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Physicians' Moral Dispositions, Role Perceptions, and Patient Interactions: Exploratory Findings from Physicians in the Midwestern United States

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Physicians' Moral Dispositions, Role Perceptions, and Patient Interactions: Exploratory Findings from Physicians in the Midwestern United States

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Abstract

We know that patients and their well-being are important to physicians, but what this means in terms of their practice is not always as clear. One potentially fruitful approach to understanding this variation is to look to physicians' value dispositions and moral foundations. Prior work within general populations has highlighted the place and importance of religion/spirituality in shaping one's values and moral foundations, but very little is known about physicians and how moral foundations matter for medicine more broadly. The purpose of this research note is to explore these issues with a sample of physicians in Michigan and share potential relationships for the purpose of future replication. I find that individual physician characteristics such as political ideology, religious service attendance rates and religious coping are related to their moral domains, and that moral domains are related to reported frequency of religious/spiritual conversations with patients. Finally, moral domains are potentially related in some ways to perceptions of what "good" physicians do, such as knowing about patients' families and whether one is obligated to perform legal procedures even if opposed to them.

Keywords: moral foundations; role perceptions; religion; medical profession

Introduction

Recent research argues that individuals' values shape "thoughts, feelings and behaviors both politically and in general" (Miles and Vaisey 2015:253). The formation of these values is the result of cumulative experiences solidifying into somewhat stable unconscious processing (Miles 2015; Vaisey 2008, 2009). For many, religious beliefs and contexts are important for this process (Bader and Finke 2010). Medical school and the medical profession more generally is a strong socialization experience, so it is of interest to see how non-medical identities shape physicians' perception of their medical duty and of what a 'good physician' does. As such, the purpose of this research note is to explore how the values of a sample of Michigan physicians are related to their biographical and religious/spiritual background, and how these values are, in turn, related to their perceptions of what physicians ought to do.

Background

Values often function as unconscious processes that give us the sensation that some actions or behaviors are good and right while others are not (Miles 2015). This unconscious cognitive processing is likely the result of habituation over time that leads to the formation of a 'practical consciousness' (Vaisey 2008). This process often, or even necessarily includes the interaction with and embeddedness within some social grouping (Archer and Elder-Vass 2012). In this way, values are highly interesting for professions that naturally imply moral action, such as caring for another person (Lawrence and Curlin 2009), combined with extended socialization processes, such as that of physicians. These physicians to be and practicing physicians are all at some school, some organization or some office, all of which will communicate or imply different modes of action that can shape their values. This embeddedness communicates professional

expectations for the physicians, but many physicians have other non-professional relationships in their life as well that may shape, refine or shift their perception of the profession.

One source of variation in how physicians perceive their work is their own religious beliefs. Religious and spiritual physicians are more likely to think religiosity/spirituality are important for medicine (Curlin et al. 2006), and physicians with high religiosity tend to see religious/spiritual influence on health to be positive (Curlin et al. 2007). Physicians who are religious and/or spiritual tend to report more religious/spiritual conversations with patients (Franzen 2015) and this may be due in part to a greater perception of the relevance for medicine or medical care (Franzen 2016). Recent literature on faith and work has picked up on this theme of communal connections. Park et al. (2014), for example, argue that workers' perception of their faith's relevance for their work will depend on the religious capital cultivated within their place of worship. While Park et al. argue that this "religious capital must be specifically identified to a particular nonreligious social domain such as a workplace" (2014:314), and this specification would likely enhance the religious effect on nonreligious domains this may still be present to some degree without explicit specification. That is, the more religious capital one has developed the more likely religion is a 'deep' scheme for the individual, thereby implying a sense of relevance that is not domain-specific (Johnson-Hanks et al. 2011). This implies that the personal experiences, background, beliefs and associated communal connections would be of interest to the degree that they play a part in shaping physicians' perceptions. One novel way to look at this is to make use of moral foundations theory.

Moral foundations theory highlights five value domains that guide action (descriptions below) – two that suppress selfishness and facilitate social interactions (harm and fairness) and three that aid in group cohesion (ingroup, authority and purity) (Graham et al. 2011; Johnson et

al. 2016). These virtues tap into individuals' moral decision making and the moral matrix in the background of their decision making process. One of the most consistent and notable findings from this literature is that those with more liberal political ideologies tend to prioritize protecting others from harm (high harm/care) and injustice (high fairness) and emphasize autonomy (low authority) while those with conservative political ideologies tend to endorse all five, thus recognizing a wider range of valid moral prohibitions (Johnson et al. 2016; Miles and Vaisey 2015). Similar to conservative political ideology, religious individuals also tend to emphasize the binding moral foundations (ingroup, authority and purity) (Graham and Haidt 2010).

It is conceivable that these moral domains pattern physicians' perception of and interactions with patients, but this remains an unstudied area. We currently do not know much, if anything, about the moral composition of physicians, how this is related to their religious and demographic background, and how these moral foundations are related to perceptions of proper role performance. If it is true that one's value dispositions are related to decisions and actions (Miles 2015), and that these value dispositions are or can be shaped by religiosity and spirituality (Bader and Finke 2010; Graham and Haidt 2010; Johnson et al. 2016), then this is an important area of study.

