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Of More than One Mind: Obstetrician-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare

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INTRODUCTION

The American College of Obstetricians and Gynecologists notes that obstetrician-gynecologists (ob/gyns) are presented with "complex ethical questions" related to sexual practices, contraception, treatment of infertility, pregnancy and termination of pregnancy, and reproductive genetics and that "it is important for physicians to improve their skills in addressing ethical decisions."[1] At stake with respect to physicians' ethical decisions are both patients' access to legally permitted medical interventions and physicians' integrity in view of personal and professional ethical commitments. Yet despite continuous debates in academia,[2] law,[3] policy,[4] and the popular media,[5] little is known about how ob/gyns deal with these complex issues in the decisive arena of the clinical encounter.

Questions regarding how ob/gyns *should* navigate moral complexity relate to a long-standing debate regarding whether, and to what extent, physicians ought to influence patients' medical decisions. This debate ranges over many subjects and invokes a variety of ethical principles and norms. Yet the heart of the debate concerns what it means to both seek patients' good and respect patients' autonomy when making medical decisions. On the one hand, few today would defend physicians' paternalism as an ethical model for decision making (apart from medical emergency or a patient's incapacity to consent). Paternalism can violate a patient's right to self-determination,[6] and problematically assumes that the physician and patient share the same criteria for judging which medical decision is best.[7] Such criteria are ambiguous in a pluralistic culture, particularly with respect to morally complex issues like sexual and reproductive healthcare.[8]

On the other hand, bioethicists from a range of perspectives have argued that the pendulum has swung too far away from paternalism toward a form of patient autonomy that markedly restricts the physician's moral agency and responsibility and at times requires physicians to violate their own sense of moral integ-

rity.[9] Quill and Brody, for example, critique models in which "the physician should objectively answer questions but avoid influencing the patient to take one path or another, even if the physician has strong opinions or if the patient asks for advice."[10] Such models, they suggest, "make the physician an obstacle to rather than a resource for medical decision making."[11]

Between the two poles of overweening paternalism and unmitigated patient autonomy, bioethicists have proposed frameworks for decision making in which the patient makes the final choice, but that choice is informed by a dynamic interaction in which patient and physician exchange their ideas, experiences, and values.[12] It is not clear how these models work in the context of sexual and reproductive health concerns, in which the patient's experience is often complicated by vulnerability, fear, anxiety, and even shame.

Despite the moral complexities that are central to ob/gyn practice, little is known regarding how ob/gyns go about medical decision making in areas of ethical complexity and whether current patterns reflect particular ethical ideals. This study aims to identify the ways that practicing ob/gyns navigate the intersection of their own convictions, patients' preferences, and professional expectations when they address ethically complex issues in sexual and reproductive healthcare.

METHODS

We conducted one-to-one, in-depth, semi-structured interviews with a purposive sample of 19 practicing ob/gyns. Semi-structured interviews are often used to explore individuals' situated and complex decisions and experiences in order to better understand how they explain and justify those decisions and experiences.[13] We began with informal contacts and used snowball sampling (a method in which respondents identify additional respondents) to deliberately recruit practicing ob/gyns from a spectrum of geographic regions and moral traditions (religious and secular).[14] As the study progressed, a mainstream approach emerged that was endorsed by the majority, but not all, of the participants. To deepen the investigation of alternative approaches, we deliberately sought, in the latter half of the study, to interview physicians who were more or less critical of this mainstream approach. Qualitative researchers commonly employ such *purposive* sampling strategies to define the dimensions along which the concepts of interest vary.[15]

After informed consent was obtained, interviews were conducted in person or by telephone. These interviews lasted an average of one hour and were designed, as Crabtree notes, to "elicit narratives detailing the informant's conception of the identified domains."[16] Rather than asking ob/gyns about their general approach to medical decision making, interviewers asked participants to focus on those areas of clinical practice that they find ethically complex or problematic. Our interview guide, shown in table 1, was constructed and revised based on insights from an in-depth evaluation of the literature, pilot interviews, and review by expert colleagues.

