

SPECIAL ARTICLE

Religion, Conscience, and Controversial Clinical Practices

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ABSTRACT

BACKGROUND

There is a heated debate about whether health professionals may refuse to provide treatments to which they object on moral grounds. It is important to understand how physicians think about their ethical rights and obligations when such conflicts emerge in clinical practice.

METHODS

We conducted a cross-sectional survey of a stratified, random sample of 2000 practicing U.S. physicians from all specialties by mail. The primary criterion variables were physicians' judgments about their ethical rights and obligations when patients request a legal medical procedure to which the physician objects for religious or moral reasons. These procedures included administering terminal sedation in dying patients, providing abortion for failed contraception, and prescribing birth control to adolescents without parental approval.

RESULTS

A total of 1144 of 1820 physicians (63%) responded to our survey. On the basis of our results, we estimate that most physicians believe that it is ethically permissible for doctors to explain their moral objections to patients (63%). Most also believe that physicians are obligated to present all options (86%) and to refer the patient to another clinician who does not object to the requested procedure (71%). Physicians who were male, those who were religious, and those who had personal objections to morally controversial clinical practices were less likely to report that doctors must disclose information about or refer patients for medical procedures to which the physician objected on moral grounds (multivariate odds ratios, 0.3 to 0.5).

CONCLUSIONS

Many physicians do not consider themselves obligated to disclose information about or refer patients for legal but morally controversial medical procedures. Patients who want information about and access to such procedures may need to inquire proactively to determine whether their physicians would accommodate such requests.

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RECENT CONTROVERSIES REGARDING PHYSICIANS and pharmacists who refuse to prescribe or dispense emergency and other contraceptives have sparked a debate about conscientious objection in health care.¹⁻⁵ On the one hand, most people believe that health professionals should not have to engage in medical practices about which they have moral qualms. On the other hand, most people also believe that patients should have access to legal treatments, even in situations in which their physicians are troubled about the moral implications of those treatments.⁶ Such situations raise a number of questions about the balance of rights and obligations within the doctor-patient relationship. Is it ethical for physicians to describe their objections to patients? Should physicians have the right to refuse to discuss, provide, or refer patients for medical interventions to which they have moral objections?

The medical profession appears to be divided on this issue. Historically, doctors and nurses have not been required to participate in abortions or assist patients in suicide, even where those interventions are legally sanctioned. In recent years, several states have passed laws that shield physicians and other health care providers from adverse consequences for refusing to participate in medical services that would violate their consciences.⁷ For example, the Illinois Health Care Right of Conscience Act protects a health care provider from all liability or discrimination that might result as a consequence of “his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.”⁸ In the wake of recent controversies over emergency contraception, editorials in leading clinical journals have criticized these “conscience clauses” and challenged the idea that physicians may deny legally and medically permitted medical interventions, particularly if their objections are personal and religious. Charo, for example, suggests that the conflict about conscience clauses “represents the latest struggle with regard to religion in America,” and she criticizes those medical professionals who would claim “an unfettered right to personal autonomy while holding monopolistic control over a public good.”⁹ Savulescu takes a stronger stance, arguing that “a doctor’s conscience has little place in the delivery of modern medical care” and that “if people are not prepared to offer legally permitted, efficient,

and beneficial care to a patient because it conflicts with their values, they should not be doctors.”⁹

In spite of such debates, there have been few empirical studies of how physicians think about their responsibilities when their own moral convictions conflict with their patients’ requests for legal medical procedures. We examined data from a national survey of U.S. physicians to determine what practicing physicians think their obligations are when a patient requests a legal medical procedure to which the physician has a religious or other moral objection. We quantify the percentage of physicians who might refrain from presenting all treatment options to patients or refuse to refer them to an accommodating provider, and we examine whether particular subgroups of physicians are more likely to do so. We then discuss the implications for ongoing debates concerning the ethics of the doctor-patient relationship.

