Physicians' Beliefs About Conscience in Medicine: A National Survey

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Abstract

Purpose
To explore physicians' beliefs about whether physicians sometimes have a professional obligation to provide medical services even if doing so goes against their conscience, and to examine associations between physicians' opinions and their religious and ethical commitments.

Method
A survey was mailed in 2007 to a stratified random sample of 1,000 U.S. primary care physicians, selected from the American Medical Association Physician Masterfile. Participants were classified into three groups according to agreement or disagreement with two statements: "A physician should never do what he or she believes is morally wrong, no matter what experts say," and "Sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so."

Results
The response rate was 51% (446/879 delivered questionnaires). Forty-two percent and 22% believed they are never and sometimes, respectively, obligated to do what they personally believe is wrong, and 36% agreed with both statements. Physicians who are more religious are more likely to believe that physicians are never obligated to do what they believe is wrong (58% and 31% of those with high and low intrinsic religiosity, respectively; multivariate odds ratio, 2.9; 95% CI, 1.2–7.2). Those with moral objections to any of three controversial practices were more likely to hold that physicians should never do what they believe is wrong.

Conclusion
A substantial minority of physicians do not believe there is ever a professional obligation to do something they personally believe is wrong.

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Medicine is a moral enterprise requiring physicians to evaluate the ethical significance of their actions.[1–4] Such a perspective suggests that doctors should view themselves as independent moral agents.[4–8] Yet, independent moral agents often arrive at different conclusions about controversial ethical questions, which makes it difficult for members of the medical profession to offer patients a unified standard of care.[3] A recent and visible expression of this difficulty was seen in the public controversy surrounding the position statement issued by the Ethics Committee of the American College of Obstetrics and Gynecology, which said that physicians have a professional, ethical obligation to facilitate patient access to the full range of legal reproductive services, notwithstanding their moral or conscientious objections to those services.[9]

When physicians disagree with their patients, their colleagues, or professional bodies about the morality of specific treatments, how should a given clinician decide what he or she is ethically obligated to do? All sides recognize the importance of physicians' maintenance of their personal moral integrity, and all recognize that the profession makes legitimate demands of its members. Yet, in the face of controversial clinical practices, some emphasize the importance of the individual physician's judgment, holding that physicians are obligated only to provide those medical interventions they believe are ethically appropriate in a given instance.[3] Lawmakers have often affirmed this approach by enacting conscience clauses, which protect physicians from penalties they might otherwise incur if they refuse to provide abortions or other controversial treatments.[10–12] Alternatively, others (mostly ethicists, theorists, and commentators, rather than lawmakers at present) have emphasized physicians' obligations to abide by the collective judgments of the profession when acting in a professional role—a principle that often translates into seeing that patients have access to all treatments endorsed by the medical profession and permitted by law.[4,13–16]

Division with respect to this issue recently surfaced after we reported that a substantial minority of physicians, particularly religious physicians and those with objections to controversial practices, are less likely to believe that they are obligated to give referrals for or information about how to obtain controversial treatments.[17] Our finding suggested that religious and worldview commitments significantly influence physicians' beliefs about their obligations,[18] and it drew attention to debates about the role of the clinician's conscience in medical decision making. The present study informs this ongoing debate by examining physicians' beliefs about whether they at times have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so. We also explore in the current study associations with physicians' ethical and religious commitments, the frequency of clinical ethical conflicts, and the obligations that doctors experiencing ethical conflict consider to be theirs.

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Method

In 2007, we mailed a confidential, self-administered questionnaire to a stratified random sample of primary care physicians drawn from the American Medical Association Physician Masterfile, a database intended to include all physicians in the United States. From the universe of practicing internal medicine, general practice, and family medicine physicians who are no more than 60 years old, we first selected 500 physicians at random. This group constituted the primary sample. Another aim of this survey was to explore physicians' religious characteristics, and, to increase Muslim, Hindu, and Buddhist representation, we used validated surname lists[19,20] to select an additional 250 physicians with typical South Asian surnames and an additional 250 physicians with typical Arabic surnames. Demographic characteristics, shown in Table 1, included sex, race, age, region of the country, and immigration history. Physicians received up to three separate mailings of the questionnaire. The first mailing included a $5 Starbucks gift card, and the third offered $30 for participation. The study was approved by the University of Chicago institutional review board.