Interviews were tape-recorded and transcribed verbatim. Transcripts were analyzed by employing an iterative process of textual analysis in the follow-

Table 1. Interview Guide

Question 1: "Do you encounter clinical situations in your practice that you find ethically complex or problematic?"
If physician responds "No," ask specifically about:

- Contraception
- Preconception counseling
- Abortion
- Maternal-fetal medicine
- Sexuality

If physician responds "Yes," ask the following, as indicated by the context:

- "What kinds of situations are these?"
- "How do you deal with or approach such situations?"
- "What do you think are the patient's expectations in that setting? Are those fair?"
- "What do you think are the expectations of the profession of ob/gyn for how you should respond in such settings? Are those fair?"
- "How do you deal with conflict between your own convictions, professional or colleagues' expectations, and patients' wishes?"

Question 2: "How would you describe your own religious convictions or commitments, if any?"
Question 3: "How do you think your religious commitments [or 'moral commitments' if physician not religious] shape your approach to the care of patients' sexual and reproductive health concerns?"

ing manner. After the fifth interview, SD and FC independently coded the full transcripts by identifying and labeling discrete units of text that referred to one or more concepts relevant to the study purpose. They met together subsequently to develop consensus and to create a working codebook of categories, subcategories, and concepts. A third investigator (SL) independently coded two manuscripts to check for consistency and adequacy of the codebook. Utilizing qualitative analysis software (Atlas TI – Scolari/Sage), all prior and subsequent transcripts were coded according to the codebook formulations. At various points throughout the study, the three investigators employed an inductive approach to the data to identify emergent themes, relationships, and patterns among them. Following the principle of *constant comparison,* the investigators examined each new transcript in relation to the prior ones to ensure that the codebook and our evolving interpretation of the findings reliably followed from the data.[17] Finally, representative quotations were chosen to tangibly demonstrate the themes identified; these are noted parenthetically in the results section by participant number using the notation (Px), where "x" corresponds to the participant number as indicated in table 2.

To strengthen the credibility of the findings, strategies commonly used in qualitative research were employed.[18] The authors, before data collection and during analysis, candidly acknowledged to one another their own judgments about how physicians should navigate areas of moral complexity in the clinical encounter and then engaged their disagreements as resources to prevent one-sided analysis.[19] Among the authors, views spanned the spectrum reflected in the study sample. Bringing to bear multiple perspectives in data analysis and interpretation strengthens the credibility of the findings and is known as investigator *triangulation*.[20] Additionally, interviews were conducted until *theoretical saturation* was reached — a point after which subsequent interviews produced no substantial new themes.[21] This study was approved by the University of Chicago Institutional Review Board.

Table 2: Characteristics of Participants

Participant	Age	Gender	Practice Setting	Region	Religious Affiliation
P1	66	Male	Private	West	Roman Catholic
P2	45	Male	Academic	Midwest	Jewish
P3	66	Male	Private	Midwest	Jewish
P4	72	Male	Private	Midwest	Jewish
P5	42	Male	Private	Midwest	Roman Catholic
P6	46	Male	Private	Southeast	Evangelical Christian
P7	63	Male	Religious hospital	Midwest	Methodist
P8	39	Female	Private	Southwest	Protestant
P9	57	Male	Private	Midwest	Jewish
P10	61	Female	HMO	Northeast	None
P11	33	Female	Academic	Northeast	Hindu
P12	44	Female	Private	Northeast	Protestant
P13	39	Female	Private	Northwest	None
P14	60	Male	Religious hospital	Midwest	Protestant
P15	66	Male	Private	Midwest	Roman Catholic
P16	50	Male	Private	Northeast	Roman Catholic
P17	44	Female	Private	Midwest	Evangelical Christian
P18	45	Male	Academic	Midwest	Roman Catholic
P19	42	Female	Private	Midwest	Roman Catholic

The interview numbers in this table correspond to those cited in the text. Religious affiliations are as defined by the participants themselves. To protect confidentiality, the order does not correspond precisely to the order in which interviews were conducted, and the ages of participants have been altered at random by +/- 0-3 years.

