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## Obstetrician–Gynecologists’ Objections to and Willingness to Help Patients Obtain an Abortion

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### Abstract

**Objective**—To describe obstetrician–gynecologists’ (ob-gyns) views and willingness to help women seeking abortion in a variety of clinical scenarios.

**Methods**—We conducted a mailed survey of 1,800 U.S. ob-gyns. We presented seven scenarios in which patients sought abortion. For each, respondents indicated if they morally objected to abortion and if they would help patients obtain an abortion. We analyzed predictors of objection and assistance.

**Results**—The response rate was 66%. Objection to abortion ranged from 16% (cardiopulmonary disease) to 82% (sex selection); willingness to assist ranged from 64% (sex selection) to 93% (cardiopulmonary disease). Excluding sex selection, objection was less likely among ob-gyns who were female (odds ratio [OR] 0.5, 95% confidence interval [CI] 0.4–0.8), urban (OR 0.3, CI 0.1–0.7), or Jewish (OR 0.3, CI 0.1–0.7) compared to male, rural, or unaffiliated ob-gyns. Objection was more likely among ob-gyns from the South (OR 1.9, CI 1.2–3.0) or Midwest (OR 1.9, CI 1.2–3.1), and among Catholic, evangelical Protestant, or Muslim ob-gyns, or those for whom religion was most important, compared to reference. Among ob-gyns who objected to abortion in a given case, approximately two-thirds nevertheless help patients obtain an abortion. Excluding sex selection, assistance despite objection was more likely among female (OR 1.8, CI 1.1–2.9) and US-born ob-gyns (OR 2.2, CI 1.1–4.7), and less likely among Southern ob-gyns (OR 0.3, CI 0.2–0.6), or those for whom religion was most important (OR 0.3, CI 0.1–0.7).

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**Conclusions**—Most ob-gyns help patients obtain an abortion even when they morally object to abortion in that case. Willingness to assist varies by clinical context and physician characteristics.

Ethicists, clinicians, and policy-makers debate the role of conscientious refusals in medical practice. Recently, the Obama administration rescinded a Bush administration rule that would have required every health care entity receiving federal funding to certify that none of its employees were required to assist in any way with medical services that would violate that employee's "individual moral beliefs or religious convictions"(1,2). At the same time, the administration affirmed a 1973 federal law that states that a health care worker cannot be required to participate in abortion or sterilization procedures that conflict with "his [sic] religious beliefs or moral convictions"(3).

These debates about federal regulations are part of broader debates about conscience in healthcare (4). Some bioethicists argue that physicians who refuse to provide legal and professionally permitted services should leave the profession (5); others argue that physicians have a basic obligation and right to act in accordance with their moral convictions (6). Most professional medical organizations endorse a limited right of refusal, balanced against patients' interests and professional obligations (7)(8). Previous studies suggest that the majority of physicians agree that doctors may not be obligated to provide an intervention to which they have a moral objection (9), but that they are obligated to refer patients for interventions they are unwilling to provide themselves (10)(11).

Obstetrician-gynecologists (ob-gyns) find themselves at the center of these debates, because many practices in women's health and reproductive medicine generate controversy, including, of course, abortion. Little is known about how ob-gyns view abortion, morally speaking, or how their views influence the care they provide. In order to describe ob-gyns' views and willingness to help women seeking abortion in a variety of clinical scenarios, we analyzed data from a national survey of practicing ob-gyns.

## Methods

From October 2008 until January 2009, we mailed a confidential, self-administered questionnaire to a stratified random sample consisting of 1800 US general ob-gyns, 65 years of age or younger (from a universe of 34,689 ob-gyns) in the American Medical Association Physician Masterfile. The questionnaire addressed a variety of practices in sexual and reproductive healthcare, including abortion. Sample size was chosen to yield a margin of error of < 3% for a dichotomous variable that is distributed 50% in the population. To increase religious minority representation, we used validated ethnic surname lists to create four strata, and oversampled in these strata (12)(13)(14). Physicians received up to three separate mailings of the questionnaire; the first included \$20, and the third offered an additional \$30 for participating. Physicians also received an advance letter and a postcard reminder after the first questionnaire mailing. All data were double-keyed, cross-compared, and corrected against the original questionnaire. The study was approved by the University of Chicago Institutional Review Board. Methods for this study have been described in depth elsewhere (15).

