

# Moral Controversy, Directive Counsel, and the Doctor's Role: Findings From a National Survey of Obstetrician–Gynecologists

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## Abstract

### Purpose

To explore physicians' attitudes toward providing directive counsel when dealing with morally controversial medical decisions, and to examine associations between physicians' opinions and their demographic and religious characteristics.

### Method

In 2008–2009, the authors mailed a survey to a stratified, random sample of 1,800 U.S. obstetrician–gynecologists. They asked participants whether, when dealing with either typical or morally controversial medical decisions, “a physician should encourage patients to

make the decision that the physician believes is best.”

### Results

Among eligible physicians, the response rate was 66%. Fifty-four percent of respondents rejected the use of directive counsel for typical medical decisions; 78% did so for morally controversial medical decisions. Physicians were less likely to refrain from directive counsel for typical medical decisions if they were older and foreign-born but more likely to refrain from directive counsel if they were more theologically pluralistic. Theological pluralism was the only characteristic significantly associated with

refraining from directive counsel for morally controversial medical decisions.

### Conclusions

Providing nondirective counsel to their patients appears to have become the norm among certain obstetrician–gynecologists in the United States, particularly when dealing with morally controversial medical decisions. These physicians tend to be female, younger, U.S.-born, and more theologically pluralistic. Shifts toward refraining from directive counsel seem to relate to shifts in physicians' demographic, cultural, and religious characteristics.

**M**edical ethicists continue to debate whether and to what extent physicians ought to be directive or nondirective in their counsel to patients. The debate becomes particularly pointed with respect to morally controversial issues in sexual and reproductive health care, the care provided most often by obstetrician–gynecologists (ob/gyns). Chervenak and McCullough,<sup>1,2</sup> who frequently write about the ethics of obstetrics–gynecology, have argued that physicians must refrain from any kind of moral persuasion that unduly influences patients' decisions.

They contend that permitting one's own moral values to influence medical decisions introduces “impermissible bias” that ultimately could “undermine the profession of medicine from within.”<sup>2</sup> In contrast, Quill and Brody<sup>3</sup> and others<sup>4,5</sup> have argued that physicians should frankly admit their biases, respectfully describe to patients their opinions about medical decisions, and then work to negotiate mutually acceptable accommodations. Quill and Brody contend that an open dialogue is a “better protector of the patient's right to autonomous choice than [is] artificial neutrality.”<sup>3</sup> Such differing views imply different ideals for the doctor's role in clinical decision making, particularly in morally contentious areas of medicine.

Despite the debate, little has been known about what practicing physicians think. Most previous studies focused on physicians' general attitudes toward clinical decision making,<sup>6–10</sup> and only a few focused specifically on decision making in areas of moral controversy.<sup>11–13</sup> With respect to the latter concern, Lawrence and Curlin<sup>11</sup> found that physicians who are more religious tend to give less decisive weight to a patient's expressed wishes and values when making an ethically complex medical

decision. Religious physicians are more likely to believe that, when patients request a legal procedure to which their physician has a moral objection, doctors may describe their objections to patients, and that doctors are not obligated to refer patients for or tell them how to obtain the requested procedure.<sup>12</sup> In the area of reproductive and sexual health care, a recent qualitative study of 19 practicing ob/gyns reported that some described more directive approaches to decision making and said that, to various extents, they emphasized the adverse consequences of those clinical options they judged to be immoral, refused to participate or provide medical options to which they had moral objections, and encouraged patients to make the decisions the physician believed were best.<sup>13</sup> However, most of the study ob/gyns distanced themselves from this view. They stated that they believe they are obligated to provide information about all available options, and they rejected the use of directive counsel to influence the patient's decision regarding which option to pursue.

The present study surveyed a large, nationally representative sample of practicing ob/gyns to obtain information on the prevalence and the predictors of the attitude that physicians should use or reject the use of directive counsel in their

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counsel to patients. We examined whether ob/gyns believed that a physician “should encourage patients to make the decision that the physician believes is best,” for both typical and morally controversial medical decisions. We then examined the physician characteristics—including religious measures—that are most associated with rejecting the use of directive counsel in these two contexts. This study aimed to inform medical educators by describing how physicians from one important medical specialty navigate the tensions between being directive and being nondirective with respect to clinical decision making.

