Letters

RESEARCH LETTER

Disclosure of Religious Identity and Health Care Practices on Catholic Hospital Websites

In 2016, 14.5% of US hospitals were Catholic hospitals, and between 2001 and 2011, the number of Catholic hospitals increased by 16% compared with a 6% decrease for all hospitals.[1] The US Conference of Catholic Bishops expects health care facilities affiliated with the Catholic church to abide by the Ethical and Religious Directives for Catholic Health Care Services (hereafter referred to as the directives).[1] The directives interpret medical care based on the church's moral teachings and limit aspects of reproductive and end-of-life care based on concern for human dignity as defined by the Catholic church.[1]

Some patients may prefer care in line with the church's teachings; other patients may prefer not to receive care in these facilities because of such restrictions. However, patients cannot make a choice unless they know whether a facility is affiliated with the Catholic church and whether it follows the directives.[1] Because many patients use the internet to find health care information,[2] we investigated whether Catholic hospital websites describe their religious identity and associated health care practices.

Methods | From July 2017 to January 2018, we analyzed the websites of all hospitals listed in the Catholic Health Care Directory (updated June 2017). The Catholic Health Association of the United States serves "to advance Catholic health."[3] Using a structured data abstraction form, we analyzed mission statements, About Us webpages, and home pages to find statements identifying the hospital as Catholic. If undisclosed, we searched for words in the mission statement suggesting religious affiliation. We also searched for the directives and the relevant terms *ethic*, *directives*, *ERD* and, secondarily, for the terms *limit*, *service*, *end*, and *abortion*, which are suggestive of restrictions. The websites were reviewed by 2 investigators (J.T. and A.C.) and there was an interrater reliability of 96%.

Results | Of 653 hospitals listed, 6 duplicates and 1 without a mission statement were excluded from analysis. Among 646 hospital websites, 297 hospitals (46%) were in the Midwest and 308 (48%) had the word *saint* in their name (**Table**). A total of 507 hospitals (79%) reported their Catholic identity on their website. Among the 139 hospital websites that did not, 107 (77%) included the religious terms *Jesus*, *Christ*, and *gospel*. There were 152 hospitals (24%) that cited the directives on their website and 95 (15%) provided a direct link. Among the 494 hospitals that did not cite the directives, 28 (4% of all hospitals) reported care restrictions and cited end-of-life care restrictions. Eight of the 494 hospitals reported reproductive care restrictions.

Discussion | Among US Catholic hospitals, 21% did not explicitly disclose their Catholic identity on their website, and only 28% specified how religious affiliation might influence patient care. Although it is unknown what proportion of Catholic facilities are in full compliance with the directives, a recent review demonstrated that patients are more likely to encounter reproductive restrictions at Catholic facilities compared with non-Catholic facilities[4]; less is known about end-of-life care restrictions. Many patients do not realize the implications of Catholic affiliation on their health care.[5] If patients are unaware of the affiliation and encounter restrictions, refusal of or delay in care due to the need to go elsewhere can result in increased medical risk and contribute to wasted health care expenditures.

This study was limited to hospitals listed in the Catholic Health Care Directory; some hospitals may have changed ownership or listings may have been inaccurate. The number of search terms was limited, but preliminary work revealed that other reproductive terms were generally linked to external sites and the

Table. Catholic Hospital Website Characteristics

Characteristic	No. (%)
No. of Catholic hospital websites	646
Hospital region	
Northeast	64 (9.9)
Midwest	297 (46.0)
South	182 (28.2)
West	103 (15.9)
Hospital name includes the word *saint*	308 (47.7)
Website specific to individual hospital rather than health care system	249 (38.5)
Catholic identity disclosed on hospital website	507 (78.5)
Hospital practice cited to be based on the directives[a]	152 (23.5)
Direct link to the directives[a] provided	95 (14.7)
Description of religious restrictions when the directives[a] were not cited	28 (4.3)
No. of hospitals with a website without disclosure of Catholic identity	139
Words related to religion in mission statement, median (range)	1.0 (0-5)
Words related to religion found in mission statement	
Jesus	34 (24.5)
Christ	29 (20.9)
Gospel	28 (20.1)
God	17 (12.2)
Christian	6 (4.3)
Saint (exclusive of hospital name)	3 (2.2)
Faith	1 (0.7)
Holy	0
No religious words on website	32 (23.0)

[a] The directives refers to the Ethical and Religious Directives for Catholic Health Care Services.

term *abortion* appeared sufficient; nevertheless, some disclosures may have been missed. Whether the low proportion of hospitals that did not cite health care restrictions reflects a lack of transparency or nonadherence to the directives is unknown. In addition, some of the hospitals that cited the directives may provide reproductive services. How often patients consult hospital websites for such information is also unknown.