In one section of the questionnaire, respondents were presented with seven scenarios in which a patient sought an abortion, and were asked to indicate whether they: 1) have any ethical or moral objection to abortion in each case (Yes/No); and 2) would help the patient obtain an abortion if asked, either by providing the abortion themselves or referring the patient to someone who would (Yes/No). We defined assistance as either provision or referral, because although providing abortion and referring for abortion are not equivalent, current ethical debates center on whether ob-gyns are required to refer for or otherwise help patients obtain an abortion when asked. The seven scenarios were: a) a 22-year-old single woman 6 weeks pregnant after failed hormonal contraception (hereafter failed contraception); b) a 38-year-old with five daughters and no sons, after chorionic villus sampling reveals the fetus is a chromosomally normal female (sex selection); c) a 36-year-old in the first trimester of pregnancy who needs radiation and chemotherapy for newly diagnosed breast cancer (breast cancer); d) a 28-year-old with type I diabetes, for whom glucose management has become very difficult at 16 weeks' gestation (difficult-to-control diabetes); e) a 34-year-old woman six weeks pregnant after being raped (rape); f) selective reduction in a healthy 37-year-old with a quintuplet pregnancy (selective reduction); and g) a 24-year-old with a cardiopulmonary abnormality associated with a 25% chance of death with gestation (cardiopulmonary disease). Demographic covariates included physician age, sex, race/ethnicity, marital status, number of children, whether they were US-born, geographic region, urbanicity of location (measured as the proportion of people in the physician's zip code that live in an urban area), religious affiliation, importance of religion in the respondent's life, and membership in the American Congress of Obstetricians and Gynecologists (ACOG).

Stratum weights were incorporated to account for the oversampling in the ethnic surname strata and to correct for differences in response rates observed among the surname categories and between U.S. and foreign medical school graduates, as described in previous reports on this data (15). By incorporating stratum weights, we are able to generate estimates for the population of U.S. ob-gyns. After generating population estimates for responses to each item, we used survey-design-adjusted multivariable logistic regression to identify independent predictors of moral objection to one or more scenarios. Because significant predictors were different for sex selection compared to other scenarios, we repeated this analysis for the scenario sex selection alone, and for objecting to one or more scenarios, excluding sex selection. Finally, we analyzed the prevalence and predictors of being willing to help a patient obtain an abortion despite having a moral objection to abortion in that case (assistance despite objection). All analyses were adjusted for survey design and were conducted using Stata MP software, v11.1.

## Results

The response rate was 66% (1154/1760) after excluding 40 potential respondents who were retired or who could not be located after two attempts to obtain a valid address. The response rate varied by stratum, and graduates of foreign medical schools were less likely to respond than graduates of US medical schools (58% vs. 68%,  $p=0.001$ ). Response rate did not differ significantly by age, sex, region, or board certification. Respondents' demographic characteristics are reported in Table 1.

The percentage of physicians with moral objection to abortion varied substantially by clinical case (Table 2). The majority (82%) of ob-gyns objected in the case of sex selection, but fewer than half objected in the other scenarios: 43% for the case of difficult-to-control diabetes; 41% for failed contraception; 29% for selective reduction; 20% for rape, 18% for breast cancer, and 16% for cardiopulmonary disease. Overall (excluding sex selection) 50% objected to one or more scenarios.

Across scenarios, most ob-gyns were willing to help patients obtain an abortion. As seen in Table 2, 64% would help a patient obtain an abortion for sex selection, and 80% would help in a patient obtain an abortion in each of the other scenarios. Overall, 60% would help a patient obtain an abortion in all scenarios; 35% would help in some scenarios, and 5% would help in none of the scenarios. When the case of sex selection was excluded, those percentages were 76%, 19% and 5% respectively.