Data and Analysis

The present data are a sample of non-surgical, actively licensed physicians in Michigan. A complete list was purchased from the state of Michigan and 500 names/addresses were randomly selected to receive a mailed, self-administered survey. Recipients were sent an initial personalized letter, survey and pre-paid envelope followed by a reminder and two more replacement surveys. Respondents were informed that a donation of $10 would be given to a

Michigan medical charity for each response received. The project was approved by the Hope College review board on June 5, 2016. All participants were guaranteed anonymity as I was unable to connect completed surveys back to specific participants. I only knew a respondent completed a survey as a separate postcard was returned indicating so independent of the survey.

The survey contained items regarding their perceptions of the profession, their religious/spiritual background and included both the moral foundations items as well as the Schwartz model of values (Vaisey and Miles 2014). Four addresses were incorrect and one physician was retired, bringing the sample down to 495, with 51 responses (10.3%). Two key contributing factors likely explain much of this non-response. First, Jepson et al. (2005) report a dramatic drop in response rates when physician survey word counts come close to 1,800 words (16.7% response vs. 60% at 849 words). I was close to this break-point. Second, in a systematic review of works focused on increasing physician response rates, VanGeest et al. (2007) show that small financial incentives are effective whereas token incentives are not (Kellerman and Herold 2001). Our strategy of sending a donation likely falls into the latter category.

Here I am presenting simple penalized B-spline curve plots showing the relationship between various measures described below and the moral foundation measures. I also show simple t-tests for how the moral foundation measures differ by practices respondents think a physician must do in order to be a 'good physician.'

Measures

I followed Graham et al. (2011) in creating the five moral foundation domains: harm/care, fairness/reciprocity, ingroup/loyalty, authority/respect, purity/sanctity. Each domain is composed to three questions (Graham et al. 2011). Beyond demographics such as whether the physician

worked in an academic/non-academic locale and gender, I measured respondents' political ideology by asking, "how would you describe yourself politically," with response options ranging from "extremely conservative" (1) to "extremely liberal" (7) with a "moderate" option in the middle. Religious service attendance was measured with nine response options, which were collapsed to "never to once or twice per year" (1), "several times a year to once a month" (2), "2-3 times a month to about weekly" (3), "weekly to several times per week" (4). To get a sense of the respondent's reliance on God to make sense of their life, I asked "think about how you try to understand and deal with major problems in your life. To what extent do you look to God for strength, support, and guidance?" with response options ranging from "a great deal" (4) to "not at all" (1). To measure perception of religion's relevance for health and medicine, I asked "overall, how much influence do you think religion/spirituality has on patients' health" with response options ranging from "very much" (5) to "very little to none" (1). I also asked "how often you ask or talk with patients about religious/spiritual issues," with response options ranging from "never" (1) to "always" (5), although none reported more than "often" (4).

Finally, I asked respondents about what physicians need to do to be 'good physicians.' The question stem stated, "please indicate your agreement with the following statements: A good physician ought to…" "get to know patients personally", "know about the patient's family", "talk to patients about their goals in life", "talk to patients about their religious beliefs", "perform procedures (such as an abortion or withdrawal of artificial life support) even if religiously or morally opposed to the procedure", and "refer patients to other medical professionals when patients want or need procedures the physician is religiously or morally opposed to." Each was measured on a six-point scale ranging from "strongly disagree" to "strongly disagree", which have been collapsed into an agree and disagree response for the present t-tests.

Results

Table 1 shows the basic range, mean, and standard deviation for each moral foundation domain, and group differences between male/female and academic/non-academic means. The only significant difference for this sample was between men and women for the ingroup domain. Men have a higher average rating for the ingroup measure than women. The moral domains of harm and fairness have the highest overall means, indicating wider support within the sample, and lower overall means for the group-based domains (ingroup, authority, and purity).

[insert Table 1 about here]

Figure 1 shows the relationship between the moral domains and political ideology. At the conservative end of the ideological spectrum the five domains tend to cluster together more, indicating that physicians with more conservative political ideology may have more moral domains to balance when acting. As we move up the x-axis towards more liberal political ideology, the more group-based moral domains remain relatively flat while harm/care and fairness/reciprocity increase in salience.

[insert Figure 1 about here]

As physicians in our sample become more embedded within a group such as a religious congregation, as indicated by reported religious service attendance rates, we see a nearly linear increase in the salience of the group-based moral domains (ingroup, authority, and purity). Religious service attendance has relatively little relationship with the domains of harm and

fairness as these are affirmed by both physicians with low attendance frequency as well as high attendance frequency.

