to anyone. A review of their judgments by ecclesial authority is not mandated, and there are no individual review boards to oversee their findings. If a violation is observed by a physician or staff member of a hospital, he or she is not now mandated to report the incident to anyone. In the current state of affairs, if the practitioner makes a formal complaint regarding a specific case to a local bishop, he or she risks violating HIPAA rules.⁵ Given these conditions, in the absence of any independent oversight mechanisms, the ERDs cannot be enforced in a uniform way (Gamble 2011).⁶

Uniformity in interpretation and implementation remain elusive because the ERDs lack best practice methods for establishing transparency and accountability. A point of comparison would be, for example, the mechanism implemented to protect minors from abuse (USCCB 2002). A best practices model would provide for the training of all doctors and staff regarding proper treatments and specific violations, as well as for the mandatory reporting of violations of the ERDs to an independent review board with failure to report incidents leading to

penalties or dismissal. Also, it would require the ethics committee of a hospital to be required to report all violations that come to their attention to an independent review board. The decisions of the ethics committee would also be mandatorily reviewed by an independent board. Another requirement would be that the hospital report their patient diagnostic and procedure codes to an independent review board and ecclesial authorities on a periodic basis. In the specific case of direct sterilization, the use of ICD-9-CM codes within the ERDs would allow objective clinical data to guide the prohibition of sterilization rather than allow the hospital to rely on subjective judgments of ethics committees using divergent moral theologies.

This study clearly reveals that diversity of practice in the implementation of the ERDs exists. It also demonstrates that it is possible to review the practices of most hospitals in the provision of direct sterilization based upon the reporting requirements of hospitals which contain specific ICD-9-CM codes. The problems of interpretation and implementation of the ERDs need to be addressed through the use of best practices for accountability, perhaps including explicit reference to ICD-9-CM codes, so that there may be uniformity of practice by those hospitals which wish to retain their Catholic identity.

ENDNOTES

1. Some examples are Task Force on the Religious and Ethical Directives of the CMA (2005), Carey (2008), Nelson (2009) and Congregation for the Doctrine of the Faith (1993).
2. *Centers for Disease Control and Prevention, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* Atlanta, Georgia, 2010.
3. Ibid.

4. Ann Carey reported on the fact that many hospital ethics committees are not current on the teachings of the Catholic Church and that there are no uniform standards for membership on such committees. She summarized a survey done by the CHAUSA and also quoted an interview with John Haas, president of the National Catholic Bioethics Center and Bishop Kevin Rhoades, chairman of the U.S. Bishops' Task Force of Health Care.
5. HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 which protects the privacy of individually identifiable health information.
6. A specific case in San Antonio, Texas, highlights this issue. A nurse reported an alleged abortion to the archdiocese and a suit was brought against her for violating HIPAA rules.

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BIOGRAPHICAL NOTE

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