## Method

Between October 2008 and June 2009, we mailed a confidential, self-administered, 12-page questionnaire to a stratified, random sample of 1,800 practicing U.S. ob/gyns aged 65 or younger. This sample was drawn from the American Medical Association’s Physician Masterfile, a database intended to include all practicing U.S. physicians. To increase Muslim, Hindu, and Jewish representation, we used validated ethnic surname lists<sup>14–16</sup> to include modest oversamples of ob/gyns with typical Arabic, South Asian, and Jewish surnames. Physicians received up to three separate mailings of the questionnaire. The first mailing included a \$20 bill, and the third offered an additional \$30 for participation. All data were abstracted twice, cross-compared, and corrected against the original questionnaires.

## Questionnaire

After a review of the medical literature and data gathered from a series of qualitative pilot interviews, we developed survey items to assess physicians’ attitudes regarding directive counsel. These items were tested and revised for clarity and relevance through multiple iterations of expert panel review and cognitive interviews. Primary criterion measures were physicians’ agreement or disagreement with two forms of the same statements. The first form read, “When dealing with *typical* medical decisions, a physician should (a) provide all relevant facts without trying to influence the patient’s decision one way or another, [or] (b) encourage the patient to make the decision that the physician believes is best.” The second form was identical

except that the word *typical* was replaced with *morally controversial*. For analysis, responses to these items were dichotomized to “agree” (agree strongly/somewhat) or “disagree” (disagree strongly/somewhat).

In cognitive pretesting with several ob/gyns, we found that, when answering these items, ob/gyns tended to think of medical decisions commonly faced in their own practice. For “typical medical decisions,” ob/gyns thought of decisions such as whether a patient in labor would undergo cesarean section. For “morally controversial decisions,” most physicians thought of decisions regarding abortion.

To assess whether physicians’ general attitudes were associated with their approaches to specific clinical decisions, we also asked physicians to respond to the following clinical scenario: “A 17-year-old college freshman presents to you seeking birth control pills. How likely would you be to encourage her to abstain from sexual activity until she is older?” Response categories were dichotomized to “likely” (very/somewhat likely) or “not likely” (not very/not at all likely).

Primary predictors were measures of physicians’ religious characteristics. We categorized religious affiliation as none, Hindu, Jewish, Muslim, Catholic (Roman Catholic [ $n = 237$ ] or Eastern Orthodox [ $n = 25$ ]), evangelical Protestant, nonevangelical Protestant, and other (includes Buddhist [ $n = 9$ ] and other religion [ $n = 39$ ]). We measured organizational religiosity as the frequency of attending religious services (response categories collapsed to never, once a month or less, and twice a month or more). We measured religious salience by physicians’ responses to the question, “How important would you say your religion is in your own life?” (not very important, fairly important, very important, or most important).

Modernity has been characterized by skepticism about whether any religion has a unique and commanding grasp of truth.<sup>17</sup> This skepticism is found to various extents even among those who endorse a religion and say their religion is important to them.<sup>18,19</sup> In an effort to capture this factor, we asked respondents to indicate whether they agreed or disagreed with the following three statements: (1) “There is truth in one religion,” (2) “Different religions have

different versions of the truth, and each may be equally right in its own way,” and (3) “There is no one, true, right religion.” After reverse-coding the first statement, we summed physicians’ responses (disagree strongly, 1; disagree somewhat, 2; agree somewhat, 3; agree strongly, 4 [Cronbach alpha = 0.73]) and used the total score (3–8, low; 9–10, moderate; 11–12, high) to create a three-level, ordered categorical measure of what we call theological pluralism—the extent to which a respondent believes that no religious tradition is uniquely and comprehensively true. To assess for construct validity, we examined theological pluralism scores by religious affiliation. Other predictors included respondents’ demographic characteristics: age, gender, race/ethnicity, region, and immigration history (U.S.-born or foreign-born).

