

Should Catholic Academic Health Centers Sponsor Residency Training in Obstetrics and Gynecology?

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Every year in the United States, approximately 1200 residents graduate from obstetrics and gynecology residency programs.¹ In 2016, there were 246 such programs whose accreditation is provided by the Accreditation Council for Graduate Medical Education (ACGME).¹ To achieve and maintain accreditation, these programs must meet program requirements (PRs) laid out in the ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology.² Of these programs, approximately 14% are sponsored by Catholic institutions, and it is estimated that about 1 in 14 obstetrician-gynecologists in the United States have graduated from programs under Catholic sponsorship.³ Due to mergers and changes in ownership of many hospitals and health care systems,⁴ the exact number of programs under Catholic sponsorship is difficult to determine on an annual basis. However, as Catholic ownership or affiliation of hospitals in this country is increasing,^{4,5} it is reasonable to conclude that a significant portion of postgraduate training in obstetrics and gynecology occurs in academic centers that are under Catholic sponsorship.

Catholic health care services also have requirements to achieve and maintain full cooperation with the moral and theological foundations of the Catholic Church. These requirements are elucidated as directives in the Ethical and Religious Directives for Catholic Health Care Services (ERDs) issued by the United States Conference of Catholic Bishops and most recently updated in 2018.⁶ The ERDs are intended to offer guidance for the administration, medical professionals, patients, chaplaincy, and sponsoring trustees in the institutional operations of the Catholic health care entity. Additionally, it is expected that, as a matter of employment or granting of health care privileges within a Catholic health care system, adherence to the ERDs occurs on institutional, employee, and clinician levels.⁶ Specific to the scope of practice of obstetrics and gynecology, the ERDs prohibit direct abortion, sterilization, contraceptive practice, in vitro fertilization, and preimplantation genetic diagnosis in Catholic health care institutions.⁶ The implications extend to other specialty programs

whose scope of practice involves reproductive health, such as family medicine, internal medicine, urology, and pediatrics. The ERDs also prohibit institutions and employees from participating in, supporting, or financially benefiting from abortion and contraceptive practice through direct patient care activities (considered “immediate, material cooperation” in wrongdoing).⁶ While it is beyond the scope of this article to fully elucidate the history and theological underpinnings of the prohibition of abortion and contraceptive practice in Catholic health care, these restrictions are not new and stem from long-standing beliefs and teachings about the nature of human sexuality and procreation.⁶ It is precisely these restricted aspects of reproductive care that residents graduating from programs sponsored by Catholic institutions often cite as deficiencies in their training.^{7,8}

The practice of gynecology has evolved, and so too have the scientific and social understandings of human sexuality, women’s reproductive health, and contraceptive practice. As the specialty most aligned with these complex dimensions of the care of women, the contemporary practice of gynecology requires expertise in women’s contraceptive health. The ACGME requires that sponsoring institutions of postgraduate education in obstetrics and gynecology offer training in abortion. These institutions “must provide training or access to training in the provision of abortions, and this must be part of the planned curriculum.”² While residents “who have a religious or moral objection . . . must not be required to participate in training in or performing induced abortions,” they must have “training in all forms of contraception, including reversible methods and sterilization.”² This presupposes that residents who choose to enter the field of obstetrics and gynecology, and those institutions that choose to sponsor graduate medical education (GME) in this specialty, understand that contraceptive health has become a core and perhaps defining attribute of the clinical practice of gynecology.

As it is now, meeting the accreditation requirements of the ACGME while at the same time attempting to maintain full cooperation with the ERDs has been challenging. Training programs have used off-site family planning rotations, simulation for abortion

and implantable contraceptive devices, and bundling of surgical and medical abortion to meet a minimum number of requirements. Despite these modifications, the suboptimal training received by graduating residents should be of evolving concern to the female patient population, who reasonably expect their gynecologists to have gained expertise in the practice of contraceptive health during their GME experience. This expectation takes on more complex policy dimensions given that GME in the United States is subsidized by a morally pluralistic society⁹ and taxpayer base through Medicare funding.¹⁰ This taxpayer funding to sponsoring institutions is intended to offset direct and indirect costs of GME and is justified in part by common interest in securing a well-educated, competent physician workforce for the United States.¹⁰ Arguably, sponsoring Catholic institutions prohibiting contraceptive education limits the intended purpose of taxpayer funding, that is, ensuring well-educated, competent gynecologists in the future.