[insert Figure 2 about here]

A similar trend as that of Figure 2 can be seen in Figure 3. As physicians in this sample report an increased reliance on God to make sense of struggles they experience we also see an increased salience of the group-based moral domains. The pattern here and in Figure 2 make sense as the more one relies on God to make sense of their life, the more prominent religious communities are likely to be in their lives (Froese 2015). As the physician comes to be more disconnected to this religious community (Figure 2) and the importance of that belief set decreases in their daily life (Figure 3), we see a corresponding decrease in the salience of group-based moral domains.

[insert Figure 3 about here]

Figure 4 shows the relationship between the five moral domains and the physician's belief that religiosity/spirituality matters for patients' health. This figure, potentially more than the others shown here, has more statistical noise from the low sample size, but we see basically the same trend. Those physicians who think that religion/spirituality has "very little to no" influence on patients' health are also primarily linked to the harm and fairness domains. On the other end of the x-axis we can see those physicians who think religion/spirituality influence patients' health "very much" rank higher and all five moral domains. Of the three group-based domains, authority appears to have a near-linear relationship.

[insert Figure 4 about here]

Figure 5 shows the relationship between the five moral domains and how often the physician reports that they talk to patients about religious/spiritual issues. Those physicians who report that they never speak with patients about these topics also score higher on the fairness and harm domains with lower scores on the three group-based domains. As we move up the x-axis to higher reported frequency of religious/spiritual conversations there is a corresponding increase in two of the three group-based moral domains (purity and authority), while the ingroup measure appears to primarily related in a curvilinear fashion. The harm moral domain also slightly increases with greater conversational frequency, while fairness remains more or less consistent.

[insert Figure 5 about here]

Table 2 shows the relationship between the moral foundations and six physician behaviors or actions. The first thing to note is that in many comparisons there is a spread between the means, but not a significant different. This is likely in part due to the present sample size, but the lack of statistical significance also shows that perceptions of what a 'good' doctor does in many ways does not depend largely upon the physician's moral foundations. All physicians, for example, think they should know patients personally, talk about their goals and beliefs, and refer patients when opposed to some procedure. Of the comparisons that are significant, however, those who score higher on the ingroup moral domain are less inclined to think that a 'good' doctor needs to know about the patient's family, and those who score higher in fairness and purity are less likely to think 'good' doctors need to perform procedures even if in opposition to them.

[insert Table 2 about here]

Discussion

I set out to begin documenting how physicians' values shape perception of their work and how the moral foundations are related to physicians' background characteristics. The response rate of the present data disallow us from generalizing the findings beyond the present sample, but the purpose of this research note is to share the findings as a step towards future replication. The present sample of physicians and their moral foundation domains, however, are similar to prior work focused on the general population (Graham et al. 2011) in that harm and fairness tend to have the highest overall means with lower sample means for the three group-based moral foundations of ingroup, authority and purity. The present sample also reflects findings in prior work with the general population in the relationship between the moral foundations and political ideology (Graham, Haidt, and Nosek 2009), and various measures of religiosity (Johnson et al. 2016) and attendance (Graham et al. 2011).

Besides highlighting physicians specifically, the present work shows the relationship between the moral foundations and physicians' belief that religion/spirituality matter for patient health, which is important for perceptions of medical relevance and clinical behavior (Franzen 2016). Specifically, this study gives potential additional evidence that the physician's personal beliefs and values are related to moral foundations (Figures 1 – 3), which may shape their perceptions of medicine (Figure 4), clinical behaviors (Figure 5), and perceptions of the ideal medical professional (Table 2). While from this work it seems as though the more group-based moral foundation domains are related to thinking religion/spirituality is important and include it more often within clinical encounters, it may also be the case that all group-based domains do not function similarly. That is, the ingroup domain appears to have a curvilinear relationship at best with religious/spiritual conversational frequency. It could be the case that even though the ingroup moral domain is linked to increased religiosity, which also predicts perceived

religion/spirituality relevance, the fact that it is defined by the control of desires and self-discipline could lead physicians scoring higher in this domain to restrain their self more often. This is in contrast to the observation (Figure 5) that increased conversational frequency is nearly directly proportional to increased score in the authority domain. As authority is linked to concerns for social order and role performance, physicians who think religion/spirituality is relevant for medical work (also higher authority scores) may feel a greater moral duty to discuss these topics with patients as it fits their perception of their professional role. These themes clearly need further work.

Limitations

The key limitation of the present study is the number of respondents and response rate, which limits our analytic options and generalizability. As mentioned in the Methods section, it is likely that this can be in large part due to our inability to offer a financial incentive (Kellerman and Herold 2001; VanGeest et al. 2007) and the number of words in the survey (Jepson et al. 2005). While I do not know whether there was a more systematic reason for non-response in this survey specifically, if this is indeed the case it is possible that concerns about the data are mitigated to some degree as both of these concerns would seemingly affect all physicians equally. This means that while these findings should not be generalized beyond those included here, it is possible that trends highlighted here could persist in future work. The topic merits further work on this topic with financial support. A second limitation of this study is its cross-sectional nature. Because of this any causal inference is only theoretical at this point. Finally, because by design this sample includes only physicians from Michigan, generalization to physicians more generally is cautioned.