## Statistical analysis

We incorporated case weights to account for the oversampling strategy (the design weight) and to correct for differences in response rate among the surname categories and between U.S. and foreign medical school graduates (the poststratification adjustment weight). Weights were the inverse probability that a person with the relevant characteristic would be in the final dataset. The final weight for each case was the product of the design weight and the poststratification adjustment weight. This method of case weighting, which is widely used in population-based research,<sup>20</sup> enabled us to adjust for sample stratification and variable response rates so that we could generate estimates for the population of U.S. ob/gyns. Respondents who left questions blank were omitted from analyses of those items. We first generated population estimates for responses to the various survey items, and then we used the Pearson  $\chi^2$  test to examine differences in responses to criterion measures by physicians’ demographic and religious characteristics. Finally, we used multivariate logistic regression to test whether bivariate associations remained significant after adjustment for relevant covariates. All analyses take into account survey design and case weights by using the survey commands of Stata/SE 10.0 statistical software (StataCorp, College Station, Texas). The institutional review board of the University of Chicago approved this study.

## Results

### Survey response

Of the 1,800 potential respondents to the survey, 40 were ineligible because they had retired or could not be contacted because of incorrect addresses. Among eligible physicians, the response rate was 66% (1,154/1,760). Response rates varied by sample: 68% (807/1,188) of the primary sample responded, as did 54% (120/221) of those with Arabic surnames, 61% (107/175) of those with South Asian surnames, and 68% (120/176) of those with Jewish surnames. Graduates of foreign medical schools were less likely to respond than were graduates of U.S. medical schools (58% versus 68%;  $P = .001$ ). Response rates did not differ significantly by age, gender, region, or board certification. The demographic characteristics of respondents are summarized in Table 1.

### Physician attitudes toward providing directive counsel in decision making

Nearly all of the respondent ob/gyns agreed that a physician should provide all relevant facts without influencing the patient's decision one way or another—whether dealing with typical medical decisions (93%) or morally controversial ones (97%). However, physicians were more divided over whether a physician should encourage the patient to make the decision that the physician believes is best: 54% disagreed with this directive approach in the context of typical medical decisions, and 78% disagreed in the context of morally controversial medical decisions (Table 2).

Table 2 also presents the prevalence and odds of rejecting the use of directive counsel, stratified by physicians' demographic and religious characteristics. After adjustment for demographic and religious characteristics, older physicians (aged 56–65 years) were less likely than were younger physicians (aged 26–35 years) to reject the use of directive counsel for typical medical decisions (odds ratio: 0.4; 95% CI: 0.3, 0.8), as were foreign-born physicians compared with those born in the United States (0.7; 0.4, 1.0). Physicians who were more religious by any of the three measures were also less likely to reject the use of directive counsel when dealing with typical medical decisions.

**Table 1**  
**Characteristics of 1,154 U.S. Obstetrician–Gynecologists Responding to a National Survey, 2008–2009\***

Variable	No. (%) <sup>†</sup>
<b>Demographic characteristics</b>	
Age <sup>‡</sup>	
26–35 years	107 (9)
36–45 years	396 (34)
46–55 years	374 (32)
56–65 years	277 (24)
Gender	
Male	617 (53)
Female	537 (47)
Region <sup>§</sup>	
Northeast	288 (25)
South	373 (32)
Midwest	249 (22)
West	242 (21)
Race/ethnicity	
Asian	202 (18)
Hispanic or Latino	64 (6)
Black, non-Hispanic	67 (6)
White, non-Hispanic	774 (69)
Other	22 (2)
Immigration history	
Born in the United States	817 (72)
Immigrated to United States at any age	323 (28)
Education	
U.S. medical school graduate	932 (81)
Foreign medical school graduate	222 (19)
Board certification	
Board certified	963 (83)
Not board certified	191 (17)
<b>Religious characteristics</b>	
Religious affiliation	
None	119 (11)
Hindu	91 (8)
Jewish	160 (14)
Muslim	54 (5)
Roman Catholic/Eastern Orthodox	262 (23)
Protestant, evangelical	91 (8)
Protestant, nonevangelical	300 (27)
Other	48 (4)
Attendance at religious services	
Never	123 (11)
Once a month or less	547 (48)
Twice a month or more	466 (41)

(Continues)

**Table 1**

(Continued)

Variable	No. (%) <sup>†</sup>
Importance of religion	
Not very important	272 (24)
Fairly important	321 (28)
Very important	385 (34)
Most important	157 (14)
Theological pluralism <sup>¶</sup>	
Low	367 (34)
Moderate	276 (25)
High	444 (41)

\* The data come from a 2008–2009 national survey among a stratified, random sample of 1,800 U.S. obstetrician–gynecologists.