Pragmatically, within an obstetrics and gynecology residency under Catholic sponsorship, noncompliance with either the PRs or the ERDs will be inevitable. Residents training or having trained in Catholic-sponsored residency programs have reported dissatisfaction with both abortion education and contraception education.^{7,8} Some residents reported never having performed postpartum sterilization, considered a routine gynecological procedure, before graduation.⁷ Even for those residents not participating in abortion education for personal reasons, dissatisfaction with overall contraceptive knowledge appears common and at least partially ameliorated by participation in structured, immersive family planning training.¹¹ To correct these deficiencies, sponsoring Catholic institutions would have to directly support the education of women's health physicians who are actively learning and practicing a scope of gynecology at odds with the ERDs. The employee-institution relationship between the designated institutional official, program director, core faculty, residents, and sponsoring Catholic institution contributes to this tenuous situation. To the extent that the moral tensions between the PRs and ERDs are increasing in polarity, the designated institutional officials, program directors, core faculty, and residents will find increasing challenges in compliance with the PRs if their programs continue under Catholic sponsorship. Likewise, the administration of Catholic academic health centers and local diocesan bishops, responsible for maintaining and promoting the Catholic identity of their institutions, will find challenges in adherence with the ERDs if they continue to sponsor GME in obstetrics and

gynecology. Gynecologists are actively learning and teaching a scope of practice contrary to the ERDs, wherever these activities occur in a Catholic-sponsored program.

Ignoring, dismissing, or concealing these tensions without authentic discourse contributes to a morally erosive environment. It leads to ambiguity in the commitment to ethical and moral development of residents as physicians as well as ambiguity in the commitment to authenticity, fidelity, and veracity in patient care that should characterize Catholic health care services. It is improper to expect Catholic institutions to forgo deeply held moral beliefs and the expression of those beliefs; it is equally improper to expect the ACGME to forgo its responsibility to residents and their female patients in ensuring sound, comprehensive education in women's reproductive health and contraception through their accreditation standards.

The implications of the current polarity in the most recent editions of the PRs and ERDs are apparent. To resolve the tensions created by this polarity, Catholic academic health centers should relinquish sponsorship of residency training in obstetrics and gynecology. This move would promote Catholic identity and moral clarity for administrators and bishops overseeing those Catholic academic health centers. It would also reduce clinical ambiguity in the educational environment in which residents, faculty, and patients interact. Relinquishing sponsorship does not necessarily mean closure of a training program. For instance, where multiple programs exist in a region with one under Catholic sponsorship, combining programs, with sponsorship transferring to the secular entity, would be worth considering. However, it would be challenging and controversial if relinquishing sponsorship resulted in closures of programs. Closing training programs in obstetrics and gynecology might negatively affect access to comprehensive reproductive care for women in the United States. Similarly, a portion of health care delivery to marginalized and disadvantaged populations could be fulfilled through a training program in obstetrics and gynecology. Closing the program might negatively affect the overall health care mission of the Catholic institution.

Until the tensions between the PRs and ERDs are fully illuminated and understood in their educational, moral, and clinical dimensions, satisfactory resolution will be challenging. The impact of limitations on abortion and contraception education in Catholic systems may be unapparent or misrepresented to residents prior to acceptance into residency under Catholic sponsorship.⁸ Catholic leadership may not realize that sponsoring institutions must actively

support, per ACGME requirements, education in aspects of reproductive health that they consider morally objectionable. In the meantime, residents, faculty, and patients remain exposed to an ambiguous educational, moral, and clinical reproductive health care environment. Once the moral tensions between the PRs and ERDs are illuminated and understood, the status quo becomes at best disingenuous and at worst deceitful. Discontinuing sponsorship of GME training in obstetrics and gynecology by Catholic academic health care institutions is the least ambiguous and most authentic path forward.

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