Teaching OB/GYN Residents Bioethics within a Catholic Healthcare Context

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ABSTRACT: Residents entering training in the specialty of Obstetrics and Gynecology (OB/GYN) often have misconceptions as to what medical interventions Roman Catholic healthcare institutions prohibit, and why certain restrictions are placed on the provision of reproductive health options that are otherwise legally available to women. The Ethical and Religious Directives for Catholic Healthcare Services, produced by the United States Conference of Catholic Bishops seeks to provide a stable framework upon which reproductive health decisions can be based. However, Catholic healthcare ethics may conflict with secular bioethical assertions that place a premium on autonomous patient choice. Residents training in part or whole at a Catholic institution may feel frustration at what they perceive to be a conflict with current secular ethics paradigms—such as access to abortion, contraception, sterilization, and assisted reproductive technologies. The recent adoption of Clinical Competencies by the Accreditation Council for Graduate Medical Education (ACGME), directs that residents shall be trained to function within the framework of their larger healthcare system ("Systems-based Practice"). This article will first, clarify areas of conflict and convergence between Catholic and secular reproductive ethics, which are unique to OB/GYN training. Next, using the ACGME's new Clinical Competency in Systems-Based practice as a model, a rationale for incorporating Catholic Healthcare ethics into an ethics curriculum for OB/GYN residents will be discussed. Finally, guidelines for faculty tackling the problem of how to teach Catholic Healthcare ethics will be described. Incorporating the

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rich tradition of Catholic healthcare ethics into the educational curriculum of OB/GYN residency fulfills training requirements while exposing young physicians to a rational decision-making framework in bioethics.

Bioethical issues arise out of conflict: whether conflict between provider and patient, patient and family, or patient and societal standards. Perhaps more than in any other medical specialty, the field of Obstetrics and Gynecology raises difficult bioethical questions that may result in conflict. While issues such as abortion and cutting-edge reproductive technology come readily to mind, the Obstetrician Gynecologist (OBGYN) also faces ethical dilemmas regarding end of life care in the field of Gynecologic Oncology.

Resident and medical student education in bioethics has focused primarily on the American College of Obstetricians and Gynecologists' (ACOG) recommendations. These broad, secular recommendations, by their very nature, do not address all the bioethical concerns when conflicts arise. Thus residents and students are left with a non-specific and often superficial framework for decision-making.

That Catholic healthcare is an integral part of the American healthcare scene is undeniable. Currently there are four medical schools associated with Jesuit Catholic educational institutions: St. Louis University, Loyola, Creighton, and Georgetown. Additionally, as of 2005, there were 615 Catholic hospitals in the United States, representing all 50 states.[1] Even if not trained at a Catholic institution, many OBGYN's will have the opportunity to work at a Catholic hospital during their career. Unfortunately, most will enter that relationship with only a superficial understanding of how and why Catholic healthcare ethics differs from ACOG's ethical positions. This fundamental lack of knowledge ultimately damages relationships between providers and institutions, and unfairly subjects Catholic institutions to derision. For instance, a recent and widely-cited campaign by the American Civil Liberties Union (ACLU), "Health Care Denied," attacked the role of the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDS) in American Catholic hospitals while simultaneously noting the immense contribution of Catholic Healthcare in this country.[2] According the ACLU, "Because of these rules [the ERDS], many Catholic hospitals across this country are withholding emergency care from patients who are in the midst of a miscarriage or experiencing other pregnancy complications."[3] Unsupported statements such as these demonstrate the profound disconnect between many in society and the Catholic institutions that serve them.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) indentified six general competencies held to be of importance for physicians. These competencies were applicable across all medical and surgical specialties, and were

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[1] Catholic Information Project, US Conference of Catholic Bishops. http://www.nccbuscc.org/comm/cip.shtml#toc10 . Accessed 2010.

[2] Kaye, J. et al. *Health Care Denied*. The American Civil Liberties Union. New York. May 2016.