<sup>†</sup> Because of rounding error, results may not sum to 100%. Numbers do not all sum to 1,154 because of partial nonresponse.

<sup>‡</sup> The mean (SD) age of respondents was 47.8 (9.2) years (range: 26–65).

<sup>§</sup> Respondents from Puerto Rico ( $n = 2$ ) are not listed here but were included in all analyses.

<sup>¶</sup> Theological pluralism measures the extent to which a person believes that no religious tradition is uniquely and comprehensively true.

As expected, the inverse was true when we evaluated respondents on the basis of theological pluralism. Physicians who were more theologically pluralistic were more likely to reject the use of directive counsel than were those who were less theologically pluralistic, and this finding remained significant after adjustment for covariates (odds ratio: 1.5; 95% CI: 1.0, 2.2, for high compared with low pluralism). Likewise, in a multivariate model, theological pluralism was the only physician characteristic significantly associated with rejecting the use of directive decision making in the context of morally controversial medical decisions (1.6; 1.0, 2.6, for high compared with low pluralism).

In further analyses (data not shown in tables), we assessed physician characteristics that are associated with endorsing directive counsel for typical medical decisions but refraining from it for morally controversial ones. Among physicians who endorsed the use of directive counsel for typical decisions ( $n = 520$ ), 56% rejected its use for morally controversial decisions. Female physicians (66% versus 47% male,  $P < .001$ ), U.S.-born physicians (59% versus 47% foreign-born,  $P = .03$ ), and more theologically pluralistic

Table 2

**Prevalence and Odds of U.S. Obstetrician–Gynecologists Who Refrain From Providing Directive Counsel to Patients, Stratified by Physicians’ Demographic and Religious Characteristics, 2008–2009\***

Variable	Typical medical decisions			Morally controversial medical decisions		
	Bivariate		Multivariate, odds ratio (95% CI) <sup>†</sup>	Bivariate		Multivariate, odds ratio (95% CI) <sup>†</sup>
	Prevalence, %	P value		Prevalence, %	P value	
<b>Demographic characteristics</b>						
All physicians	54			78		
Age						
26–35 years	61	.000	Referent	80	.000	Referent
36–45 years	60		1.1 (0.6, 1.8)	85		1.7 (0.9, 3.3)
46–55 years	55		0.8 (0.5, 1.4)	79		1.1 (0.6, 2.2)
56–65 years	42		0.4 (0.3, 0.8) <sup>‡</sup>	62		0.5 (0.3, 1.1)
Gender						
Male	53	.327	Referent	72	.000	Referent
Female	56		0.8 (0.6, 1.1)	84		1.4 (1.0, 2.1) <sup>§</sup>
Immigration history						
Born in the United States	57	.004	Referent	80	.001	Referent
Immigrated to United States	45		0.7 (0.4, 1.0) <sup>§</sup>	68		0.7 (0.4, 1.2)
<b>Religious characteristics</b>						
Attendance at religious services						
Never	64	.015	Referent	82	.530	Referent
Once a month or less	56		0.8 (0.5, 1.4)	78		0.9 (0.4, 1.9)
Twice a month or more	50		0.7 (0.3, 1.3)	76		1.1 (0.5, 2.7)
Importance of religion						
Not very important	62	.047	Referent	83	.065	Referent
Fairly important	50		0.8 (0.5, 1.1)	74		0.6 (0.4, 1.1)
Very important	53		1.0 (0.6, 1.7)	78		0.8 (0.4, 1.5)
Most important	49		0.9 (0.5, 1.8)	73		0.7 (0.3, 1.5)
Theological pluralism						
Low	50	.013	Referent	72	.002	Referent
Moderate	51		1.0 (0.7, 1.5)	76		1.1 (0.7, 1.7)
High	61		1.5 (1.0, 2.2) <sup>¶</sup>	84		1.6 (1.0, 2.6) <sup>¶</sup>