RESULTS

The characteristics of participants are listed in table 2. All participants described patients as the *final* decision makers in contexts of moral complexity. Yet participants disagreed about the proper scope of physician involvement in the decision-making process, particularly when patients and physicians disagreed about what should be done.

The majority of participants held that, in contexts of moral complexity, patients should ideally make informed, deliberate, personal decisions that are not unduly influenced by others, particularly physicians. We term this the *mainstream approach* because even its critics agreed that it predominates within contemporary ob/gyn practice. Ob/gyns who endorsed this ideal sometimes suggested that the good of the patient is either difficult to know or can only be known by the patient: "What may be right for one person may not be right for another. The thing about medicine is that there's usually no right or wrong answer" (P12). In light of ambiguity about the patient's good, the ob/gyns should avoid making moral judgments: "As a provider or physician, that you are called to offer service or help people and not judge or instruct them morally" (P12). Ob/gyns should rather "inform patients to the full extent" (P11) by providing all pertinent medical data and by disclosing all available medical options. As one noted, "I would just tell [the patient] that it's [prenatal genetic screening] available, give her the statistics . . . and let her decide" (P16). If a physician cannot provide the service requested, then he or she is "obliged to refer [the patient] and let her know about another doctor out there who might be willing to help" (P2).

Further emphasizing patient autonomy, these ob/gyns said that they make efforts to prevent undue outside influences from impinging on patients' voluntary decisions in areas of moral complexity. At times, they question the influence of patients' family members or sexual partners: "I asked her, 'Why are you doing this [seeking an abortion]? Is this for you or for your partner or for other people?' . . . she was being swayed by her family and her partner's family" (P12). And although these ob/gyns "help people explore their own feelings and evaluate the pros and the cons," they try to do so "without directing them one way or to any particular decision" (P13). Even if asked for advice (for example, about selective reduction of a multiple gestation), one explained, "I would put the ultimate decision back up to them. I probably would not say what I would do" (P11).

Ob/gyns who endorsed the mainstream approach, as a general rule, did describe situations in which they could not go along with patients' requests. For example, if a patient requests something that the physician believes will cause medical harm, the physician might invoke the responsibility of the medical profession to determine which interventions are medically indicated: "There certainly are limits. You certainly don't just do whatever the patient requests or demands if it's something that you consider totally medically inappropriate" (P14). Or, if a patient's request violates a widely held societal norm, the physician might invoke that norm. For example, several implied what one physician noted regarding sex selection: "I do draw the line at toying or playing with nature and biology" (P11). In other contexts, some appealed to the moral authority of the profession, noting that colleagues and/or the standards of the American College of Obstetricians and Gynecologists (ACOG) would not support what the patient requests.

Yet those who were more supportive of the mainstream approach noted that cases in which they refused patients' requests were exceptions to the general rule of honoring patients' wishes, and they typically added that they would offer to refer a patient to another physician if they could not come to agreement. The following quotation demonstrates the way that patient autonomy was emphasized as the ideal even when it was not fully carried out: "I realize this is an amazingly paternalistic thing to think [that a 19-year-old unmarried woman should not have in vitro fertilization], and I don't usually think like that. . . . As a general rule, my default is always to be the exact opposite. I'm here to provide services as long as they're not hurting anybody" (P2).

For some ob/gyns, boundaries to the mainstream approach arise in the most routine aspects of patient care. In our sample these were, with few exceptions, Roman Catholic or Evangelical Christians who experi-

ence frequent tensions between their patients' wishes and their own convictions about sexuality and reproduction. These ob/gyns talked about being obligated to make judgments about which medical decisions are more and less morally right, and they described their efforts to influence patients to make choices that the physician believes are in the patient's best interest. They justified their divergence from the mainstream approach by challenging its premises or reinterpreting its implications.

For example, several said that they fulfill the obligation to fully inform patients about medical options by talking to patients about the ostensible harms of those medical decisions that the ob/gyn judges to be immoral. One said that, unlike "many doctors," he informs patients that abortion may hurt them in the "long term" by influencing "depression, suicide rates, cancer, possible risk of infertility in the future, emotional and mental distress, as well as social distress between the partners" (P5). These ob/gyns often do not see their own influence as a threat to the patient, but rather as a force that countervails other societal pressures. They therefore challenge influences "from people, from society, and from [patients'] partners" that may lead patients to do something that the physician does not believe "is in their best interest" (P19).