Questionnaire

The primary criterion variable was whether physicians believe there is ever a professional obligation to provide services that they personally believe are morally wrong. This variable was operationalized by asking physicians whether they agreed or disagreed with two statements: (1) A physician should never do what he or she believes is morally wrong, no matter what experts say, and (2) Sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so. These two test statements were located among several ethical questions; however, no specific instructions or vignettes were provided. Physicians were categorized into three groups: (1) those who agreed with the first statement and disagreed with the second, (2) those who agreed with the second statement and disagreed with the first, and (3) those who agreed with both statements. The few physicians (n = 8) who agreed with neither statement were excluded from this analysis.

Table 1

Demographic and Religious Characteristics of Respondents to a 2007 Ethics Survey Among a Stratified Random Sample of U.S. Primary Care Physicians

Characteristics	No. (%)*
Demographic	
Sex (n = 446)	
Female	176 (39)
Male	270 (61)
Race (n = 437)	
Asian	191 (44)
Black or African American	18 (4)
Latino or Hispanic	23 (5)
White or Caucasian	192 (44)
Other	13 (3)
Age (years)† (n = 446)	
26–29	107 (24)
30–34	119 (27)
35–46	112 (25)
47–60	108 (24)
Immigration history (n = 433)	
Born in the United States	216 (50)
Immigrated to United States at any age	217 (50)
Specialty (n = 446)	
Family medicine or general practice	118 (26)
Internal medicine	328 (74)
Region‡ (n = 436)	
South	125 (29)
Midwest	110 (25)
Northeast	129 (30)
West	72 (17)
Religious	
Affiliation (n = 445)	
None	50 (11)
Hindu	93 (21)
Muslim	76 (17)
Catholic or Orthodox§	94 (21)
Evangelical Protestant	26 (6)
Non-Evangelical Protestant	71 (16)
Other	35 (8)
Intrinsic religious motivation (n = 443)	
Low	153 (35)
Medium	120 (27)
High	170 (38)
Attendance at religious services (n = 444)	
Never	53 (12)
No more than once a month	244 (55)
Twice a month or more	147 (33)
Identify as religious or spiritual (n = 443)	
Religious	248 (56)
Spiritual but not religious	101 (23)
Neither	94 (21)

* Because of rounding error, results may not sum to 100%. The "n" count does not always sum to 446 because of partial nonresponse.
† Average respondent age in years, 38.2 (SD = 10.2); range, 26–60.
‡ Respondents from Puerto Rico (n = 10) were included in all analyses but are not listed here.
§ Eleven respondents were Orthodox.

Predictor variables included measures of religious characteristics. Religious affiliation was categorized as no religion, Hindu, Muslim, Catholic or Orthodox, Evangelical Protestant, non-Evangelical Protestant, and other (includes Buddhist, Jewish, and other). Intrinsic religious motivation—the extent to which a person's religion is, in the phrase of Allport and Ross,[21] the "master motive" that guides and gives meaning to his or her life—was measured by asking the participants how much, on a scale of 1 to 4, they agreed or disagreed with seven statements: (1) I try hard to carry my religious beliefs over into all my other dealings in life, (2) My whole approach to life is based on my religion, (3) My faith involves all of my life, (4) I seek God's guidance when making every important decision, (5) My faith sometimes sets limits on my actions, (6) Nothing is as important to me as serving God as best I know how, and (7) In my life, I experience the presence of the Divine. These items are derived from the Hoge Intrinsic Religious Motivation Scale,[22] and they have a Cronbach alpha of 0.94 in our sample. Responses, which ranged from 1 (strongly agree) to 4 (strongly disagree), were averaged, and respondents were classified as having high, medium, or low intrinsic religious motivation. Organizational or participatory religiosity was measured by frequency of attendance at religious services, which was categorized as never, once a month or less, or twice a month or more. A substantial minority of physicians consider themselves *spiritual* but not *religious*. To identify this group, we asked physicians, "To what extent do you consider yourself a spiritual person?" and "To what extent do you consider yourself a religious person?" Responses were dichotomized (very or moderately versus slightly or not at all), and respondents were categorized as religious, spiritual but not religious, or neither spiritual nor religious.