Table 3 presents the adjusted odds ratios for reporting a moral objection to abortion in one or more scenarios, in the scenario of sex selection alone, and in one or more scenarios excluding sex selection. Odds ratios are adjusted for all variables in the table. Considering all seven scenarios, objection was less likely among black ob-gyns (OR 0.4, 95% CI 0.2–0.9) and Jewish ob-gyns (OR 0.5, 95% CI 0.2–1.0) compared to whites and those without religious affiliation. Compared to ob-gyns for whom religion was not very/not at all important, objection was more likely among ob-gyns for whom religion was very important (OR, 2.0, 95% CI 1.1–3.4) or most important (OR 6.3, 95% CI 2.3–17.6) in their lives. Significant covariates were different for objection to sex selection alone and objection to one or more cases other than sex selection. Objection to sex selection was more likely among Midwest ob-gyns (OR 1.9, 95% CI 1.1–3.5), Muslims (OR 4.4, 95% CI 1.0–18.8) and respondents for whom religion was very important (OR 2.2; 95% CI 1.3–3.8) or most important in their life (OR 6.1, 95% CI 2.3–15.8) compared to their respective reference groups. Objection to sex selection was less likely among black (OR 0.4, 95% CI 0.2–0.9), Jewish (OR 0.5, 95% CI 0.2–0.9) and older (OR .98, 95% CI 0.95–0.99) respondents. Excluding sex selection, objection in one or more scenarios was less likely among women (OR 0.5; 95% CI 0.4–0.8), Jewish (OR 0.3; 95% CI 0.1–0.7), older (OR 0.96, 95% CI 0.94–.98) and more urban (OR 0.3, 95% CI 0.1–0.7) ob-gyns compared to respective reference groups. Objection was more likely among those practicing in the South (OR 1.9, 95% CI 1.2–3.0) or Midwest (OR 1.9; 95% CI 1.2–3.1), who had Catholic (OR 2.7, 95% CI 1.4–5.1), Evangelical Protestant (OR 3.7, 95% CI 1.4–10.0) or Muslim (OR 3.4, 95% CI 1.2–9.6) affiliation, or who indicated religion was fairly (OR 1.7, 95% CI 1.1–2.8), very (OR 3.6; 95% CI 2.2–5.9) or most (OR 16.9, 95% CI 7.7–37.1) important in their life compared to reference groups. Marital status, number of children, ACOG membership, or being US-born was not associated with objection to abortion.

For each clinical scenario, approximately two-thirds of ob-gyns who object to abortion in that case would still assist the patient to obtain an abortion: 57% in cases of sex selection and difficult-to-control diabetes; 64% in cases of rape and selective reduction, 65% in the case of failed contraception; 67% in the case of breast cancer, and 70% in the case of heart disease. Overall, 55% would assist patients in all scenarios to which they have a moral objection to abortion, 18% would assist in some scenarios but not others, and 26% would

not assist in any scenario to which they had an objection. Excluding the sex selection case, those percentages were 58%, 17% and 23%, respectively.

Table 4 displays the adjusted odds of being willing to assist despite objection in: one or more cases in which one has a moral objection; in the case of sex selection alone; and in one or more scenarios when sex selection was excluded. Considering all scenarios, assistance despite objection was more likely among Jewish ob-gyns (OR 3.0; 95% CI 1.4–6.5) and less likely among older ob-gyns (OR 0.98, 95% CI 0.95–0.99), ob-gyns from the South (OR 0.6, 95% CI 0.4–1.0), or ob-gyns for whom religion was most important (OR 0.4, 95% CI 0.2–0.7) compared to their respective reference groups. We observed similar demographic predictors of assistance despite objection when we examined the sex selection case alone. Considering all cases except sex selection, female ob-gyns were more likely to assist despite objection than male ob-gyns (OR 1.8; 95% CI 1.1–2.9) as were US born ob-gyns compared to those born outside of the US (OR 2.2, 95% CI 1.1–4.7). Southern ob-gyns were less likely to assist despite objection (OR 0.3, 95% CI 0.2–0.6), as were those who said that religion was most important in their life (OR 0.3; 95% CI 0.1–0.7).