\* These data come from a 2008–2009 national survey among a stratified, random sample of 1,800 U.S. obstetrician–gynecologists. This table presents survey-design-adjusted population estimates of U.S. obstetrician–gynecologists who disagree (either strongly or somewhat) with either or both of the following statements: (1) “When dealing with typical medical decisions, a physician should encourage the patient to make the decision that the physician believes is best” and (2) “When dealing with morally controversial medical decisions, a physician should encourage the patient to make the decision that the physician believes is best.”

† Multivariate analyses included age, gender, immigration history, race/ethnicity, religious affiliation, attendance at religious services, importance of religion, and theological pluralism.

‡  $P < .01$ .

§  $P = .06$ .

¶  $P < .05$ .

physicians (64% high versus 49% low,  $P = .04$ ) were more likely to make this shift. Race/ethnicity, religious affiliation, religious salience, and organizational religiosity were not associated with this shift, and only female gender remained significant after adjustment for other covariates (odds ratio: 1.6; 95% CI: 1.0, 2.6).

We also examined whether rejecting the use of directive counsel in principle predicts that a physician would do so (e.g., encourage sexual abstinence) in the specific case of a 17-year-old woman seeking birth control without parental consent (data not shown in tables). Physicians who refrain from directive counsel for both typical and morally controversial medical decisions

were significantly more likely to predict that they would refrain from directive counsel in that particular situation. These associations remained significant (odds ratio: 1.7; 95% CI: 1.2, 2.2 and 2.1; 1.4, 3.0, respectively), even after control for theological pluralism and other demographic and religious characteristics.

### Relationships of theological pluralism to other physician characteristics

To further explore the construct of theological pluralism, we examined theological pluralism levels by physicians' other characteristics (data not shown in tables). Theological pluralism did not vary significantly by race/ethnicity or immigration history, but physicians who were younger, female, and from the Northeast and the West tended to be more theologically pluralistic. As we had hypothesized, beliefs in theological pluralism varied markedly by religious affiliation. High theological pluralism was displayed by 56% of those with no religious affiliation, 56% of those who indicated "Other" with regard to religion, 54% of Hindu physicians, 48% of Jewish physicians, 40% of Catholic physicians, and 28% of Muslim physicians. Among Protestants, only 3% of evangelicals reported high theological pluralism compared with 39% of nonevangelicals. In a post hoc analysis of Jewish respondents, we found that 11% (1/9) of those who identified themselves as Orthodox reported high theological pluralism compared with 36% (27/75) of Conservative Jews, 62% (37/60) of Reform Jews, 60% (15/25) of secular Jews, and 62% (8/13) of other Jews ( $\chi^2$ :  $P = .001$ ).

Those who attended religious services less frequently or who rated the importance of religion less highly also tended to be more theologically pluralistic. In post hoc, within-religion analyses, we found patterns of association among Hindus ( $P = .41$  for attendance,  $P = .04$  for importance), Jews ( $P < .001$  for attendance,  $P < .001$  for importance), Muslims ( $P = .004$  for attendance,  $P = .09$  for importance), Catholics ( $P < .001$  for both attendance and importance), nonevangelical Protestants ( $P < .001$  for both attendance and importance), and evangelical Protestants ( $P = .001$  for attendance,  $P = .1$  for importance).

### Discussion

Most U.S. ob/gyns believe that doctors should reject the use of directive counsel to patients, particularly when dealing with morally controversial medical decisions. Even among those who endorse the use of directive counsel for typical decisions, more than half reject its use for morally controversial decisions.

Those who refrain from providing directive counsel tend to be female, younger, born in the United States, less religious, and more likely to believe that no religious tradition is uniquely and comprehensively true.