Finally, we examined interactions between physicians' responses to the primary questions and their responses to items regarding moral controversies that arise in clinical practice. Physicians were asked whether they object to three controversial clinical procedures (physician-assisted suicide, abortion because of failed contraception, and abortion because the fetus has Down syndrome). Physicians were also asked how often patients request a medical procedure or treatment that the physician finds morally problematic. To study the ways doctors handle such controversies, we asked two questions: (1) "If a patient requests a legal medical procedure or treatment, but the patient's physician objects to the procedure/treatment for religious or moral reasons, does the physician have an obligation to provide the procedure/treatment him/herself?" and (2) "If the physician will not provide the procedure/treatment, does he or she have an obligation to refer the patient to someone who will?" Response categories for these items are shown in Table 2.

Statistical analysis

Case weights were assigned and included in the analyses to account for the oversampling of Arabic and South Asian surnames and for different response rates associated with gender, geographic region, and medical specialty. The weight for each of these four variables was the inverse of the probability that a person with the relevant characteristic would be included in our dataset, and the overall weight for each respondent was the product of these four weights. This method of case weighting—widely used in population-based survey research[23]—enabled us to adjust for sample stratification and variable response rates in order to generate estimates for the population of U.S. primary care physicians. After estimating the proportion of primary care physicians who agreed with each of the criterion measures, we used the chi-square test to examine the associations between each predictor and each criterion measure. Finally, we used multivariate logistic regression to test whether bivariate associations changed after adjustment for other relevant covariates. All analyses were conducted by using the survey-design-adjusted commands of Stata SE statistical software (version 10.0; Stata Corp., College Station, Tex).

Results

Approximately 12% (121) of the questionnaires were returned as undeliverable. The overall response rate among eligible physicians was 51% (446/879). Response rates varied by sample: 55% (246 respondents /450 eligible) of the primary sample responded, 49% (104/212) of the sample members with South Asian surnames responded, and 44% (96/217) of those with Arabic surnames responded. There was no significant variation in response by gender, region, or specialty. In our sample, 50 respondents had no religion; 93 were Hindu, 76 were Muslim, 94 were Catholic or Orthodox, 26 were Evangelical Protestant, 71 were non-Evangelical Protestant, and 35 belonged to some other religion (Buddhist, n = 5; Jewish, n = 16; and other, n = 14). The religious characteristics of our sample were similar to those found in a prior national survey of U.S. physicians from all specialties[17]: Most physicians were religious to some degree. Respondent characteristics are shown in Table 1. (It should be noted that, for all tables, "n" counts do not always sum to 446 because of selective item nonresponse.)

After adjustment for survey design, analyses showed that 78% of primary care physicians agreed with the statement, "A physician should never do what he or she believes is morally wrong, no matter what experts say." Yet, 57% agreed with the statement, "Sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so." According to the categorization described above, 42% of primary care physicians believed that physicians are never obligated to do what they personally believe is wrong; 22% believed that, as professionals, physicians are sometimes obligated to do what they personally believe is wrong; and 36% held a middle view, in which they agreed with both survey measures. When physicians had objections to controversial but legal medical procedures, most believed that they were not obligated to provide the procedures themselves (77% overall) but that they must refer patients to a physician who will provide the services (82% overall) (Table 2).