Although they conceded that patients make the *final* decisions, these ob/gyns do not always avoid being directive in their counsel. One described his approach this way: "I think one of our jobs is to help counsel patients, to uncover for them the truth, to point out to them the lies that they are subjected to, or to make sure that they are informed before they end up going down a wrong course of action" (P18). Others said they probe patients' motivations and thought processes: "I ask them questions. How do you feel about it? What do you think? . . . And then I sometimes ask, 'Are you interested in any suggestions?' "(P6).

Paradoxically, these ob/gyns at some points justified the influence of their own biases, and at other points said that they make every effort to be unbiased. For example, one ob/gyn said, "I would work very hard to keep my life bias [referring to the topic of abortion] out of this discussion, but . . . the flaw in the system, from my personal perspective, is that the politically correct bias isn't represented as a bias. It is totally inherent in the system . . . I am getting more comfortable saying, 'Well, by the way, I'm in the minority here, and I hope that this won't affect my ability to care for you, but my bias is on the other side of this issue' " (P17).

When they are not able to persuade patients, these ob/gyns may clarify their boundaries by explaining to patients why they will not provide or participate in what the patient has requested. Some will make their proscriptions explicit up-front. For example, an ob/gyn who will not prescribe contraceptives said, "When [patients] call to make an appointment, they are told . . . 'You should know that she does not prescribe the birth-control pill [or] Depo [depot medroxyprogesterone] shot [or] place IUDs . . .' We actually rattle all that off — the whole laundry list" (P19). Yet if a patient requests a medical intervention that the ob/gyn does not support, the ob/gyn may refuse to provide a referral for the patient. Such refusals were described most often in reference to abortion. One ob/gyn explained, "I've told patients, 'You are doing something I don't agree with, so I can't in good conscience tell you where to go' " (P8). Others say they defer problematic requests by having the patient talk with or be seen by a colleague. One described her ambivalence about telling patients to talk to someone else in the office: "It is an indirect referral . . . it is a line I have to draw, but it is also living in an information era. They can easily access this information" (P17).

All of the supporters of the alternative approaches eventually described the religious roots of their objections to certain medical decisions. Yet they tended to initially justify their approaches in nonreligious and even morally neutral terms. When they did articulate moral judgments, these ob/gyns generally justified them by reference to uncontroversial concepts, such as a commitment to the patient's medical good, the physician's obligation to do no harm, or the Hippocratic Oath, rather than by reference to particular religious commitments or traditions. As the following quotations demonstrate, this pattern at times seemed to obscure the sources of the physicians' counsel.

> [Talking to patients about sexuality] is easy because the science works for me. I don't have to say anything about my values. (P17)

> Even though I'm a Christian, [patients] are not coming to see me for my faith. They are coming to see me for medical care, so I try and keep it on a medical level. (P19)

> It is not very often that I have to bring in my Catholic beliefs although that is definitely what forms my beliefs. (P5)

DIFFERENT APPROACHES YIELD DIFFERENT CONCLUSIONS

Participants disagreed sharply regarding what patients expect from their physicians in morally complex clinical scenarios. Those who more strongly endorsed the mainstream approach said that patients neither expect nor desire moral counsel from their ob/gyns. Several noted what one expressed in this way: "I haven't ever been in a situation that I can remember that the person didn't already have her mind made up [about having an abortion] when she came in" (P2). Others commented that even undecided patients would prefer for their physicians to stick to the medical facts and empathically support the choice the patient makes: "[A patient expects me] to outline the options, to go over the complications, to let her and her significant other know that ultimately it's their decision, not my choice" (P3).