Conclusion

This study sought to link values of physicians to biographical and religious/spiritual background characteristics, and attempt to connect these values to perceptions of what physicians ought to do and to perceptions of religion/spirituality's relevance for medicine. The moral foundations of physicians are connected to background characteristics such as political ideology, religious attendance frequency, and religious coping. They are also linked to perceptions regarding the relevance of religion/spirituality to patient care and reported frequency of religious/spiritual conversations with patients. Moral foundations are largely unrelated to the present measures of 'good' doctors, indicating that physicians are in general agreement apart from some small variations.

Further research should attempt to further and replicate the present findings with different data that is not region-specific or suffer from the low samples numbers present here. Further work on this topic would help make sense of when and how perceptions of medical practice and medical work differ from one physician to the next within any given population. While all physicians likely think that they should know their patients (Kitson et al. 2013), there are some areas of medicine and medical care that do not appear to have this taken-for-grantedness about them (such as getting to know a patient's family and procedures one is opposed to in the present study). This may be a way to understand and make sense of these differences between physicians. Additionally, the means here are different enough (Table 2) to think that better, more precise estimates could be obtained with a larger sample, allowing us to better understand these relationships.

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Table 1: Group Mean and Standard Deviations

		Range	Mean	St. Dev.
Harm		2 - 5.5	4.24	0.74
Fairness		2.25 - 5.75	4.25	0.70
Ingroup		1.25 - 5.25	3.55	0.72
Authority		1.75 - 5.25	3.72	0.69
Purity		1.5 - 5	3.57	0.94
Harm	Female	3.25 - 5	4.32	0.51
	Male	2 - 5.5	4.20	0.83
Fairness	Female	3.25 - 5	4.29	0.51
	Male	2.25 - 5.75	4.24	0.78
Ingroup*	Female	2.25 - 4.5	3.24	0.64
	Male	1.25 - 5.25	3.70	0.72
Authority	Female	1.75 - 5	3.76	0.85
	Male	2.25 - 5.25	3.70	0.60
Purity	Female	2 - 4.25	3.32	0.80
	Male	1.5 - 5	3.69	1.00
Harm	Non-Academic	2 - 5.5	4.18	0.73
	Academic	2.75 - 5.5	4.33	0.76
Fairness	Non-Academic	2.5 - 5.25	4.18	0.62
	Academic	2.25 - 5.75	4.36	0.80
Ingroup	Non-Academic	1.25 - 4.75	3.49	0.75
	Academic	2.25 - 5.25	3.62	0.70
Authority	Non-Academic	1.75 - 5	3.71	0.75
	Academic	2.75 - 5.25	3.74	0.60
Purity	Non-Academic	1.5 - 5	3.58	0.95
	Academic	1.75 - 5	3.54	0.95

Note: * $p < 0.1$

Table 2: Moral Foundations and Practices to be a "Good Physician

	Know Patients Personally		Know About Family	
	No	Yes	No	Yes
Harm	4	4.26	4.44	4.22
Fairness	4.08	4.27	4.75	4.21
Ingroup	3.83	3.53	4.19*	3.49*
Authority	4.25	3.69	3.81	3.72
Purity	4.17	3.53	3.56	3.56
	Talk about Goals		Talk about Beliefs	
	No	Yes	No	Yes
Harm	4.35	4.23	4.3	4.2
Fairness	4.15	4.27	4.31	4.22
Ingroup	3.8	3.52	3.73	3.41
Authority	3.6	3.74	3.81	3.66
Purity	3.5	3.57	3.42	3.68
	Perform Procedure even if Opposed		Refer When Opposed to Procedure	
	No	Yes	No	Yes
Harm	4.3	4.11	4.32	4.23
Fairness	4.36*	4.02*	4.18	4.27
Ingroup	3.65	3.32	3.68	3.52
Authority	3.93*	3.28*	3.99	3.68
Purity	3.85*	2.94*	3.8	3.53