Measures of religious intensity, rather than specific religious affiliations, were the strongest predictors of believing that physicians are never obligated to do what they personally believe is wrong (Table 3). Specifically, bivariate analysis indicated that Christians were the most likely to be in this group (Catholic or Orthodox, 54%; Evangelical Protestant, 56%; non-Evangelical Protestant, 49%; no religion, 33%). However, multivariate analyses that adjusted for sex, age, region,

Table 2

Beliefs About Ethical Questions and Experiences of Moral Controversy Among Respondents to a 2007 Ethics Survey Among a Stratified Random Sample of U.S. Primary Care Physicians

Survey items	No. (%)*
Primary criterion variable statement #1: A physician should never do what he or she believes is morally wrong, no matter what experts say (n = 435)	
Agree	327 (78)
Disagree	108 (22)
Primary criterion variable statement #2: Sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so (n = 435)	
Agree	272 (57)
Disagree	163 (43)
Composite result: Is there ever a professional obligation for a physician to do what he or she personally believes is wrong? (n = 424)†	
Physicians are never obligated to do what they personally believe is wrong	154 (42)
Middle view	172 (36)
As professionals, physicians are sometimes obligated to do what they personally believe is wrong	98 (22)
Controversial procedures to which respondents objected	
Physician-assisted suicide (n = 431)	303 (68)
Abortion because of failed contraception (n = 427)	184 (44)
Abortion because fetus has Down syndrome (n = 425)	167 (44)
Frequency of encountering a clinical controversy‡ (n = 434)	
Never	227 (49)
No more than once a month	167 (42)
More than once a month	40 (9)
Clinical obligations if a patient requests a legal medical procedure or treatment, but the patient's physician objects to the procedure for religious or moral reasons	
Does the physician have an obligation to provide the procedure or treatment himself or herself? (n = 439)	
Yes	80 (14)
No	315 (77)
Undecided	44 (9)
If the physician will not provide the treatment or procedure, does he or she have an obligation to refer the patient to a doctor who will do so? (n = 440)	
Yes	365 (82)
No	44 (11)
Undecided	31 (7)

* Percentages reflect survey-design-adjusted estimates for the population of U.S. physicians, whereas the "n" counts reflect the raw number of respondents in our sample. The "n" count does not always sum to 446 because some questionnaires were returned without being completed.

† This composite result excludes the eight respondents who disagreed with both statements.

‡ Respondents were asked, "In your own practice, how often do patients request a medical procedure or treatment that you find morally problematic?"

immigration history, and specialty showed that only Catholic or Orthodox respondents were significantly more likely to be in this group than were those with no religion (odds ratio, 2.4; 95% CI, 1.0–5.7). Religious intensity measurements, however, were significant predictors in both bivariate and multivariate analyses. Doctors with high intrinsic religious motivation were more likely than were those with low intrinsic religious motivation to believe that physicians are never obligated to do what they personally believe is wrong (58% compared with 31%; OR, 2.8; 95% CI, 1.5–5.3). Similar findings were obtained in comparisons between those who attend services twice a month or more and those who "never" attend (58% compared with 31%; OR, 3.0; 95% CI, 1.2–7.2) and between those who described themselves as religious and those who are neither religious nor spiritual (53% compared with 28%; OR, 3.0; 95% CI, 1.6–5.7).

The position that physicians are never obligated to do what they personally believe is wrong had greater support from physicians who object to physician-assisted suicide (OR, 2.5; 95% CI, 1.4–4.5), abortion because of failed contraception (OR, 3.1; 95% CI, 1.8–5.3), or abortion because the fetus has Down syndrome (OR, 3.3; 95% CI, 1.9–5.5). Yet physicians' judgments on this issue were not significantly associated with actually having experienced moral conflict due to patients' requests (Table 3).

Unexpectedly, immigration history also emerged during multivariate analysis as an independent predictor. After adjustment for religious characteristics, sex, age, region, and specialty, physicians born in the United States were more than twice as likely as those born in other countries to report that physicians are never obligated to do what they personally believe is wrong (52% compared with 25%; OR, 2.7; 95% CI, 1.3–5.5).

As shown in Table 4, those who believe that physicians are never obligated to do what they personally believe is wrong were also less likely to believe that physicians must provide procedures to which they have a religious or moral objection (6% compared with 30%; OR, 0.2; 95% CI, 0.1–0.5) and less likely to believe that they have an obligation to refer the patient in such cases (67% compared with 94%; OR, 0.2; 95% CI, 0.1–0.5).