METHODS

This study’s methods have been described in detail elsewhere.^{10,11} In 2003, we mailed a confidential, self-administered, 12-page questionnaire (see the Supplementary Appendix, available with the full text of this article at www.nejm.org) to a random sample of 2000 practicing U.S. physicians 65 years of age or younger. The sample was stratified according to specialty. These physicians were chosen from the American Medical Association Physician Masterfile — a database intended to include all physicians in the United States. We included modest oversamples of psychiatrists and physicians who work in several other subspecialties that deal particularly with death and severe suffering, in order to enhance the power of analyses that are not central to this article. Physicians received up to three separate mailings of the questionnaire, and the third mailing offered \$20 for participation. The study was approved by the institutional review board of the University of Chicago.

QUESTIONNAIRE

The primary criterion variables were physicians’ responses to the following three questions: “If a patient requests a legal medical procedure, but the patient’s physician objects to the procedure for religious or moral reasons, would it be ethical for the physician to plainly describe to the patient why he or she objects to the requested procedure? Does the physician have an obligation to present all possible options to the patient, including infor-

mation about obtaining the requested procedure? Does the physician have an obligation to refer the patient to someone who does not object to the requested procedure?" Response categories were yes, no, and undecided.

We also assessed physicians' intrinsic religiosity and religious affiliations. Intrinsic religiosity — the extent to which a person embraces his or her religion as the "master motive" that guides and gives meaning to his or her life¹² — was measured on the basis of agreement or disagreement with two statements: "I try hard to carry my religious beliefs over into all my other dealings in life" and "My whole approach to life is based on my religion." Both statements are derived from Hoge's Intrinsic Religious Motivation Scale¹³ and have been validated extensively in previous research.¹³⁻¹⁵ Intrinsic religiosity was categorized as being low if physicians disagreed with both statements, moderate if they agreed with one but not the other, and high if they agreed with both.

The religious affiliations of the physicians in the survey were categorized as none (a category that included atheist, agnostic, and none), Protestant, Catholic, Jewish, or other (a category that included Buddhist, Hindu, Mormon, Muslim, Eastern Orthodox, and other). Organizational¹⁶ or participatory¹⁷ religiosity was measured according to the frequency of attendance at religious services (never, once a month or less, or twice a month or more).

To determine whether physicians' judgments about their ethical obligations are associated with their views on controversial clinical practices, we asked the survey respondents whether they have a religious or moral objection to terminal sedation (administering sedation that leads to unconsciousness in dying patients), abortion for failed contraception, and the prescription of birth control to adolescents without parental approval. Secondary predictors were the demographic characteristics (age, sex, race or ethnic group, and region) of the physicians surveyed and whether they worked in an academic health center or a religiously oriented or faith-based institution. The primary medical specialty was included as a control variable in the multivariate analyses.

STATISTICAL ANALYSIS

Weights¹⁸ were assigned and included in the analyses to account for the sampling strategy and the modest differences in response rates according to the respondents' sex and whether they had

graduated from a U.S. or foreign medical school. We first generated overall population estimates for agreement with each of the criterion measures. We then used a Mantel-Haenszel test for trend with one degree of freedom (for ordinal predictors) and the chi-square test (for nonordinal predictors) to examine the associations between each predictor and each criterion measure. Finally, we used multivariate logistic regression to examine whether associations persisted after controlling for other covariates. All reported P values are two-sided and have not been adjusted for multiple statistical testing. All analyses were conducted with Stata SE statistical software (version 9.0).

RESULTS

Of the 2000 potential respondents, an estimated 9% could not be contacted because their addresses were incorrect or they had died (see the Supplementary Appendix). Among physicians who could be contacted, the response rate was 63% (1144 of 1820). Graduates of foreign medical schools were less likely to respond than graduates of U.S. medical schools (54% vs. 65%, $P < 0.001$), and men were less likely to respond than women (61% vs. 67%, $P = 0.03$). These differences were accounted for by assigning case weights. The response rates did not differ significantly according to age, region, or board certification. The characteristics of the respondents are listed in Table 1.

On the basis of these results, we estimated that when a patient requests a legal medical procedure to which the doctor objects for religious or moral reasons, most physicians believe it is ethically permissible for the doctor to describe that objection to the patient (63%) and that the doctor is obligated to present all options (86%) and to refer the patient to someone who does not object to the requested procedure (71%) (Table 2).