We conducted a separate analysis of the 194 respondents who indicated that they perform abortions. Sixty-five percent (95% CI, 57–72%) objected to abortion for sex selection, but 81% (95% CI, 75–88%) were willing to assist despite objection. Otherwise, abortion providers morally objected to abortion at low rates: 4% (95% CI, 0–8%) in failed contraception; <1% in the case of breast cancer; 8% (95% CI, 4–13%) for diabetes; 2% (95% CI, 0–4%) in the setting of rape; 3% (95% CI, 0–6%) for selective reduction, and <1% for a potentially fatal cardiopulmonary anomaly. Most assisted – 81%–100%, depending upon the scenario). Seventy percent of abortion providers assist despite objection in all scenarios (95% CI, 61–80%), 3% in some scenarios (95% CI, 0–6%), and 27% (95% CI, 17–36%) in no scenarios. When the sex selection case was excluded, very few (n=16) abortion providers with objections remained in the sample. Among these, 11 assist despite objection in all scenarios, 1 in some, and 4 in none.

## Discussion

In this national survey, we found that the context in which a woman seeks abortion matters to many ob-gyns—both to their judgments about the morality of abortion and to whether they will help a woman obtain the abortion she seeks. These findings contrast with public debates about the ethics of abortion, which often focus only on the moral status of the fetus: if the fetus is a person, then abortion is the moral equivalent of murder; if the fetus is not a person, abortion may be permissible. These data suggest that ob-gyns also consider contextual factors, including risk of physical harm to the woman by continuing pregnancy (breast cancer, cardiopulmonary disease), the circumstances of the sexual encounter that resulted in pregnancy (rape), the impact abortion may have on pregnancy outcome (selective reduction), the potential for fetal anomaly (diabetes), and the duration of pregnancy (second versus first trimester). Ob-gyns may be more likely to object to abortion when they believe that the health risks of pregnancy can be mitigated with careful medical management (e.g., in diabetes); when the patient had the capacity to prevent the pregnancy with better compliance with contraception; or when the request for abortion is motivated by unjustified

prejudice (e.g., sex selection). However, that context matters raises concerns that socioeconomic, racial, or other power imbalances might result in inequities in meaningful access to abortion: to the extent a woman's reasons for seeking abortion are relevant, ob-gyns are in the position of determining if those reasons are "good enough."

In addition to context, physician characteristics matter, in that they are associated with objecting to and being willing to help a patient obtain abortion. Apart from the case of sex selection, female ob-gyns are less likely to object to abortion than their male counterparts. When they do object, women are more likely to assist despite their objections. Nearly 30 years ago psychologist Carol Gilligan found that men tend to mediate moral decisions by using universal principles or well-defined rules, while women are more likely to make moral decisions by appealing to context, particularity, and relationships (16). Our data show that apart from sex selection, male ob-gyns were less likely to assist despite objection, consistent with a more rule or principle-oriented view that abortion is either acceptable or not. Female ob-gyns on the other hand were more likely to assist when they objected. They may experience abortion as simultaneously objectionable and acceptable, depending on nuances of the particular clinical context.

Geographic variations in objection and assistance despite objection highlight concerns that ob-gyns' refusals to help patients obtain a requested abortion contribute to unequal access to abortion services (7). For example, despite the fact that refusals of abortion services have the potential to significantly impact patient access to abortion more in rural areas where there are fewer providers, working in a more rural setting was not associated with willingness to assist despite objection. With respect to religion, aside from the case of sex selection, religious affiliation was not independently associated with assistance despite objection, whereas physician religiosity was. This suggests that the lived experience of religion shapes ob-gyns' decisions about abortion more than religious affiliation per se.

One way to interpret these findings is that most (but not all) ob-gyns embrace what has been called the "conventional compromise" regarding conscientious refusals (17). According to Brock, the conventional compromise holds that if a physician has a conscientious objection to a legal and professionally permitted medical intervention, under certain circumstances the physician may not be obligated to provide the intervention, but he or she is obligated to refer to someone who will. However, sometimes a physician might consider even referring the patient to be immoral; indeed, a recent study found that 43% of US physicians do not believe doctors are obligated to refer in such cases (14).