Table 3

Beliefs, as Stated in Responses to a 2007 Ethics Survey Among a Stratified Random Sample of U.S. Primary Care Physicians, About Whether a Physician Ever Has a Professional Obligation to Do What He or She Personally Believes Is Wrong, Stratified by the Respondents' Religious Characteristics and Objections to Controversial Clinical Practices*

Characteristics	Are physicians ever obligated as professionals to do what they personally believe is wrong?† Sometimes No. (%)	Middle view No. (%)	Never No. (%)	*P* (χ^2)	Multivariate odds of answering "never" OR (95% CI)
Religious characteristics					
Religious affiliation (n)					
No religion (47)	17 (32)	15 (35)	15 (33)	.001	1.0 referent
Hindu (84)	26 (22)	45 (56)	13(22)		0.9 (0.3–2.8)
Muslim (72)	16 (33)	40 (49)	16 (18)		1.0 (0.3–3.0)
Catholic or Orthodox (93)	17 (20)	25 (26)	51 (54)		2.4 (1.02–5.7)‡
Evangelical Protestant(25)	2 (7)	9 (36)	14 (56)		2.6 (0.8–3.0)
Non-Evangelical Protestant (69)	9 (14)	26 (36)	34 (49)		1.5 (0.6–4.0)
Other (34)	11 (35)	12 (38)	11 (26)		0.6 (0.2–1.9)
Intrinsic religious motivation (n)					
Low (146)	46 (31)	59 (38)	41 (31)	<.001	1.0 referent
Medium (111)	32 (31)	45 (37)	34 (32)		1.1 (0.5–2.1)
High (165)	20 (8)	67 (33)	78 (58)		2.8 (1.5–5.3)‡
Attendance at religious services (n)					
Never (50)	17 (35)	17 (33)	16 (31)	<.001	1.0 referent
No more than once a month (229)	62 (26)	102 (40)	65 (34)		1.3 (0.5–3.0)
Twice a month or more (143)	19 (11)	52 (31)	72 (58)		3.0 (1.2–7.2)‡
Self-identified as religious or spiritual (n)					
Neither religious nor spiritual (91)	26 (31)	41 (41)	24 (28)	<.001	1.0 referent
Spiritual but not religious (93)	31 (34)	34 (35)	28 (31)		0.9 (0.4–2.0)
Religious (237)	41 (13)	96 (34)	100 (53)		3.0 (1.6–5.7)‡
Responses to controversial practices					
Physician-assisted suicide (n)					
Do not object (121)	41 (35)	46 (36)	34 (30)	<.001	1.0 referent
Object (291)	53 (15)	119 (35)	119 (49)		2.6 (1.4–4.6)‡
Abortion because of failed contraception (n)					
Do not object (232)	72 (31)	100 (40)	60 (29)	<.001	1.0 referent
Object (176)	25 (12)	66 (31)	85 (57)		3.1 (1.8–5.4)‡
Abortion because fetus has Down syndrome (n)					
Do not object (247)	74 (31)	109 (40)	64 (30)	<.001	1.0 referent
Object (163)	23 (11)	56 (30)	84 (59)		3.3 (1.9–5.6)‡
Any experience of clinical controversy (n)					
Yes (199)	48 (23)	74 (33)	77 (44)	.56	1.3 (0.7–2.1)
No (217)	49 (21)	93 (39)	75 (40)		1.0 referent

* Multivariate analyses were adjusted for sex, age, region, immigration history, and specialty.
† Percentages reflect survey-design-adjusted estimates for the population of U.S. physicians in each category, whereas the "n" counts reflect the raw number of respondents in our sample belonging to each category. Because of rounding error, results may not sum to 100%.
‡ $P < .05$.