Those who believed that patients do not expect directive counsel also believed that patients are unlikely to be influenced by such counsel, particularly regarding sexual behaviors. Noted one, "Chances are no matter how long I talk to [the patient] and tell her what I think is important, she's still going to have sex, and she's still going to get pregnant, and she's still going to get sexually transmitted diseases" (P2). Most participants focused instead on preventing medical harms that may accompany sexual activity: "When they do get involved with multiple partners then I feel I do need to counsel them. I talk to them about protection for pregnancy and sexually transmitted diseases" (P7).

Physicians who challenge patients about their sexual behavior were more ambivalent about what patients expect. They acknowledged that patients are often surprised — "They tell me that no one has ever had this discussion with them" (P18) — and that some women are unlikely to change their sexual behavior regardless of what her physician says. Yet several argued that many patients are looking to their physicians for directive counsel. One described his perception this way: "I think most of them are looking for guidance, direction . . . and truth in an ethical situation. They're looking for insight . . . and help. They are in a situation and they are coming to you saying, 'What would you do?' " (P6). Others said that even when patients were not looking for advice, their counsel "has caused some patients to take a hard look at some of the decisions that they have made" (P5). As such, they expect to influence those who are "on the fence," if not those who have "made up their mind" (P19).

Across the board, participants seemed cautious to avoid the impression that they were *imposing* their values on their patients or that they were acting without compassion. Those who followed the mainstream approach often commented that they would not make or disclose moral judgments about patients' decisions, because to do so would be "judgmental" (P2, P3, P4, P9, P12, P13), and a breach of professional boundaries. One noted, "I think that for a physician to superimpose his or her moral standing on that patient is not the right thing to do professionally" (P10).

Supporters of alternative approaches tried to distinguish making moral judgments from lacking compassion toward patients. They justified their approaches as consistent with a commitment to the patient's long-term good (P5). One ob/gyn invoked a religious concept to express an idea that several mentioned in other terms: "You are your brother's keeper to a certain extent . . . and when you see your brothers and sisters going the wrong way . . . you have an obligation, I believe, to at least voice your concern about that behavior" (P18). Some supporters of the alternative approach argued that they were not imposing their values on patients, but rather were trying to live out their own commitments with integrity: "Just as I do not ask my patients to compromise their morals and ethics, I will not compromise on mine" (P18).

All participants said that they willingly continue to care for patients regardless of moral disagreements, even after patients go elsewhere to obtain a service that the ob/gyn has refused to provide. Yet two ob/gyns

did note that they had found it difficult at times to care for patients who had had an abortion. One described a conversation with such a patient the following way: "I told her . . . 'I'm having a hard time with this. I'll take good care of you. However, if I feel like I cannot act competently, I'll have you talk with one of my partners.' We've worked through it, but I thought my job as her physician was to let her know that I might have some issues, that we would have to see how it goes" (P19).

Supporters of alternative approaches said that, for the most part, patients have been "understanding" (P5) and "respectful" (P19) regarding their boundaries and "grateful" (P17) to hear their opinions. Yet they acknowledged that some patients avoided them altogether and that, as one put it, "The [patients] that transfer care are the ones that are upset" (P19).

IMPLICATIONS FOR THE PROFESSION OF OBSTETRICS AND GYNECOLOGY

Both subscribers to and critics of the mainstream approach to morally complex medical decisions agreed that the latter are in the minority among ob/gyns. The critics said that at times they feel ostracized from and alienated by the rest of the profession, and they expressed deep disappointment with and frustration toward what they judge to be the majority's "politically correct" (P17) and "irresponsible" (P6) approach to sexual and reproductive health.

Those in the mainstream charged their critics with "inflicting" (P12, P13), "imposing" (P9) and "forcing" (P3) their values on patients and thereby violating professional boundaries. One concluded, "If they want to become priests or ministers and practice religion that's fine, but they shouldn't be practicing medicine" (P3). Those who followed the mainstream approach were most disturbed by refusals to refer patients for what are legal medical interventions, actions one described as "breaking a professional code of responsibility to the patient" (P2).