Note: * $p < 0.1$

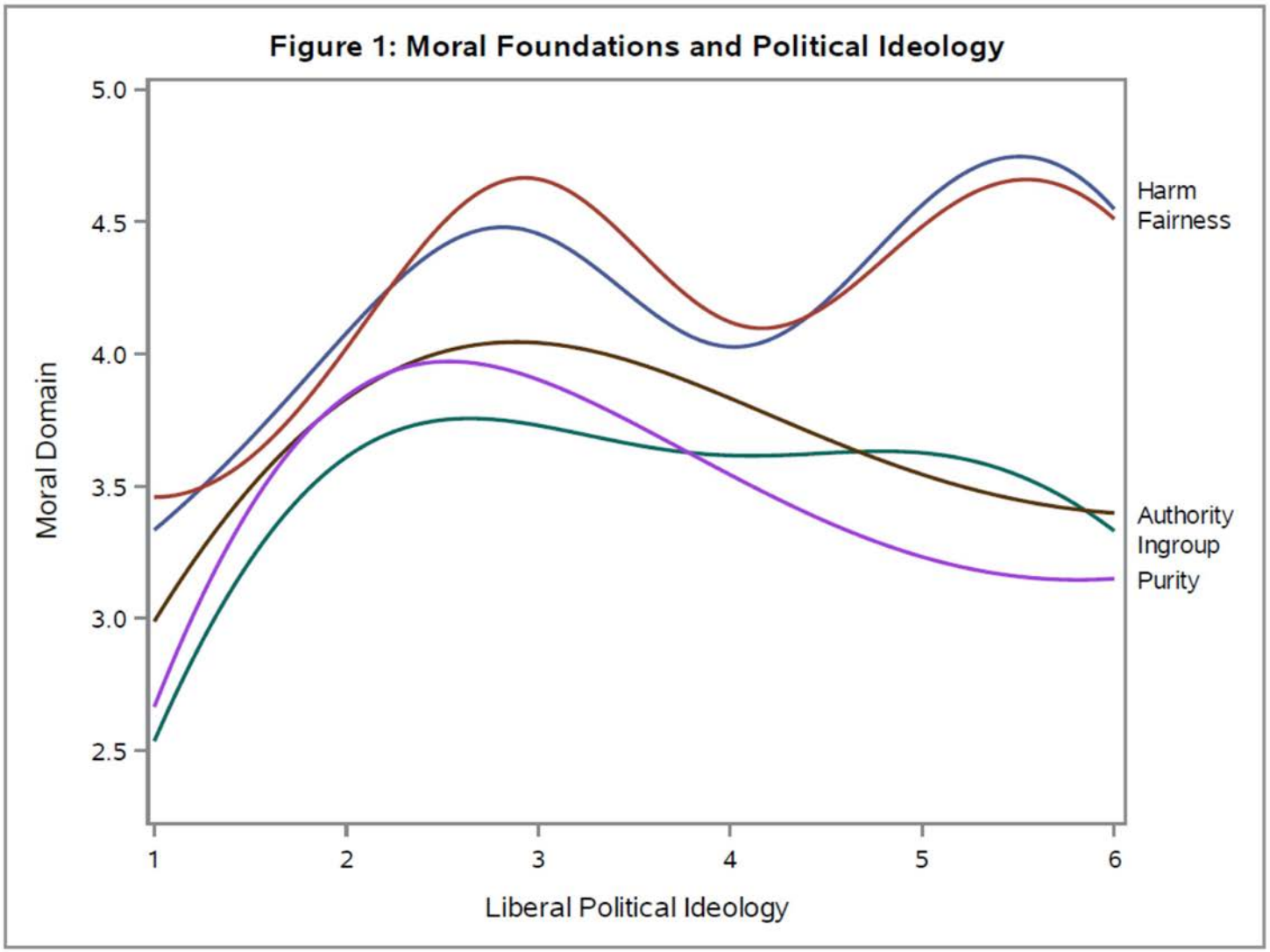


Figure 1: Moral Foundations and Political Ideology
5.0
4.5
4.0
3.5
3.0
2.5
Moral Domain
1
2
3
4
5
6
Liberal Political Ideology
Harm
Fairness
Authority
Ingroup
Purity