Physicians who were more religious (as measured by either their attendance at religious services or their intrinsic religiosity) were more likely to report that doctors may describe their objections to patients, and they were less likely to report that physicians must present all options and refer patients to someone who does not object to the requested procedure (Table 3). As compared with those with no religious affiliation, Catholics and Protestants were more likely to report that physicians may describe their religious or moral objections and less likely to report that physicians are obligated to refer patients to

Table 1. Characteristics of the 1144 Survey Respondents and Objections to Controversial Clinical Practices.*

Characteristic	No./Total No. (%)	Characteristic	No./Total No. (%)
Female sex	300/1142 (26)	Religious characteristics	
Race or ethnic group†		Intrinsic religiosity	
White, non-Hispanic	869/1121 (78)	Low	407/1098 (37)
Asian	138/1121 (12)	Moderate	292/1098 (27)
Hispanic or Latino	57/1121 (5)	High	399/1098 (36)
Black, non-Hispanic	26/1121 (2)	Attendance at religious services	
Other	31/1121 (3)	Never	114/1128 (10)
Region		Once a month or less	499/1128 (44)
South	386/1142 (34)	Twice a month or more	515/1128 (46)
Midwest	276/1142 (24)	Religious affiliation	
Northeast	264/1142 (23)	Protestant	428/1127 (38)
West	216/1142 (19)	Catholic	244/1127 (22)
Practice in academic medical center	353/1115 (32)	Jewish	181/1127 (16)
Practice in religiously oriented center	138/1111 (12)	None	117/1127 (10)
Primary specialty		Other	157/1127 (14)
Medical and subspecialties	231/1142 (20)	Opinions about controversial clinical practices	
Family practice	158/1142 (14)	Terminal sedation	
Pediatrics and subspecialties	147/1142 (13)	Do not object	915/1097 (83)
General internal medicine	129/1142 (11)	Object	182/1097 (17)
Psychiatry	100/1142 (9)	Abortion due to failed contraception	
Surgery and subspecialties	100/1142 (9)	Do not object	527/1091 (48)
Obstetrics and gynecology	80/1142 (7)	Object	564/1091 (52)
Other	197/1142 (17)	Prescription of birth control to adolescents without parental consent	
		Do not object	647/1108 (58)
		Object	461/1108 (42)

* Numbers do not all sum to 1144 because not all respondents answered all the questions. The mean (\pm SD) age of respondents was 49.0 \pm 8.3 years.

† Race and ethnic group were reported by patients on the survey.

someone who does not object to the requested procedure.

Physicians who objected to abortion for failed contraception and prescription of birth control for adolescents without parental consent were more likely than those who did not oppose these practices to report that doctors may describe their objections to patients ($P < 0.001$ for both comparisons); the association for the objection to terminal sedation was not significant ($P = 0.11$) (Table 4). Physicians who objected to the three controversial medical practices were less likely to report that doctors must present all options and refer patients to other providers ($P < 0.001$ for

all comparisons). The associations for religious characteristics and objections to controversial clinical practices persisted after controlling for age, sex, ethnic group, region, and specialty.

After adjustment for religious characteristics and other covariates, region, race or ethnic group, practice in an academic medical center, and practice in a religiously oriented health center were not significantly associated with any of the criterion variables. However, with increasing age, physicians were more likely to report that doctors may describe their objections to patients (odds ratio for each additional year of age, 1.02; 95% confidence interval [CI], 1.00 to 1.04). Men were more likely

than women to report that physicians may describe their objections (odds ratio, 1.8; 95% CI, 1.3 to 2.5) and less likely to report that physicians are obligated to present all options (odds ratio, 0.5; 95% CI, 0.3 to 0.9) and refer patients to an accommodating provider (odds ratio, 0.5; 95% CI, 0.3 to 0.7).