Despite their differences, it seemed that the physicians try to work together peaceably as colleagues. Several mainstream ob/gyns expressed what one summarized this way: "I don't have much patience for [physicians of the alternative approach], but I would not want them to do anything that they could not do in conscience" (P4). Those outside the mainstream noted that they have been able to work out collegial relationships that allow them to practice conscientiously. "[My colleagues] have come to the understanding that I am not compromising anybody's care and that I am just serving a different part of the community that feels more in line with my beliefs" (P5).

DISCUSSION

Interviews with a geographically and religiously diverse purposive sample of practicing ob/gyns revealed two different narratives about the process of medical decision making in the context of moral complexity. The narrative of those who follow the mainstream approach emphasizes the primacy of patients' autonomy, and its adherents aim to maintain moral neutrality in their counsel if not also in their own minds. When dilemmas arise, moral decisions are referred to the patient. In contrast, an alternative approach is described wherein ob/gyns address moral complexity by engaging strategies such as persuasion, sharing of personal values, reference to a moral authority, or clarification of boundaries to influence the decisions that patients ultimately make. Some — in our sample most were Roman Catholic and Evangelical Christians (though other Roman Catholic and Protestant Christians in our sample employed a mainstream approach) — engaged a directive, persuasive approach to medical decision making even for routine matters in sexual and reproductive healthcare.

To characterize these approaches as rigid for given physicians over time would both oversimplify and overstate our findings. In fact, our data suggested that individual physicians may vary their approach in relation to factors such as the quality and history of the patient-physician relationship, the individual patient's circumstances, experience, and the practices of their professional partners or colleagues. Finally, the participants were clearly aware that, among ob/gyns, there are differing approaches to areas of moral complexity.

While some expressed animosity or disdain toward the approaches of those who differed from them, others stated that they could practice compatibly even with colleagues who disagreed on these basic issues. This latter observation corroborates previous findings.[22]

Our findings suggest that, for practicing ob/gyns, debates about the proper role of the physician in medical decision making are complicated by concerns about personal moral integrity and by disagreements about how the patient's best interest can best be known and protected. The familiar rubric of paternalism versus autonomy usually presumes that physicians at least are agreed about the patient's best interest, even if the patient is not so persuaded. Yet, with respect to morally controversial aspects of sexual and reproductive healthcare, ob/gyns who all profess to be committed to the patient's best interest apparently disagree about what that interest entails. Some defer to patients' judgment and accommodate patients' requests so long as those requests are in accord with professional medical standards. Others encourage patients to make what the physician believes to be, based on convictions the patient may not share, morally "admirable"[23] medical decisions. These differences undoubtedly shape the care that patients receive in areas of moral complexity.

Siegler has argued that the clinical encounter has always been less a neutral exchange than a dynamic process of mutual influence and negotiation, which culminates in a *physician-patient accommodation.*[24] One danger in that process, particularly in areas of moral disagreement, is that "mutuality" will devolve toward coercive or patronizing paternalism.[25] Against that tendency, Childress and Siegler recommend three procedural safeguards.[26]

The first procedural value is *disclosure:* ob/gyns must not withhold information that is relevant to the patient's decision, and they must be *candid* about their own biases.[27] Quill and Brody argue that an open dialogue, "in which the physician frankly admits his or her biases, is ultimately a better protector of the patient's right to autonomous choice than artificial neutrality would be."[28] In that respect, it would be better for ob/gyns who endorse the alternative framework to be explicit about what their commitments are than to misrepresent those commitments or to leave them operative but undisclosed. Some authors have suggested that disclosure should occur prior to initiation of the physician-patient relationship, for example, via a sign posted in a waiting room, a brochure sent to prospective patients in advance of a visit, or via phone when the patient calls for an appointment — a practice reported by a few of the ob/gyns in our study.[29]

The second procedural value is *voluntariness:* the patient must not be coerced.[30] Some suggest that physicians may unduly influence patients by disclosing their own moral judgments. Chervenak and McCullough have argued, for example, that with respect to abortion, "No judgments about the morality of those decisions should be expressed to the pregnant woman, for whom the obstetrician acts exclusively in the role of physician, not private person."[31] In contrast, Thorp and Bowes, in defending the "pro-life" perinatologist, argue that any ob/gyn is justified in "forthrightly announcing his or her worldview, as long as the patient understands the point of view (biases) held by her counselor."[32] Although they disagree about whether physicians' moral judgments should be disclosed, they share the judgment that the physician-patient relationship should "never be used to coerce a patient into complying with her physician's morality."[33]