[3] Health Care Denied. The American Civil Liberties Union. https://www.aclu.org/feature/health-care-denied?redirect=healthcaredenied. Accessed 23 Mar 2017.

the basis for the evaluation of outcomes of a residency training program's stated goals. Thus, each program was required to evaluate how well its training prepared graduates in these six competencies: patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The latter states in part that residents are expected to "work effectively in various health care delivery settings and systems relevant to their clinical specialty," and, "coordinate patient care within the health care system relevant to their clinical specialty."[4] By failing to train residents in the ethical framework of healthcare delivery within Catholic hospitals, many graduate medical education programs in fact fall short of this requirement.

In Monty Python's "The Meaning of Life,"[5] one musical number contrasts a prolific Catholic family with their neighbors, abstentious protestants who are nonetheless free to use birth control. As the name suggests, the musical number, "Every Sperm is Sacred," parodies a common misunderstanding of Catholic doctrine on contraception. This misunderstanding isn't limited to secular British comedy troupes, however; a basic lack of knowledge of Church teaching is common among practicing Catholics.[6] It is even more mystifying for an evangelical protestant such as me, who enters practice in a Catholic University and hospital without prior exposure to such teachings. Given the role Catholic institutions play in healthcare delivery, it would be beneficial for all resident physicians to have some idea of what informs Catholic institutional ethics. I have tried to provide basic examples to introduce both residents and faculty discussion facilitators to principles in the ERDS, recognizing that there may be situations where neither faculty nor residents are familiar with the document.

ACOG's Approach

For years the ethical guidelines most readily available to OBGYN's for use in residency training have been ACOG's "Ethical Decision Making in Obstetrics and Gynecology."[7] While acknowledging a multiplicity of approaches to ethical dilemmas, ACOG emphasizes a fundamental basis of three "major" principles: autonomy, justice, and beneficence / nonmalfeasance. This approach provides the overarching framework taught to residents for ethical decision-making; however, the document recognizes that using these simple principles falls short of providing guidance when principles conflict. For example, when does patient autonomy trump the desire to "do no harm"; or, when does beneficence toward an individual trump the just rationing of health care to a group?

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[4] Common Program Requirements, Accreditation Council for Graduate Medical Education, Feb 2007.

[5] Goldstone, J. (Producer), Jones, T. & Gillia, T (Directors). 1983. *The Meaning of Life* [Motion Picture]. United States: Universal Pictures.

[6] Giroux, J. Catholic News Agency. *What is the Big Deal About Catholics Using Birth Control?* http://www.catholicnewsagency.com/cw/post.php?id=638. Accessed 23 Mar 2017.

[7] Committee on Ethics, American College of Obstetricians and Gynecologists. *Committee Opinion: Ethical Decision Making in Obstetrics and Gynecology.* Number 390, Dec 2007.

Catholic Healthcare Ethics

The theological underpinnings of Catholic healthcare ethics are based on Natural Law and Divine Law. For Catholics, Divine Law is based on the both the Old and New Testament as interpreted by the Magisterium of the Roman Catholic Church.[8] These were initially elucidated in the 1981 United States Conference of Catholic Bishops,' *Health and Healthcare: A Pastoral Letter of the American Catholic Bishops*.[9] They were subsequently codified into principles in the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs).[10] The ERDs are directed primarily at the provider, chaplain, and hospital staff member; and provide a clear framework on which to evaluate ethically relevant clinical issues.

Utilizing the ERDs allows the health care team to frame their ethics discussion and decision-making around several key concepts. When addressing any ethical issue, several questions can be answered. First, what are options and alternatives for the patient? How severe is her disease process, and will the interventions under discussion ameliorate loss of life, or merely impact quality of life? If the patient is adamantly seeking a healthcare option that directly conflicts with Catholic values and the ERDs can the patient find care at another institution? Asking these questions will help illuminate the often murky ethical dilemmas that can arise in the real world.

Modules for Teaching Residents and Students

The modules presented are created to provide an introduction to the topic of Catholic healthcare ethics and the ERDS. They are created to be administered by faculty without a prior understanding of the ERDS, including faculty of any faith or philosophical belief. Further, the modules are intended to be presented within an already-full didactic curriculum. Thus, not all important bioethical issues that intersect OBGYN can be addressed: as examples, embryo adoption, the care of families with prenatal anomalies, and gender reassignment.