DISCUSSION

Most of the physicians in our survey reported that when a patient requests a legal medical intervention to which the physician objects for religious or moral reasons, it is ethically permissible for the physician to describe the reason for the objection but that the physician must also disclose information about the intervention and refer the patient to someone who will provide it. However, the number of physicians who disagreed with or were undecided about these majority opinions was not trivial. If physicians' ideas translate into their practices, then 14% of patients — more than 40 million Americans — may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients — or nearly 100 million Americans — may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments. The proportion of physicians who object to certain treatments is substantial. For example, 52% of the physicians in this study reported objections to abortion for failed contraception, and 42% reported objections to contraception for adolescents without parental consent.

The findings of this study may be important primarily for patients. They should know that many physicians do not believe they are obligated to disclose information about or provide referrals for legal yet controversial treatments. Patients who want full disclosure from their own physicians might inform themselves of possible medical interventions — a task that is not always easy — and might proactively question their physicians about these matters. Patients may not have ready access to information about physicians' religious characteristics and moral convictions. Thus, if patients are concerned about certain interventions for sexual and reproductive health and end-of-life care, they should ask their doctors ahead of time whether they will discuss such options.

Table 2. Opinions about the Ethical Obligations of a Physician Who Objects to a Legal Medical Procedure Requested by a Patient.

Question and Response	No. (%) [*]
Would it be ethical for the physician to plainly describe to the patient why he or she objects to the requested procedure?	
Yes	715 (63)
Undecided	168 (15)
No	244 (22)
Does the physician have an obligation to present all possible options to the patient, including information about obtaining the requested procedure?	
Yes	981 (86)
Undecided	61 (6)
No	86 (8)
Does the physician have an obligation to refer the patient to someone who does not object to the requested procedure?	
Yes	820 (71)
Undecided	114 (11)
No	194 (18)

^{*} Population estimates account for the survey design. Percentages reflect weighted results.

If a patient wants a treatment that the physician will not provide, the patient may choose to consult a different physician.

Physicians' judgments about their obligations are significantly associated with their own religious characteristics, sex, and beliefs about morally controversial clinical practices. Female physicians are more supportive of full disclosure and referral than are male physicians, perhaps because many controversial issues in medicine (e.g., abortion, contraception, and assisted reproductive technologies) disproportionately involve the sexual and reproductive health of women. Religious physicians are less likely to endorse full disclosure and referral than are nonreligious physicians, perhaps because, as many previous studies have shown, religious physicians are more likely to have personal objections to many controversial medical interventions. Thus, those physicians who are most likely to be asked to act against their consciences are the ones who are most likely to say that physicians should not have to do so.

These conflicts might be understood in the context of perennial debates about medical paternalism and patient autonomy. Strong forms of

Table 3. Opinions about Physicians' Ethical Obligations According to the Religious Characteristics of the Respondents.*

Religious Characteristic	No. of Respondents (N=1144)	Physicians May Describe Their Moral Objections			Physicians Are Obligated to Disclose All Possible Options			Physicians Are Obligated to Refer the Patient		
		%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)
Intrinsic religiosity			0.001			0.001			0.001	
Low†	405	56		1.0	92		1.0	82		1.0
Moderate	290	62		1.4 (1.0-2.0)	84		0.4 (0.2-0.7)	73		0.6 (0.4-0.8)
High	397	73		2.5 (1.7-3.5)	81		0.3 (0.2-0.5)	56		0.3 (0.2-0.4)
Attendance at religious services			0.001			0.001			0.001	
Never†	111	51		1.0	94		1.0	84		1.0
Once a month or less	496	59		1.5 (0.9-2.4)	89		0.5 (0.2-1.3)	79		0.7 (0.4-1.3)
Twice a month or more	513	71		2.7 (1.6-4.3)	82		0.3 (0.1-0.7)	60		0.3 (0.2-0.6)
Religious affiliation			0.003			0.002			0.001	
Protestant	427	70		2.3 (1.4-3.8)	86		0.5 (0.2-1.3)	65		0.3 (0.2-0.6)
Catholic	243	63		1.8 (1.1-3.0)	79		0.2 (0.1-0.6)	66		0.3 (0.2-0.6)
Jewish	179	56		1.1 (0.6-1.9)	93		0.9 (0.3-2.7)	80		0.6 (0.3-1.4)
None†	116	52		1.0	92		1.0	88		1.0
Other	153	63		1.5 (0.8-2.7)	89		0.4 (0.1-1.2)	71		0.4 (0.2-0.9)

* Population estimates account for the survey design. Percentages reflect weighted results.