A clear point of tension among our participants was whether an ob/gyn ever has sufficiently compelling reasons to justify not counseling about or referring a patient for a legal medical intervention to which the ob/gyn objects (the case of abortion was most often referenced in our interviews). In the articles we consider here, the bioethicists do not definitively answer this question. Childress and Siegler say that, in such situations, physicians "may" have a duty to inform patients about other physicians who would provide what the patient requests,[34] and Quill and Brody comment that physicians are "perhaps" obligated to facilitate the transfer of care.[35] Yet these authors do suggest that disclosure and voluntariness are prerequisites to and necessary conditions for the final safeguard — that all negotiations between physicians and patients end in a *mutually acceptable accommodation.*[36]

It is not clear that a mutually acceptable accommodation is always possible if a physician will not counsel about or refer for a particular medical intervention. Siegler allows for a physician to refuse to participate in that which "would violate his personal sense of responsible conduct," so long as "the patient's emergency health care needs are attended to."[37] A point of debate is to what extent "health care needs" would

include, for example, providing postcoital contraception or abortion to a woman who cannot readily access another physician because of her limited resources, the practice location, or the acuity of her medical condition.[38] Moreover, Siegler suggests that, at points of deep disagreement, the only possible accommodation may be a termination of the particular physician-patient relationship.[39] Others have noted that, in decisions related to pregnancy, such accommodations may be regarded by patients as acts of coercion or abandonment, particularly in the absence of alternative and accessible sources for care.[40] The issue becomes particularly acute with respect to women who have been the victims of sexual violation or assault.

Disclosure, voluntariness, and the negotiation of acceptable accommodations all protect against paternalistic abuses of physician power. Yet even the best procedural safeguards can be circumvented or distorted if ob/gyns, whatever their moral frameworks, are not sufficiently committed to their patients' good. Ultimately, deliberative and interactive models for medical decision making depend on ob/gyns being *caring* physicians who put their patients' interests before their own.[41] Creativity, honesty, and flexibility within the individual patient-physician relationship are required to find accommodations that require neither the physician nor patient to violate their own integrity. Physicians must be, in Thomasma's words, motivated by conscience rather than the superego and must have "a healthy appreciation for moral ambiguity."[42]

Our study has important limitations. First, qualitative methods are powerful for generating rich descriptions of the ways that ob/gyns think about this complex topic, yet they do not allow any statistical inference regarding how the themes we found are distributed within the broader population of physicians. Second, the analysis and interpretations are those of the authors. It remains possible that somewhat different interpretations might emerge with different investigators and a different sample, and future studies are warranted to see if our findings are corroborated by other investigators in other settings.

In conclusion, our findings suggest that, within the one profession of obstetrics and gynecology, there are different and dissonant ideas about how a caring physician should approach medical decision making in areas of moral ambiguity. These differences have implications for ob/gyns and their patients. The intensity of rhetoric used by some ob/gyns to describe others suggests that these are sensitive and charged issues. In light of that, ob/gyns might take up respectful discourse about their disagreements by starting with the apparent fact that they are often able to work together and accommodate one another as colleagues, even in the same practice groups.

Moreover, our study suggests that in the area of sexual and reproductive healthcare, patients' experiences, and potentially their medical decisions, may differ based on the ethical approaches of their ob/gyns, a hypothesis supported by data from a recent national survey.[43] This observation may have important implications for how women approach the selection of a physician, where such choice is available, and for maximizing harmony between patients and physicians in medical decision making. Simultaneously, this observation should caution ob/gyns against the real possibility of harm that could result from alienating or abandoning a patient in need, particularly one who cannot access other care due to limitations in personal or practice setting resources. As such, we hope our study will spur further deliberation and inquiry about the appropriate forms of physician-patient communication in contexts where patients' and physicians' moral judgments conflict.

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NOTES

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