The following modules are designed to stimulate discussion and to introduce the ERDs to residents. In creating them an attempt has been made to keep them as clinically uncomplicated as possible; at the same time, these modules represent potential real-life occurrences. These issues were chosen because they commonly conflict with ACOG's perspective on health care delivery. ACOG generally favors unrestricted access to abortion, contraception / sterilization and fertility treatments, with restrictions placed on individuals and entities rights of "conscientious refusal."[11] Comments under the discus-

[8] Boudinhon, A. (1910). Canon Law. In *The Catholic Encyclopedia*. New York: Robert Appleton Company. Retrieved from New Advent: http://www.newadvent.org/cathen/09056a.htm. Accessed 24 Mar 2017.

[9] United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops*. Washington, DC: United States Conference of Catholic Bishops, 1981.

[10] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Healthcare Services* (Washington, DC: United States Conference of Catholic Bishops, 2009).

[11] Committee on Ethics, The American College of Obstetricians and Gynecologists. *Committee Opinion: The Limits of Conscientious Refusal in Reproductive Medicine*. Number 385. November 2007 (Reaffirmed 2016).

sion below represents the discussion leader's information that may be introduced after the residents / students have had an opportunity to speak openly about their solutions.

It would be helpful for the discussion leader to review the ERDs, which are widely available in print and electronic formats. During discussion, however, questions may arise that are not covered in the module. This would be a valuable time to introduce the topic of the institutional ethics committee. Far from being simply a rubber stamp for medical decisions or an impediment to be overcome, the institutional ethics committee can be an invaluable aid in wading through the sometimes complex issues involving healthcare ethics. Residents/students should be introduced to the concept of the hospital ethics committee, familiarized with the members of the committee, and given information on how to obtain an ethics consultation. Having a member of the ethics committee sit in on the modules is an invaluable way to build rapport.

Module 1, Abortion

Mrs. J is a 21 year old G2 P1 at 20 weeks gestation who presents to labor and delivery with spontaneous rupture of membranes 3 hours ago; this is confirmed on sterile speculum exam. Her antenatal course has been unremarkable and all laboratory tests have been normal; her pregnancy is dated by her last menstrual period and by an ultrasound at 10 weeks that confirmed her gestational age.

She reports no fevers, no chills or other systemic signs. Her cervix appears closed on speculum exam. She is not contracting, her white blood cell count is 10.1, and fetal heart tones are in the range of 150 beats per minute. Her vital signs are stable.

1. What management options would you consider and discuss with the patient? Please list at least two.

The participant should recognize that general medical care provides two options for this patient: either delivery or continuation of the pregnancy. Since the patient is pre-viable, induction of labor would inevitably result in the death of the baby. Most residents / students will recognize the Catholic position on abortion as stated in ERDS 45:

> Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

In this case, the mother is clinically stable. While there is concern about the development of infection with the patient's membranes ruptured, there is no evidence of infection at this time. Also, while the patient may have a higher likelihood of delivery with her membranes ruptured, there is a potential that medical therapies could prolong labor to the point of viability. As such, induction of labor would not be supported by the ERDS.

2. What clinical events would lead you to re-assess the patient's situation?

As noted above, evidence of intrauterine infection such as increasing abdominal pain, fevers, fetal heart rate abnormalities or purulent discharge would suggest chorio-amnionitis. In which case, ERDS 47 states:

> Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

The concept of "proportionality" is extremely important in this case. When prolongation of the pregnancy is likely to result in the death of the mother (for instance, with chorioamnionitis where the patient could become septic), the ERDS permits delivery of the fetus. Obviously, the physician's input on the likelihood of death is critical. A morbidly obese pregnant woman may have more of an increased risk of death during pregnancy than a normal weight woman, but this does not mean per se she is *likely* to die during pregnancy.

Module 2, Birth Control

Mrs. S is a 26 year married old non-smoker, who is overweight. She is without other medical problems. She is interested in contraception. She has irregular menses which may occur between 21 and 48 days. After evaluation she is found to be oligo-ovulatory. She reports that she may be interested in pregnancy in the next year.