These findings seem to confirm the observation that a generation of U.S. physicians has been trained under the independent choice<sup>3</sup> or informative<sup>5</sup> models of medical decision making. In these models, physicians objectively inform patients of the scientific data and the range of clinical options, but they withhold their own experiences, judgment, and personal values in order to avoid unduly influencing patients' decisions. Much in the same way that nondirective counsel is the most universally espoused norm in genetic counseling literature,<sup>21,22</sup> our data suggest that today's physicians have also internalized such models as ideals, at least within the specialty of obstetrics–gynecology, and particularly with respect to decisions that involve morally controversial clinical practices.

Several prominent physicians and ethicists<sup>3–5,23</sup> have worried that the pendulum has swung too far away from the paternalism of an earlier generation toward a contemporary emphasis on autonomy that amounts to what a presidential commission of the 1980s called "patient sovereignty."<sup>24</sup> In response, Quill and Brody<sup>3</sup> have argued for a model of "enhanced autonomy," Emanuel and Emanuel<sup>5</sup> for a "deliberative" model, and Siegler<sup>4</sup> for a model of "physician accommodation"—in all of which physicians would respectfully encourage patients to make the decision that the physician believes is best. Our study suggests, however, that a confluence of interrelated cultural and demographic shifts makes it unlikely that we will soon see a return to these more physician-directive models.

First, our findings confirm that the shift away from providing directive counsel is in part generational. Earlier eras of medical education encouraged the use of directive counsel,<sup>25</sup> whereas today's medical education is shaped by a contemporary emphasis on the patient's rights, choice, and autonomy. In this light, it is not surprising that our data confirm earlier studies<sup>6,7,11</sup> in showing that younger physicians are more likely to

reject a directive role for physicians in clinical decision making. As younger physicians replace older physicians, nondirective counsel will increasingly become the norm.

Second, younger physicians are also more likely to be women, particularly in the field of obstetrics–gynecology,<sup>26</sup> and female ob/gyns are more likely to refrain from directive counsel regarding morally controversial medical decisions. This latter finding is consistent with the finding of Wertz and Fletcher<sup>21</sup> in the genetic counseling literature that female practitioners are more likely to be nondirective in their counsel than are their male counterparts. Furthermore, our finding parallels the earlier finding of Curlin and colleagues<sup>12</sup> that women from all medical specialties are more likely to oppose physicians' telling patients why they object to a morally controversial practice, and female physicians are more likely to agree that physicians must present information about all clinical options, including those to which the physician has a moral objection.

Third, the shift away from providing directive clinical counsel may also reflect deep cultural shifts that have affected the modern West more than other regions of the world. The philosopher Charles Taylor<sup>17</sup> noted that, in modernity, the ideal of individual authenticity (i.e., being true to oneself) involves resisting traditional norms, including received norms of religious traditions, as well as resisting the expectations of those in traditional positions of authority (e.g., physicians). In parallel, modern bureaucratic institutions (e.g., medicine) tend to elevate technology and instrumental reason (e.g., what works and what the options are) while making relative judgments about how we ought to live and practice (e.g., which medical decision is best). In medicine, these cultural shifts are expressed by what Schneider<sup>27</sup> described as the "paradigmatic status" of patient autonomy in modern Western bioethics.

However, not all U.S. physicians have been equally shaped by Western cultural expectations. As did the investigators in previous studies,<sup>6,8</sup> we found that foreign-born physicians are less likely than are those born in the United States to refrain from providing directive counsel. This finding may reflect the

influence of Asian cultures, which traditionally encourage what many in the West might consider paternalistic models of decision making.<sup>28–30</sup> Fifty percent of the foreign medical graduates in our sample identified themselves as Asian.

Religion lies at the heart of most cultures, and many religions provide structured guidelines for reasoning about moral issues and arriving at a correct decision. As did the investigators in previous studies,<sup>11,13</sup> we found that physicians who are more religious are less likely to refrain from providing directive counsel in clinical decision making. Among the religious characteristics that we examined, the strongest predictor for rejecting the provision of directive counsel was theological pluralism—the belief that no religion is uniquely and comprehensively true. Theological pluralism seems to be consistent with the cultural trends described above, in that it mitigates against looking to one’s religion for authoritative guidance, particularly in the face of counterclaims from other traditions. Those who believe that different religions may be “equally right” with respect to truth may also allow for multiple “equally right” decisions in a given clinical context, particularly in the setting of moral controversy. These physicians tend to be more theologically pluralistic and less religious. In contrast, physicians who believe that one religion is uniquely and comprehensively true may have greater confidence that the best decision for a given patient can be discerned by the physician and that that decision should be encouraged. As expected, these physicians tend to be less theologically pluralistic and more religious.