Discussion

The results of this survey provide a snapshot of primary care physicians' beliefs about their obligations when facing moral controversy. We found that physicians are divided about whether they ever have a professional obligation to do things they may personally believe are wrong. Many seem to be caught in the middle, which suggests that the accommodation of personal and professional commitments is not always a straightforward process.[24]

The disagreements reflected in these data are also present in ongoing discussions about the degree to which health care professionals should have the freedom of conscientiously refusing to provide or participate in clinical practices to which they have moral objections. That physicians generally ought to act conscientiously seems uncontroversial. The difficulty has been defining the range of conscientious actions that the medical profession ought to tolerate, particularly in light of significant concerns about patients' timely access to legal medical interventions. LaFollette and LaFollette[25] suggested that, because the actions of physicians often have such a profound effect on others, "We should not recognize—nor should medical professionals claim—an unqualified right of conscience." Mark Wicclair[10] argued, "[W]hen medicine is said to be a moral enterprise, the implication is not that physicians should be guided by their personal values, irrespective of their content. Rather, the implication is that physicians should be guided by the goals and values of medicine." He continued by suggesting that a physician's appeal to conscience has significant moral weight "only if the core ethical values on which it is based correspond to one or more core values in medicine."[10]

In light of these concerns, it would seem that a critical and perhaps perennial task for the medical profession is to determine which conscientious decisions are to be praised and encouraged, which are to be tolerated, and which are to be proscribed and actively resisted. Making these judgments will be challenging, in light of the fact that a significant percentage of physicians affirm an absolute duty to follow their own conscience, no matter what experts say. Moreover, whereas nonreligious physicians are fairly evenly divided among the three categories we

Table 4

Beliefs, Among Respondents to a 2007 Ethics Survey Among a Stratified Random Sample of U.S. Primary Care Physicians, About Their Clinical Obligations When Asked to Perform a Morally Controversial Procedure, Stratified According to Whether a Physician Ever Has a Professional Obligation to Do What He or She Personally Believes Is Wrong*

	Physician is obligated to provide procedure/treatment him/herself			Physician is obligated to refer patient to a doctor who will provide the treatment/procedure		
Question	No. (%)	*P* (χ^2)	OR (95% CI)	No. (%)	*P* (χ^2)	OR (95% CI)
Are physicians ever obligated as professionals to do what they personally believe is wrong? (n)						
Sometimes (98)	34 (30)	<.001	1.0 referent	91 (93)	<.001	1.0 referent
Middle view (170)	31 (14)		0.4 (0.2– 0.9)†	153 (93)		1.0 (0.3–3.5)
Never (154)	11 (6)		0.2 (0.1–0.5)†	108 (67)		0.2 (0.1–0.5)†

* Percentages reflect survey-design-adjusted estimates for the population of U.S. physicians in each category, whereas the "n" counts reflect the raw number of respondents in our sample belonging to each category. Multivariate analyses were adjusted for sex, age, immigration history, specialty, and region.
† $P < .05$.

defined, strongly religious physicians tend toward the category avowing an absolute obligation of conscience. If this finding indicates that disagreements about the role of conscience are grounded in differences between religious and secular worldviews, then consensus may be particularly difficult to achieve.

The idea that physicians should never act against conscience follows from a long Western tradition, expressed in the maxim, "Let your conscience be your guide." This tradition is rooted in part in Catholic moral theology, which says that an individual "must always obey the certain judgment of his conscience. If he were deliberately to act against it, he would condemn himself."[26] That this is a Western tradition not necessarily emphasized in all cultures may explain why physicians who have immigrated to the United States are much more likely than are those born here to endorse the idea that, as professionals, physicians are sometimes obligated to do what they personally believe is wrong. Alternatively, this finding may indicate that immigrants make a special effort to accommodate and adapt to what they perceive to be the expectations of the host culture.