1. How would you counsel her on contraceptive options?

In assessing this patient, it's important to note that the patient has a number of options for birth control. It is also valuable to discuss their desire for future child bearing. In general, Catholic healthcare does not promote the use of contraceptive agents. According to directive 52, Catholic institutions are restricted from the use of contraceptive agents:

> Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

Many individuals, whether or not they are members of the Catholic Church, do not understand the rationale for the Church's stand against contraception. According to the Papal Encyclical, *Humanae Vitae*, the use of contraception violates "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[12] Catholic reproductive health ethics does not allow the separation of human sexuality within the context of marriage from the generative potential of the act.

There are certain pastoral exceptions; some women may benefit from oral contraceptive pills to treat medical problems. Conditions such as profound menometro-

[12] Giroux, J., *supra* note 6.

rrhagia may be treated primarily with hormonal contraception without the intention of using them for birth control. Thus, there may be a "proportional benefit" for some women to use birth control pills though these pills may, as an indirect effect, have a contraceptive effect. Directive 33 states that:

> The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

Module 3, Infertility

Mr. and Mrs. P are a 35 year old couple, unsuccessfully attempting pregnancy for 3 years. They have undergone a full evaluation including a normal semen analysis, normal hysterosalpingogram, normal thyroid stimulating hormone and normal prolactin. In discussion with the couple they question whether in vitro fertilization may be an option, but report that they're not sure about it since they try to follow the teachings of the church.

1. How would you counsel the couple about IVF?

[This section was discussed in the module on contraception and may be skipped if covered in the same session]. Many individuals, whether or not they are members of the Catholic Church, do not understand the rationale for the Church's stand against contraception. According to the Papal Encyclical, *Humanae Vitae*,[13] the use of contraception violates "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning." Catholic reproductive health ethics does not allow the separation of human sexuality within the context of marriage from the generative potential of the act.

Fertilization of the ovum extracorporally violates this principle. IVF separates the unitive act of human sexuality from procreation. As such, Directive 41 states:

> Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).

2. What other options could you offer?

Directive 39 does permit the use of certain services for infertility:

> When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.

[13] Pope Paul VI, Encyclical Letter *On the Regulation of Birth* (*Humanae Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 12.

Natural family planning affords a safe option for some patients. When more aggressive treatment is warranted, the use of medications to stimulate the production of gametes and to trigger ovulation is acceptable.

Module 4, Justice

An individual suffering from severe intellectual disability presents to your office for her first GYN exam at age 25, having been sent by the physician in charge of the group home in which she lives. It takes up a significant amount of time getting the patient into the exam room and undressed; unfortunately, it becomes clear that the patient is very resistant to undergoing a pelvic exam.

1. What options do you have?

Three options exist: to assess the situation as "too traumatic" for her and forego the exam, to press ahead and complete the exam despite the minimal patient cooperation, or to reschedule the exam to be done with sedation at a same day surgery unit.

Catholic healthcare places emphasis on the protection of the marginalized in society, recognizing the biblical concept that all persons bear the image of God and thus have intrinsic value regardless of their situation. While some would be tempted to proceed with the exam despite the patient's protestations, this would violate her autonomy. Directive 3 states that:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination…. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

Close discussion with the patient's guardian is warranted to decide the relative benefit of performing a gynecologic exam under anesthesia. A prudent provider might also look for other opportunities to provide needed healthcare services to the patient while undergoing the exam: for instance, dental care might be performed concomitantly. Ultimately the patient and her guardian should be involved in the decision making, as Directive 27 makes clear:

> Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

Conclusion

There are a number of reasons why it is vital for residents and medical students to be introduced to Ethical and Religious Directives for Catholic Healthcare. First, many residents already work within an institution affiliated with the Roman Catholic Church. As a rule, physicians in training benefit from standardization and guidelines. It is difficult for them to have to arrange care for their patients while functioning in a system

that they do not understand. Second, those same physicians may eventually go on to practice in a Catholic institution. At that point, knowledge of the boundaries in which they practice will go far toward alleviating frustration. Third, from a very pragmatic standpoint the RRC has mandated a “systems-based” approach to resident education. So far no resources are generally available integrating the ERDs into the educational curriculum and this project fills a much-needed space in national resources.

The information has been directed toward OB/GYN residents but it may be utilized with minimal modification with medical students. It may be necessary to emphasize certain important clinical points—such as the understanding in module 1 that the mother with ruptured amniotic membranes is not immediately in distress.