† This was the reference category.

paternalism are based on the assumption that physicians know what is best for their patients and may therefore make decisions without informing their patients of all the facts, alternatives, or risks. Paternalism is widely criticized for violating the right of adults to self-determination. The inverse of strong paternalism is a strict emphasis on patient autonomy, which suggests that physicians must simply disclose all options and allow patients to choose among them. Models that emphasize patient autonomy to such an extent have been criticized for diminishing the moral agency and responsibility of physicians by making them mere technicians or vendors of health care goods and services.^{2,19-23}

This study suggests that the balance that most physicians strike between paternalism and autonomy involves both full disclosure and an open dialogue about the options at hand. This balance resembles the interactive models proposed by Emanuel and Emanuel,¹⁹ Quill and Brody,²⁰ Siegler,²³ and Thomasma.²¹ These ethicists have all recommended models for the doctor-patient relationship that retain the moral agency of both the physician and the patient by encouraging them to engage in a dialogue and negotiate mutually acceptable accommodations that do not require either of the parties to violate their own convictions. In Emanuel and Emanuel's terms, these interactive models retain a role for the influence of "the physician's values, the physician's understanding of the patient's values, [and] his or her judgment of the worth of the patient's values."¹⁹ Although these models require physicians to disclose all information relevant to patients' decisions, they do not require physicians to be value-neutral. Rather, they allow physicians to explain the reasons for their objections to the requested procedures.

The lack of consensus among physicians about whether referrals to other providers who will offer a controversial treatment should be required mirrors the ambivalence about this point within the field of bioethics. Childress and Siegler²² say that physicians "may" have a duty to inform patients about other physicians who would provide what the patient requests, and Quill and Brody²⁰ comment that physicians are "perhaps" obligated to facilitate the transfer of care. This ambivalence stems from a long-standing concern that physicians not be asked to act in ways that "would violate [their] personal sense of responsible con-

Table 4. Opinions about Physicians' Ethical Obligations According to Views on Controversial Clinical Practices.*

View on Controversial Clinical Practice	Respondents (N = 1144)		Physicians May Describe Their Moral Objections		Physicians Are Obligated to Disclose All Possible Options		Physicians Are Obligated to Refer the Patient	
	%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value
Terminal sedation								
Do not object†	911	0.11	1.0	78	0.001	1.0	75	0.001
Object	182		1.4 (0.9–2.0)	89		0.4 (0.2–0.6)	58	
Abortion for failed contraception								
Do not object†	524	0.001	1.0	91	0.001	1.0	83	0.001
Object	562		2.0 (1.5–2.7)	83		0.4 (0.3–0.7)	60	
Prescription of birth control to adolescents without parental consent								
Do not object†	646	0.001	1.0	92	0.001	1.0	83	0.001
Object	459		1.6 (1.2–2.2)	78		0.3 (0.2–0.5)	71	

* Population estimates account for the survey design. Percentages reflect weighted results.

† This was the reference category.

duct."²³ Unfortunately, at times the only accommodation that is acceptable to both the patient and the physician may be termination of the clinical relationship.^{19,20,22,23}

Our study has several important limitations. Although we did not find substantial evidence of a response bias,^{10,11} unmeasured characteristics may have systematically affected physicians' willingness to respond in ways that bias our results. In addition, physicians in different specialties face different arrays of morally controversial practices. Because this study included physicians from all specialties, many participants were asked to report moral judgments about medical practices with which they may have had little or no clinical experience. Moreover, physicians' judgments about their general obligations do not necessarily correspond with their judgments about any particular clinical scenario, and we do not know how their judgments about their obligations translate into their actual practices. Finally, we had three criterion measures and several predictors. Therefore, although hypotheses were theoretically specified and the expected associations were consistently observed, there was the risk of an inflated type 1 error due to multiple comparisons. For all of these reasons, our findings should be considered preliminary, and future studies should use

vignettes, patients' reports, or direct observation to measure more directly the ways in which physicians respond to moral conflict in the clinical encounter.