Greater transparency about religious affiliation and care restrictions may allow patients to make more informed choices.[1] In the state of Washington, hospitals must provide their reproductive health and end-of-life care policies on publicly available websites.[6] Further research on the effect of this initiative on patient satisfaction and health care choices is warranted.

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1. Guiahi M. Catholic health care and women's health. *Obstet Gynecol*. 2018;131(3):534-537. doi:10.1097/AOG.0000000000002477

2. Hesse BW, Nelson DE, Kreps GL, et al. Trust and sources of health information: the impact of the Internet and its implications for health care providers: findings from the first Health Information National Trends Survey. *Arch Intern Med*. 2005;165(22):2618-2624. doi:10.1001/archinte.165.22.2618

3. Catholic Health Association of the United States. Catholic Health Care Directory. Catholic Health Association of the United States website. https://www.chausa.org/catholic-health-care-directory. Accessed December 6, 2018.

4. Thorne NB, Soderborg TK, Glover JJ, Hoffecker L, Guiahi, M. Reproductive health care in Catholic facilities: a scoping review. *Obstet Gynecol*. 2019;133(1):105-115.

5. Guiahi M, Sheeder J, Teal S. Are women aware of religious restrictions on reproductive health at Catholic hospitals? a survey of women's expectations and preferences for family planning care. *Contraception*. 2014;90(4):429-434. doi:10.1016/j.contraception.2014.06.035

6. Washington State Legislature. WAC 246-320-141: patient rights and organizational ethics. https://apps.leg.wa.gov/wac/default.aspx?cite=246-320-141. Accessed December 6, 2018.

COMMENT & RESPONSE

Challenges in Research on Suicide Prevention

To the Editor In a Viewpoint, Drs Sisti and Joffe[1] expressed concern that interventions to reduce suicide have not been well studied in clinical trials and proposed inclusion of actively suicidal individuals in trials. The US Food and Drug Administration (FDA) provides regulatory advice on clinical trials for psychiatric drug development. We wish to comment on several issues in the article.

In the recent FDA draft guidance to industry on antidepressant drug development,[2] inclusion of patients with suicidal ideation and behavior in clinical trials was encouraged. Other conditions with increased risk of suicidal ideation and behavior, including bipolar disorder and schizophrenia, were not mentioned because separate guidances are pending; however, the FDA agrees with the inclusion of such patients in trials. To the extent possible, study populations should reflect the full severity range of patients encountered in clinical practice.

However, we do not believe that including patients with suicidal ideation or behavior in clinical trials obviates the need to provide standard-of-care treatment for acutely suicidal patients. In a previous FDA guidance,[3] it was recommended that patients with suicidal ideation (ie, Columbia-Suicide Severity Rating Scale[4] score ≥4) should be excluded or discontinued from most clinical trials so that they can receive immediate psychiatric intervention. We have additional concerns about including patients with suicidal ideation or behavior in trials for nonpsychiatric indications because psychiatric monitoring is limited in these settings. Nevertheless, such inclusion may be possible with appropriate precautions.

In recent years, some drug development programs have proposed reduction of suicidal ideation or behavior as a treatment indication. Such studies are ethically supportable if patients receive standard-of-care interventions based on severity of suicidal ideation or behavior, although they may require inpatient settings. Unlike the authors, we believe that adverse events related to suicidal ideation or behavior should be reported as adverse events in these studies, but only if the events are more severe than at baseline. This recommendation would permit appropriate safety monitoring while avoiding overreporting. Moreover, events reported as adverse events could still be included in the efficacy analyses.

As the authors noted, death due to suicide is not a practicable primary end point for trials of interventions to reduce suicidal ideation or behavior. The FDA is open to considering surrogate end points to support indications for treatment of suicidal ideation or behavior. We agree that data on suicidal behavior and deaths should be collected with suicidal ideation because the relationship between them is not yet fully characterized.

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