Of note, while current debates tend to attach the term "conscientious" only to refusals to provide or refer for abortion, these data suggest that providing or helping a patient obtain an abortion can also be a conscientious act—an act done with due moral consideration and done even in the face of personal moral objection to abortion (18). Our data further suggest that acting "conscientiously" does not necessarily mean providing only medical interventions to which one has no moral objections. This study includes both ob-gyns who object to abortion but nevertheless help a woman obtain one, and ob-gyns who generally support abortion – even provide abortion – but who would not help a patient obtain an abortion for sex selection. Whether conscientious provisions or refusals of abortion care are



ethical is the subject of ongoing debate, even among the authors of this study. Either way, these findings point to an understanding of conscience as a capacity that judges the moral quality of one's actions, (19) all things considered (20).

Finally, public discourse sometimes makes it seem as if there are only two categories of providers in the US with respect to abortion: those who do not object to abortion, and therefore assist women seeking abortion, or those who oppose abortion and do not. In contrast, our data indicate at least two further categories: ob-gyns who oppose abortion in general but still find it acceptable sometimes, and those who support abortion in general—even provide it—but still find it unacceptable sometimes. Ongoing debates about abortion should take note of these nuances regarding abortion practices.

This study has several limitations. We did not ask about other common situations in which patients might seek abortion, including situations in which contraception was not used, in which the patient faces financial hardships, in which women's work or educational goals led to the decision to seek abortion, or in which a patient seeks an abortion in the setting of fetal anomaly. In addition, trimester of pregnancy was not uniformly identified in case scenarios, so we cannot be sure the extent to which ob-gyns' responses reflected their inferences regarding the duration of pregnancy in each scenario. We used the zip codes of physicians' primary mailing address, which might be a home address and might not represent the level of urbanicity of the zip code in which they practice. Finally, as is characteristic of studies such as ours, data may not reflect how physicians practice in real life; further, non-respondents may differ from respondents in ways that bias the findings.

Notwithstanding these limitations, this study has important implications for understanding the relationship between physicians' personal moral views and the clinical care they provide. Among ob-gyns, support for abortion varies widely depending on the context in which abortion is sought and physician characteristics. Furthermore, most ob-gyns assist a patient seeking abortion even when they object to abortion in that patient's case. A broader appreciation of the moral considerations that shape physician decisions will be critical to shaping practice guidelines and public policy that both meet patients' needs and promote moral integrity among the physicians who care for them.

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Table 1

## Demographics of sample\*

Characteristic	No	(%)
Age, mean (SD)	47.8	9.2 SD
Percent urban <sup>†</sup> , median (1 <sup>st</sup> , 3 <sup>rd</sup> quartiles)	99.9	91.4, 1
Female sex	537	(46)
Region		
Northeast	288	(25)
South	373	(32)
Midwest	249	(22)
West	242	(21)
Race/Ethnicity		
Asian	202	(18)
Hispanic or Latino	64	(6)
Black, non-Hispanic	67	(6)
White, non-Hispanic	774	(68)
Other	22	(2)
Marital Status		
Married	965	(84)
Single/Divorced/Widowed	178	(16)
Children		
None	162	(14)
1 or more	973	(86)
Immigration History		
Born in the USA	817	(72)
Immigrated to USA as a child or adult	323	(28)
Religious affiliation		
None	119	(11)
Hindu	91	(8)
Jewish	160	(14)
Muslim	54	(5)
Roman Catholic/Eastern Orthodox	262	(23)
Protestant, Evangelical	91	(8)
Protestant, Non- Evangelical	300	(27)
Other Religion	48	(4)
Importance of religion in life		
Most important	157	(14)
Very important	385	(34)
Fairly important	321	(28)
Not very important	272	(24)
ACOG Member	1052	(92)

\* Total sample size is 1,152. Some groups add up to less than that number because of missing responses. Numbers and percentages are unweighted.

<sup>†</sup>Percent Urban was obtained from 2000 Census data linked to zipcodes. It is calculated as the total population in a zipcode living in an urban area divided by the total population in that zipcode.