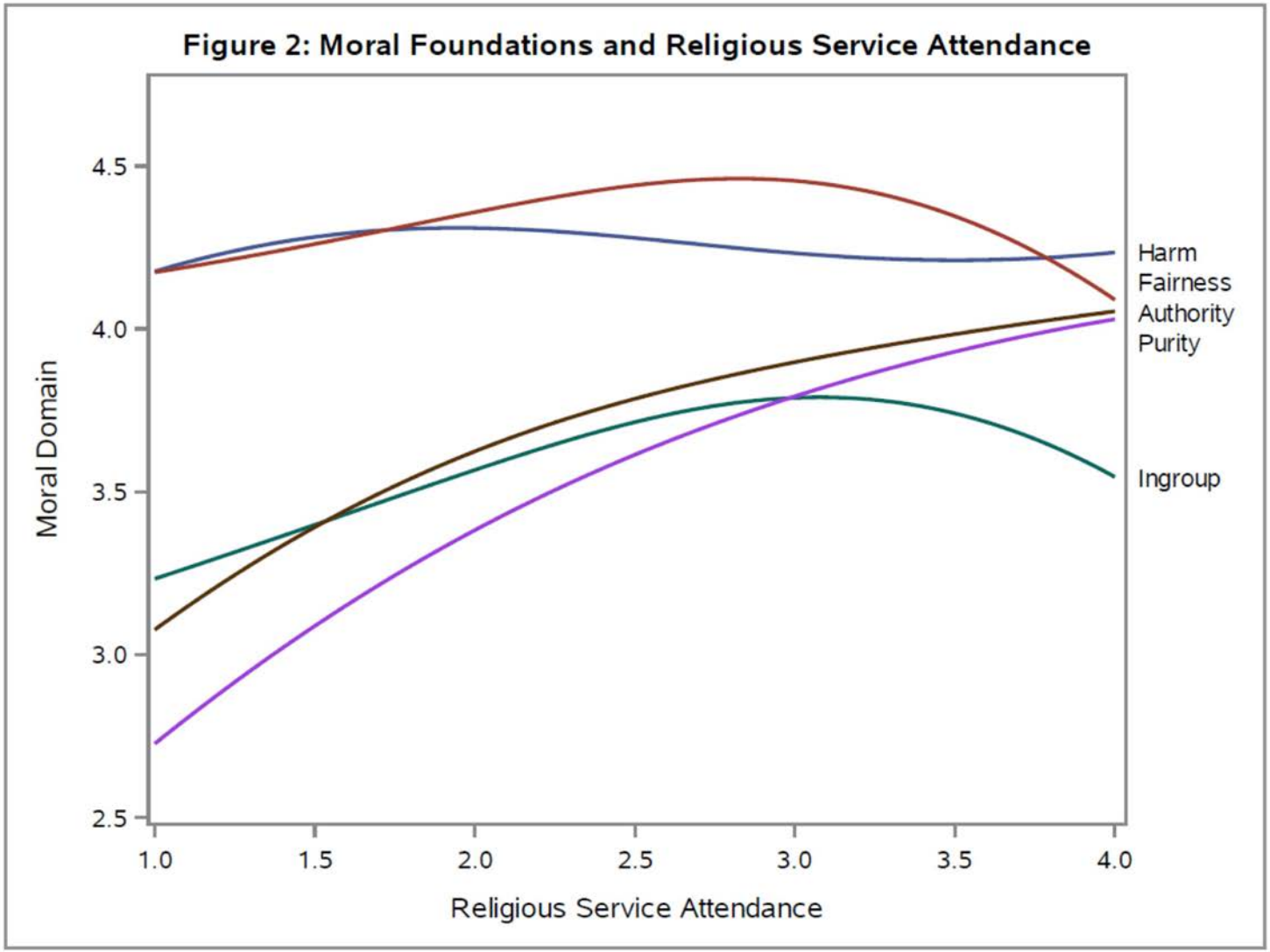


Figure 2: Moral Foundations and Religious Service Attendance
Moral Domain
4.5
4.0
3.5
3.0
2.5
1.0
1.5
2.0
2.5
3.0
3.5
4.0
Religious Service Attendance
Harm
Fairness
Authority
Purity
Ingroup