At the core of the clinical encounter, and therefore at the core of medical education, is the art of negotiating clinical decisions with patients. For medical educators, our study shows that physicians are shifting in their habitual norms about influencing patients’ decisions and that such norms are shaped by the cultures that medical students, trainees, and clinicians inhabit and the worldviews that they gain during their professional formation.<sup>31</sup> Kinghorn and colleagues<sup>32</sup> have argued that medical education “should be characterized by open pluralism: a commitment to explore, understand, and hear the voices of the particular moral communities that

constitute our culture.” This approach might encourage honest and respectful dialogue regarding contentious issues in medicine, particularly when such debates reflect deeper disagreements over whether a clinical practice is consistent with the goals of medicine.<sup>33</sup> Given the moral pluralism both inside and outside the profession, educators might integrate learning about a range of worldviews and encourage students to reflect on and discuss how those worldviews affect the practice of medicine.<sup>34,35</sup>

Such a dialogue may be fostered in many educational settings, but logical starting places are courses on medical ethics, the social context of medicine, and spirituality and medicine. With respect to the latter, the Association of American Medical Colleges<sup>36</sup> has urged medical schools to “incorporate awareness of spirituality, and . . . [cultural] beliefs and practices, into the care of patients in a variety of clinical contexts. . . [and to] recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients.” In addition, Tilburt and Geller<sup>34</sup> argued for the incorporation of longitudinal curricular elements that “encourage [medical] students to recognize their own worldviews and those of their professional culture.” Such elements may include reflective journaling, educational portfolios, small-group case discussions, and other activities in which students work through their expectations about how they are to influence clinical decisions.<sup>31,37,38</sup> Through these curricular elements, medical educators can also invite students to become more conscious of and articulate about the sources of their own convictions and practices. Together, these efforts might deepen students’ appreciation of the moral and spiritual dimensions of the practice of medicine, and they might help students develop workable strategies for respectfully negotiating with patients regarding both typical and morally controversial medical decisions.

In addition, we propose that the time is right for the development of a national longitudinal study of the moral and professional formation of U.S. physicians over the course of medical training.<sup>35</sup> A longitudinal study would allow for a more nuanced examination of how physicians’ worldviews interact with both

shared and individual aspects of medical training to shape patterns of “professionalism,” medical ethics, the doctor–patient relationship, and shared decision making.

This study had important limitations. It is possible that respondents envisioned different “typical” and “morally controversial” clinical scenarios when completing the survey measures, and we cannot say with confidence how these general measures of physicians’ attitudes affected their actual practices in any specific clinical domain. It is unlikely that clinicians use a single decision-making approach in all clinical situations.<sup>5,7</sup> That said, we did find that general attitudes were associated with self-predicted behaviors in the specific clinical scenario of a 17-year-old seeking birth control. Further research could measure clinical decisions in this and other domains through patient reports or through gathering physician reports at the level of clinical encounters. Our measure of theological pluralism has face validity, but findings related to it should be considered provisional until the measure has been further refined and studied. In addition, although we had a good survey response rate (66%), unmeasured characteristics still may have systematically affected physicians’ willingness to respond to this survey. Finally, it is evident that several different cultural and demographic characteristics are associated with doctors’ beliefs about providing or not providing directive counsel, but the cross-sectional design of this study does not permit inferences about causation among these different factors.

## Conclusions

Despite these limitations, this study affirms that the provision of nondirective counsel has become the norm among ob/gyns in the United States, particularly with respect to morally controversial medical decisions. These physicians, who tend to be female, younger, born in the United States, and more theologically pluralistic, reject the idea that physicians should encourage patients to do what the doctor believes is best. These findings both affirm and suggest the need for further study of the influence of physicians’ religious and other moral and cultural characteristics on their clinical practices.

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