Opinion | Why Was a Catholic Hospital Willing to Gamble With My Life?

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Katherine Stewart

Ms. Stewart has reported on the religious right for more than a decade. She is the author of "The Power Worshippers: Inside the Dangerous Rise of Religious Nationalism."

More than 20 states are poised to ban or severely restrict abortion if the Supreme Court decides to overturn or undermine Roe v. Wade this year. We know these laws and

regulations will have a devastating effect on women's rights and liberty, but many people do not realize how deeply they will reach into maternal medicine. You can't take away the right to abortion without risking the health and lives of all women who become pregnant.

We can get a sense of why this is so by taking a look at the Catholic hospital systems. All Catholic health care facilities, including hospitals and clinics, and many affiliated providers are governed by the Ethical and Religious Directives, a numbered set of rules that apply Catholic doctrine to health care. These directives, which act as guidelines and impose limitations on the types of services and procedures these facilities are able to deliver, are codified by the United States Conference of Catholic Bishops.

Employees of Catholic health care systems must follow the Ethical and Religious Directives as a condition of their employment. The directives also extend to many contractors. Given that one in six acute care hospital beds in America is in a Catholic health care setting, the impact of the directives is widespread. In many regions, the number is much higher, leaving people with few other options for care.

Consistent with Catholic doctrine, the directives prohibit abortion. According to Directive 45, "Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted." Less widely appreciated is the fact that as a consequence of this prohibition, many Catholic hospitals restrict a number of miscarriage-related procedures that fall within (or close to) the directives' definition of abortion.

The consequences can be devastating, and yet the stories rarely make the news. In a 2016 report by the American Civil Liberties Union (for which I served as an investigator), "Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives," Dr. David Eisenberg recalled the story of a young woman experiencing a miscarriage, who came in after having sought care at a Catholic facility outside Chicago. Although her water had broken, the Catholic hospital, because of its restrictions on abortion, had denied her the procedures that would have been required to hasten the completion of the miscarriage.

By the time she transferred to another hospital and came under Dr. Eisenberg's care, 10 days later, she had a fever of 106 degrees and was dying of sepsis. She survived, Dr. Eisenberg said, but suffered a cognitive injury as a result of the severity of the sepsis as well as an acute kidney injury. After spending nearly two weeks in the hospital, Dr. Eisenberg says, she was sent to a long-term-care facility.

"To this day I have never seen someone so sick," Dr. Eisenberg said, remarking that in a non-Catholic health care setting "we would never wait that long before evacuating the uterus."

I too came close to paying for the directives' ban on abortion with my life. In December 2003, I was pregnant and elated at the expectation of having a second child. Then one afternoon I began to bleed heavily. Leaving my husband at home to care for our toddler, I was loaded on a stretcher and taken by ambulance to the nearest hospital, St. Vincent's Hospital, a Catholic facility in Manhattan's West Village.

I was passing in and out of consciousness, but I remember the ambulance paramedic telling me my blood pressure was dangerously low. As I later learned, what I needed was a D & C, a procedure that removes tissue from the uterus. It is one of the procedures that in other circumstances is commonly called an abortion. But when I arrived at the hospital, hours passed and no doctors or nurses would attend to me. Hospital attendants changed one blood-soaked sheet after another, and yet they did nothing to help me. It made no sense.

When an E.R. doctor walked past, I drew her attention to what I thought was obvious — that I was bleeding out — and pleaded with her to examine me. But she just grimaced and walked away. At some point I started shaking violently; I was going into shock. I later learned that I lost nearly 40 percent of my blood. Only then did the hospital give me the D & C procedure that saved my life.

When I finally got home, my 2-year-old didn't recognize me. "Who's that lady?" she asked. It took weeks to recover my strength, and much longer to stop reliving the experience in my mind. Upon reviewing the medical records from the provider, I could find no reasonable explanation for the roughly four-hour delay in treatment that resulted in the extreme loss of blood. Given what I now know about the Catholic health care systems' restrictions, my best guess is that the hospital was willing to gamble with my life in the name of its ethical directives.

Given that as many as one in four pregnancies ends in miscarriage, complications are not uncommon. The 2016 A.C.L.U. report to which Dr. Eisenberg contributed his story detailed a number of other ways in which women experiencing pregnancy complications may not receive the kinds of medical care from Catholic facilities that they desperately need.

These facts may help explain some alarming trends in maternal health, particularly among women of color. According to a 2018 report, "Bearing Faith: The Limits of Catholic Health Care for Women of Color," by the The Law, Rights, and Religion Project at Columbia Law School, in conjunction with Public Health Solutions, "Pregnant women of color are more likely than their white counterparts to receive reproductive health care dictated by bishops rather than medical doctors." America's maternal mortality rate is startlingly high among nations in the developed world, and Black women are roughly three times as likely to die from a pregnancy-related cause as white women.

"In many states women of color disproportionately receive reproductive health care restricted by ERDs," the authors wrote, before suggesting that this "should be evaluated against the backdrop of vastly inferior health care delivered to women of color across the board."

Religious restrictions on maternal medicine are not exclusive to Catholic hospitals. In a 2021 report, "The Southern Hospitals Report: Faith Culture, and Abortion Bans in the U.S. South," the results of a two-year investigation also by the Law, Rights, and Religion Project, researchers concluded that Protestant and even secular hospitals across the South delay or deny care to women facing severe pregnancy complications at the behest of anti-choice administrators or boards, community pressure, or fear of losing private or public funds.

"Our research reveals that access to abortion, including during medical emergencies, is even more severely curtailed than already restrictive state laws might suggest," the authors wrote. If Roe v. Wade is overturned or weakened, state abortion bans "will make hospital restrictions on abortion even more significant, as patients facing serious pregnancy complications or underlying health conditions, such as cancer, will no longer have any legal alternative for abortion care in their state."

There is no indication that the so-called pro-life movement has any great concern for the millions of women whose lives and health it is endangering. At this year's National Pro-Life Summit, a gathering of anti-abortion activists, Rachel Bovard of the Conservative Partnership Institute, a right-wing networking and strategy organization, was in a celebratory mood. "God willing, we are in a post-Roe world later this year," she said. "We have to demand relentless advocacy from our legislators, not head pats, not excuses."

At the same gathering, Kristan Hawkins, president of Students for Life of America, laid out the action plan: "We want to see the decision on abortion to go back to the states, where we will then fight a 50-state battle. Is that where we will stop? No."

"Let me just tell you what the secret is," she added: "The ultimate goal is a constitutional amendment barring abortion throughout America. But that takes time."

Restrictions on early-stage abortion are crude instruments that compel doctors to navigate a complex web of legislative, religious and institutional limitations. "People who write these restrictive laws and policies clearly do not understand the complexities of patient care, because many of the so-called exceptions only create more confusion," Dr. Jen Villavicencio, an obstetrician-gynecologist and specialist in complex family planning, said. "In some situations like a pregnancy-related medical crisis, any interference can be life-threatening."

There is no official count of the number of pregnant women who have turned to hospitals and clinics when something goes wrong, only to be denied the medical treatment they need on religious grounds. And it's not easy to publicize the most intimate details of traumatic experiences in order to prove what should not have to be proved: that pregnancy carries significant risk of complications, and hospitals and medical professionals in a modern society ought to allow best practices, rather than religious dogma, to guide their protocols of care.

I was fortunate, eventually, to deliver my second child at a hospital that puts care over creed. If the Supreme Court decision in Dobbs v. Jackson Women's Health Organization undermines or destroys Roe v. Wade, too many American women won't have that choice.

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