**Table 2**

The percentage of US Ob/Gyns [N = 1154] that reports moral objection to abortion, and willingness to help patients obtain abortion, in seven hypothetical clinical scenarios

Clinical Scenario	Do you morally object to abortion in this case? (Yes)	Would you help the patient obtain the abortion if asked? (Yes)
	N (%) (95% CI)	N (%) (95% CI)
A. A 22-year-old single woman 6 weeks pregnant after failed hormonal contraception	420 ( <b>41</b> ) (38–44)	970 ( <b>85</b> ) (82–87)
B. A 38 year old with five daughters and no sons, after chorionic villus testing at 10 weeks gestation reveals the fetus is a chromosomally normal female	923 ( <b>82</b> ) (80–85)	719 ( <b>64</b> ) (61–67)
C. A 36 year old in the first trimester of pregnancy who needs radiation and chemotherapy for newly diagnosed breast cancer	178 ( <b>18</b> ) (16–21)	1046 ( <b>91</b> ) (89–93)
D. A 28 year old with brittle type 1 diabetes, for whom glucose management has become very difficult at 16 weeks gestation	445 ( <b>43</b> ) (40–46)	915 ( <b>80</b> ) (78–83)
E. A 34-year-old woman 6 weeks pregnant after being raped	206 ( <b>20</b> ) (18–23)	1041 ( <b>91</b> ) (89–93)
F. Selective reduction in a healthy 37-year-old patient with quintuplet pregnancy	294 ( <b>29</b> ) (26–32)	1001 ( <b>88</b> ) (86–90)
G. A 24 year old with a cardiopulmonary abnormality associated with a 25% chance of death with gestation	155 ( <b>16</b> ) (14–18)	1060 ( <b>93</b> ) (91–95)

**Table 3**

Adjusted odds of reporting a moral objection to abortion in one or more scenarios, in the case of sex selection, and in one or more scenarios other than sex selection, by physician characteristics

Characteristic	Object		
	To one or more scenarios	To sex selection	To one or more scenarios other than sex selection
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Age, yrs	.98 (.95–1.0)	.98 (.95–.99)*	.96 (0.94–.98)*
Female sex	1.3 (0.9–2.0)	1.2 (0.8–1.8)	0.5 (0.4–0.8)*
Race/Ethnicity			
White, non- Hispanic	Referent	Referent	Referent
Black, non- Hispanic	0.4 (0.2–0.9)*	0.4 (0.2–0.9)*	0.8 (0.4–1.6)
Asian	0.7 (0.3–1.5)	0.8 (0.4–1.6)	0.7 (0.3–1.3)
Hispanic/Latino	0.5 (0.2–1.1)	0.6 (0.3–1.3)	0.7 (0.3–1.4)
Other	1.4 (0.4–4.9)	1.7 (0.5–6.1)	1.0 (0.1–10.0)
Married	1.2 (0.7–2.0)	1.4 (0.8–2.3)	1.1 (0.6–1.8)
Children	1.4 (0.8–2.6)	1.3 (0.7–2.3)	1.5 (0.9–2.6)
US born	1.0 (0.5–1.8)	1.3 (0.7–2.3)	0.8 (0.4–1.3)
Region			
Northeast	Referent	Referent	Referent
South	1.8 (1.1–3.1)*	1.6 (1.0–2.7)	1.9 (1.2–3.0)*
Midwest	1.9 (1.1–3.4)*	1.9 (1.1–3.5)*	1.9 (1.2–3.1)*
West	0.9 (0.6–1.6)	0.8 (0.5–1.3)	1.3 (0.8–2.1)
Religious affiliation			
None	Referent	Referent	Referent
Hindu	0.5 (0.2–1.4)	0.6 (0.2–1.6)	1.0 (0.4–2.8)
Jewish	0.5 (0.2–1.0)*	0.5 (0.2–0.9)*	0.3 (0.1–0.7)*
Muslim	2.7 (0.7–10.3)	4.4 (1.0–18.8)*	3.4 (1.2–9.6)*
Roman Catholic/Eastern Orthodox	1.5 (0.8–3.1)	1.3 (0.7–2.6)	2.7 (1.4–5.1)*
Protestant, Evangelical	2.6 (0.8–8.8)	2.7 (0.8–9.3)	3.7 (1.4–10.0)*
Protestant, Non- Evangelical	1.4 (0.7–2.7)	1.4 (0.8–2.8)	1.7 (0.9–3.2)
Other Religion Importance of religion in life	0.7 (0.2–1.8)	0.6 (0.2–1.6)	0.8 (0.3–2.2)
Not very/not at all important	Referent	Referent	Referent
Fairly important	1.6 (1.0–2.6)	1.7 (1.0–2.8)	1.7 (1.1–2.8)*
Very important	2.0 (1.1–3.4)*	2.2 (1.3–3.8)*	3.6 (2.2–5.9)*
Most important	6.3 (2.3–17.6)*	6.1 (2.3–15.8)*	16.9 (7.7–37.1)*
ACOG Member	1.0 (0.5–2.0)	1.0 (0.5–2.0)	0.7 (0.4–1.3)
Percent Urban	1.5 (0.5–4.9)	1.7 (0.6–5.2)	0.3 (0.1–0.7)*