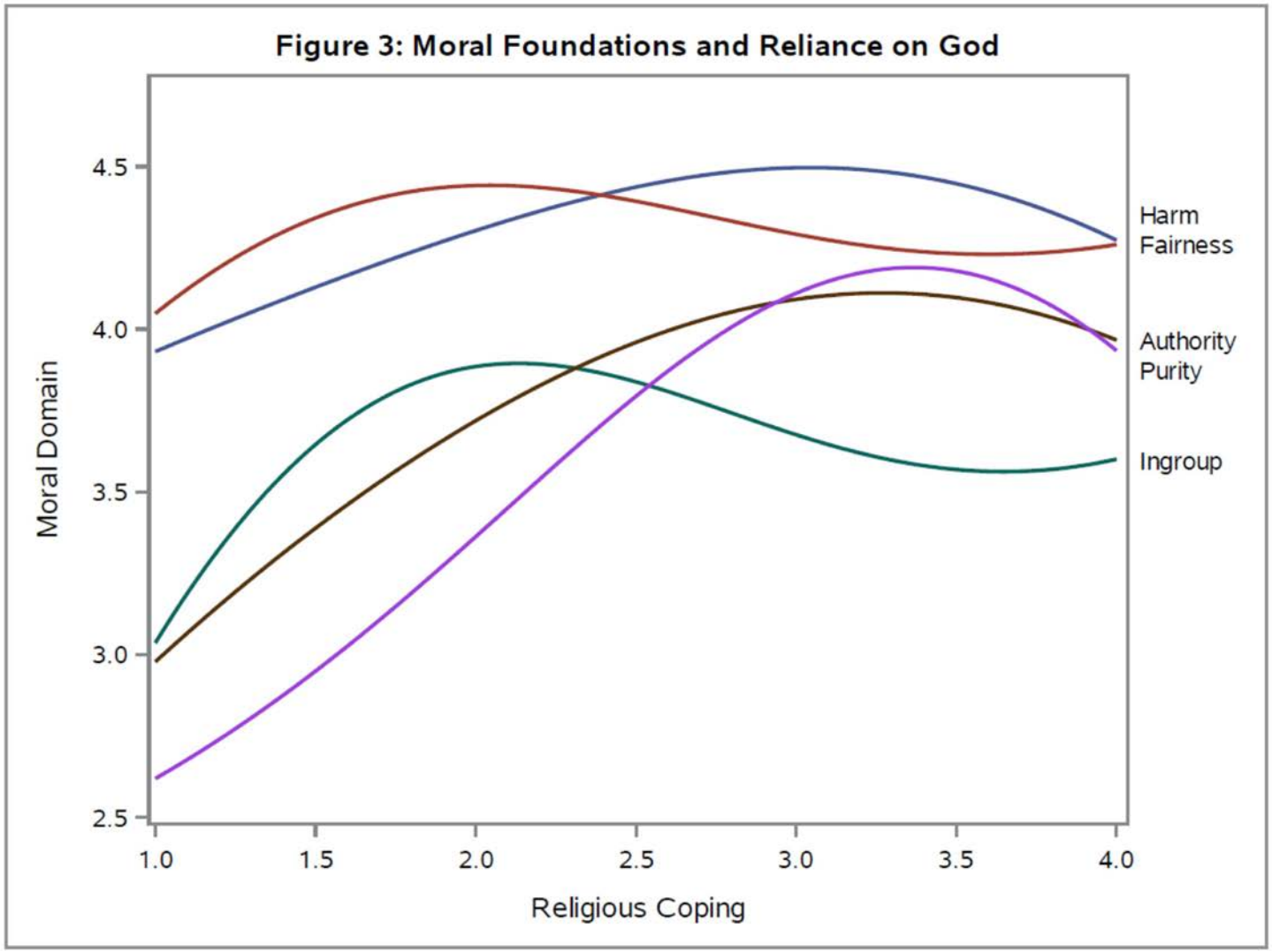
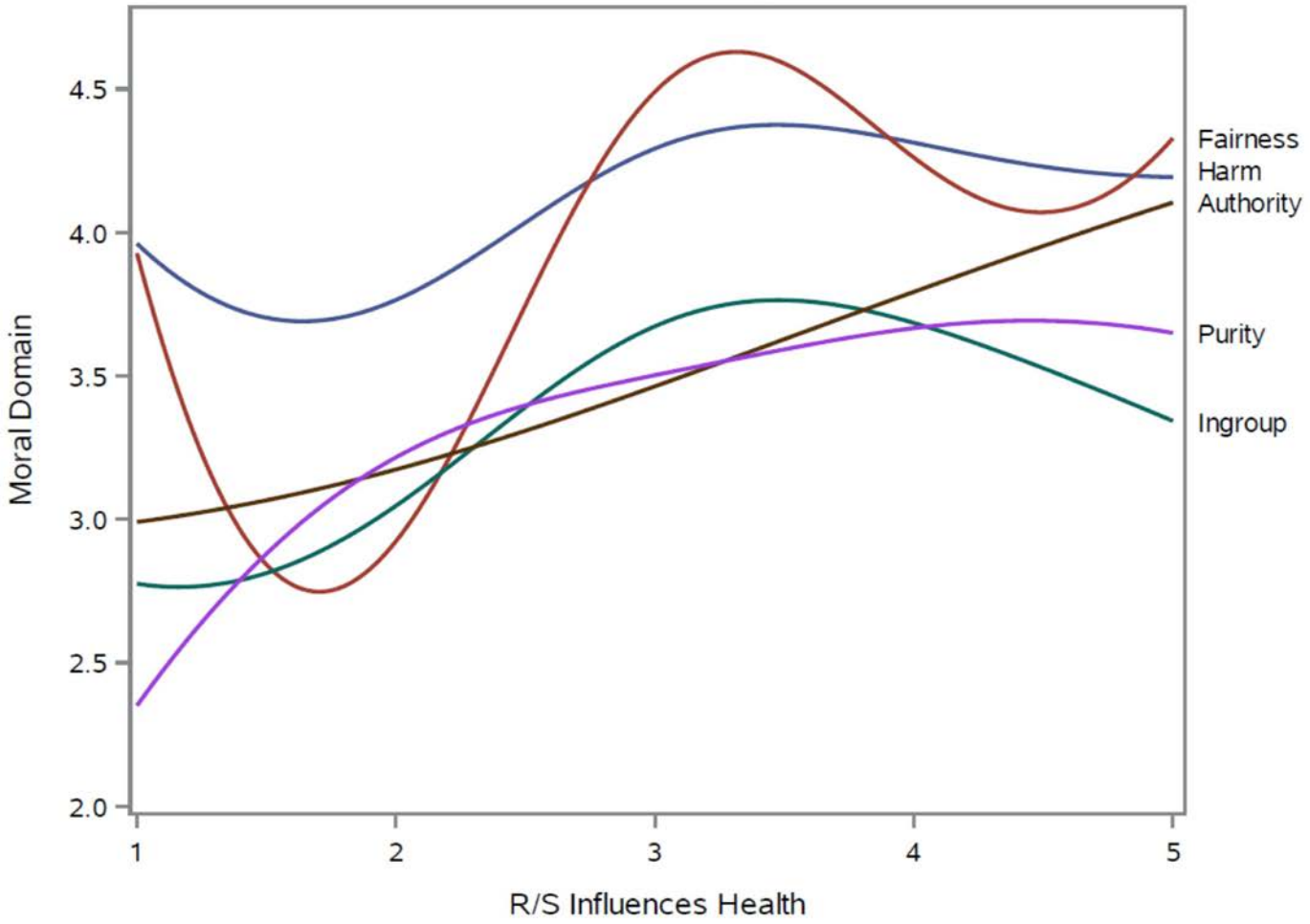