Notwithstanding these limitations, the results of our study suggest that when patients request morally controversial clinical interventions, male physicians and those who are religious will be most likely to express personal objections and least likely to disclose information about the interventions or to refer patients to more accommodating providers. Ongoing debates about conscientious objections in medicine should take account of the complex relationships among sex, religious commitments, and physicians' approaches to morally controversial clinical practices. In the meantime, physicians and patients might engage in a respectful dialogue to anticipate areas of moral disagreement and to negotiate acceptable accommodations before crises develop.

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REFERENCES

- Dana L. What happens when there is no Plan B? *Washington Post*. June 4, 2006:B1.
- Charo RA. The celestial fire of conscience — refusing to deliver medical care. *N Engl J Med* 2005;352:2471-3.
- Cantor J, Baum K. The limits of conscientious objection — may pharmacists refuse to fill prescriptions for emergency contraception? *N Engl J Med* 2004;351:2008-12.
- Stein R. Seeking care, and refused. *Washington Post*. July 16, 2006:A6.
- Idem*. For some, there is no choice. *Washington Post*. July 16, 2006:A6.
- White KA. Crisis of conscience: reconciling religious health care providers' beliefs and patients' rights. *Stanford Law Rev* 1999;51:1703-49.
- Vischer RK. Conscience in context: pharmacist rights and the eroding moral marketplace. *Stanford Law Pol Rev* 2006;17:83-119.
- Health Care Right of Conscience Act, 745 Ill. Comp. Stat. § 70/1-14.
- Savulescu J. Conscientious objection in medicine. *BMJ* 2006;332:294-7.
- Curlin FA, Chin MH, Sellergren SA, Roach CJ, Lantos JD. The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. *Med Care* 2006;44:446-53.
- Curlin FA, Lantos JD, Roach CJ, Sellergren SA, Chin MH. Religious characteristics of U.S. physicians: a national survey. *J Gen Intern Med* 2005;20:629-34.
- Allport GW, Ross JM. Personal religious orientation and prejudice. *J Pers Soc Psychol* 1967;5:432-43.
- Hoge DR. A validated intrinsic religious motivation scale. *J Sci Study Relig* 1972;11:369-76.
- Koenig H, Parkerson GR Jr, Meador KG. Religion index for psychiatric research. *Am J Psychiatry* 1997;154:885-6.
- Gorsuch RL, McPherson SE. Intrinsic/extrinsic measurement, I/E-revised and single-item scales. *J Sci Study Relig* 1989;28:348-54.
- Multidimensional measurement of religiousness/spirituality for use in health research: a report of the Fetzer Institute/National Institute on Aging Working Group. Kalamazoo, MI: Fetzer Institute, October 1999. (Accessed January 12, 2007, at http://www.fetzer.org/PDF/Total_Fetzer_Book.pdf)
- Ellison CG, Gay DA, Glass TA. Does religious commitment contribute to individual life satisfaction? *Soc Forces* 1989;68:100-23.
- Groves RM, Fowler EJ, Couper MP, Lepkowski JM, Singer E, Tourangeau R. *Survey methodology*. Hoboken, NJ: John Wiley, 2004.
- Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA* 1992;267:2221-6.
- Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Ann Intern Med* 1996;125:763-9.
- Thomasma DC. Beyond medical paternalism and patient autonomy: a model of physician conscience for the physician-patient relationship. *Ann Intern Med* 1983;98:243-8.
- Childress JF, Siegler M. Metaphors and models of doctor-patient relationships: their implications for autonomy. *Theor Med* 1984;5:17-30.
- Siegler M. Searching for moral certainty in medicine: a proposal for a new model of the doctor-patient encounter. *Bull N Y Acad Med* 1981;57:56-69.

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