Most physicians in our study believe that, when faced with a controversial request, they are not obligated to provide services to which they have moral or religious objections. Their view contrasts with that of Savulescu,[14] who recently argued that doctors who conscientiously refuse to perform legal procedures are offering partial medical services and are not fulfilling their obligation to care for their patients. The widespread reaction against pharmacists who refused to dispense emergency contraception[27] suggests that our society may be willing to give physicians greater leeway for conscientious refusals than it gives other health care professionals.[12,28]

Many theorists have argued that, if a physician will not provide a requested legal procedure himself or herself, he or she must refer the patient to another provider who will do so.[2,9,10,15,29] Most physicians in our study agreed with this approach; however, we observed some dissent among those who believed that physicians are never obligated to do what they believe is wrong. One may suppose that many in this latter group believe that, if it is wrong to perform a procedure, it may also be wrong to help a patient obtain it elsewhere.[3,30,31]

These patterns suggest a significant obstacle to efforts geared toward providing a unified standard of care for patients. Brock[32] has argued, "[E]ach profession has a responsibility to provide to the public a competent level of services—medical or pharmaceutical—and to monitor its individual members to [en]sure that they do so . . . . This level of services should include all legal and beneficial medical interventions sought by patients." He explained that, through a complex process, state and federal agencies, the courts, the public, and all professionals decide what these professional responsibilities entail. Patients can legitimately expect the profession to fulfill such responsibilities, because professionals have voluntarily accepted their role. Therefore, said Brock, individual physicians are not at liberty to exercise conscientious refusal unless (1) they inform the patient of all treatment options, (2) they refer the patient to a provider, and (3) the referral does not impose an unreasonable burden on the patient.[32] Our data suggest that this model, in which medical services are defined by society and made equally available to all patients, would be difficult to implement, inasmuch as physicians disagree about what is required of them as professionals. Furthermore, a substantial minority believes that physicians are never obligated to do what they personally believe is wrong, even if such a stance means refusing to refer a patient to an accommodating provider.

Considering the number of physicians who believe they are never obligated to do what they personally think is wrong, who have objections to controversial procedures, and who do not believe themselves to be obligated to provide services or refer patients, it was surprising that this group did not more frequently report having moral difficulty with patient requests. Perhaps physicians avoid practicing in areas of medicine they find morally problematic.[3,24,33] Perhaps physicians attract patients with similar values.[30,34,35] Alternatively, physicians may not recognize when their views contrast with those of their patients, or they may not give patients sufficient opportunities for open dialogue about controversial treatment options. All of these possibilities suggest that physicians should learn to engage various perspectives respectfully, so they will be less likely to skirt or overlook areas of conflict.

We were surprised to find that so many physicians agreed with both statements (the "middle view"), because we intended the two statements to be incompatible with one another. We can only speculate as to what accounts for this finding. Indeed, the form of the two test statements differed, with the first being an absolute statement—"A physician should never . . ."—and the second being a more circumscribed and moderate

statement—"Sometimes physicians have . . . ." In one sense, the whole debate centers on whether conscience holds an absolute or a relative claim, but it is possible that some physicians' responses reflected a reaction to the different forms of the statements as much as to the ideas within them. Another possibility is that most physicians strongly endorse both prima facie commitments—(1) always act according to conscience and (2) fulfill one's professional obligations—and have a hard time imagining a scenario in which the two would conflict for them. Or, perhaps many physicians believe they should never engage in practices that they believe are wrong, and that they should therefore stay out of areas of clinical practice in which professional expectations would include such practices. Finally, respondents may have felt genuinely caught in the middle or may have misunderstood what was being asked. Further research is warranted to clarify these ambiguities.

This study has several other limitations. We surveyed primary care physicians, but we recognize that specific concerns about conscience may manifest themselves differently in other areas of medicine. While our analysis found many correlations, the cross-sectional design cannot indicate the causes of these associations. Our response rate was consistent with averages for other published reports of mailed physician surveys,[36] but it is always possible that nonrespondents differed from respondents in ways that biased the findings in this study. Finally, self-reports are always imperfect measures of physicians' beliefs and practices.

In conclusion, we found significant variation among primary care physicians regarding whether they believe they sometimes have a professional obligation to provide medical services even if they personally believe doing so would be unethical. These findings suggest that, with respect to morally controversial practices, it will be difficult for members of the profession to provide a unified standard of care.

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Disclaimer

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