Figure 3: Moral Foundations and Reliance on God
Moral Domain
4.5
4.0
3.5
3.0
2.5
1.0
1.5
2.0
2.5
3.0
3.5
4.0
Religious Coping
Harm
Fairness
Authority
Purity
Ingroup

Figure 4: Moral Foundations and Thinking Religion Matters for Health



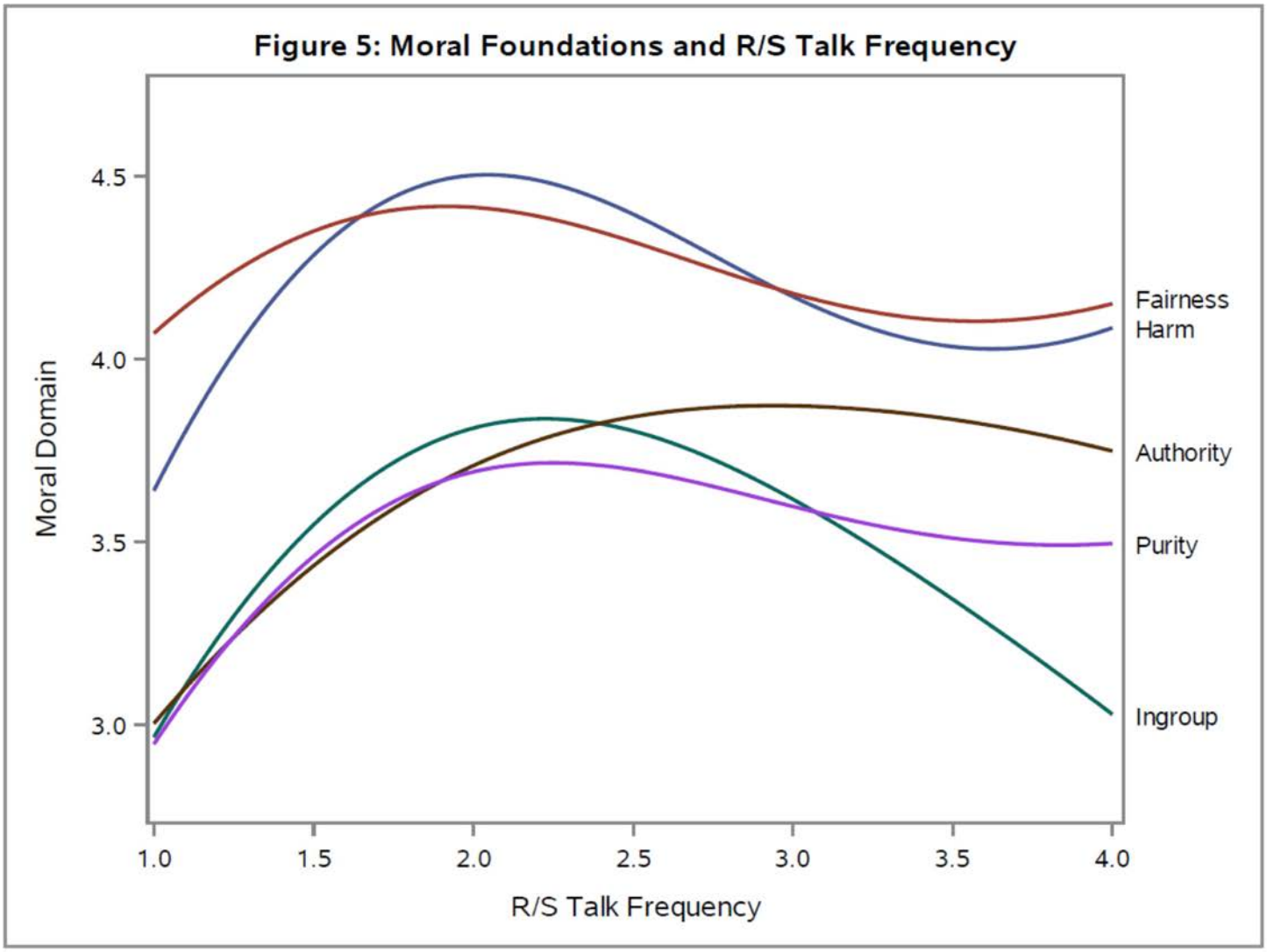


Figure 5: Moral Foundations and R/S Talk Frequency
Moral Domain
4.5
4.0
3.5
3.0
1.0
1.5
2.0
2.5
3.0
3.5
4.0
R/S Talk Frequency
Fairness
Harm
Authority
Purity
Ingroup