Table presents results of multivariable logistic regression analyses that adjust for all variables in the table.

\*  
p[lt].05

**Table 4**

Adjusted odds of being willing to assist in all scenarios objected to, in the case of objecting to sex selection, and in all scenarios objected to other than sex selection, by physician characteristics

Characteristic	Willing to assist despite objection		
	All scenarios OR (95% CI)	Sex selection OR (95% CI)	All scenarios other than sex selection OR (95% CI)
Age, yrs	.98 (.95-.99)*	.98 (.95-.99)*	.99 (.96-1.02)
Female sex	1.3 (0.9-1.8)	1.3 (0.9-1.8)	1.8 (1.1-2.9)*
Race/Ethnicity			
White, non- Hispanic	Referent	Referent	Referent
Black, non- Hispanic	0.6 (0.3-1.2)	0.6 (0.3-1.2)	0.7 (0.3-1.4)
Asian	1.1 (0.6-2.1)	1.2 (0.6-2.5)	1.6 (0.6-4.3)
Hispanic/Latino	1.0 (0.5-2.1)	1.2 (0.5-2.5)	1.6 (0.6-4.3)
Other	1.9 (0.3-10.6)	4.8 (1.0-22.4)*	0.6 (0.1-4.5)
Married	0.8 (0.5-1.3)	0.7 (0.4-1.2)	0.9 (0.5-1.7)
Children	0.6 (0.3-1.1)	0.6 (0.3-1.1)	0.6 (0.3-1.4)
US born	1.2 (0.7-1.9)	1.0 (0.6-1.7)	2.2 (1.1-4.7)*
Region			
Northeast	Referent	Referent	Referent
South	0.6 (0.4-1.0)*	0.6 (0.4-0.9)*	0.3 (0.2-0.6)*
Midwest	0.7 (0.4-1.2)	0.7 (0.4-1.2)	0.5 (0.3-1.1)
West	1.1 (0.7-1.8)	1.1 (0.6-1.8)	0.8 (0.4-1.7)
Religious affiliation			
None	Referent	Referent	Referent
Hindu	0.6 (0.2-2.1)	0.5 (0.1-1.7)	3.0 (0.5-17.3)
Jewish	3.0 (1.4-6.5)*	2.9 (1.3-6.5)*	2.5 (0.5-13.3)
Muslim	0.8 (0.3-2.1)	0.7 (0.3-1.9)	0.8 (0.2-3.5)
Roman	1.4 (0.7-2.7)	1.4 (0.7-2.7)	1.1 (0.4-3.5)
Catholic/Eastern Orthodox			
Protestant, Evangelical	0.9 (0.4-2.0)	1.1 (0.5-2.6)	1.0 (0.3-3.4)
Protestant, Non- Evangelical	1.5 (0.8-2.9)	1.5 (0.8-3.0)	1.2 (0.4-3.9)
Other Religion	0.6 (0.2-1.8)	0.6 (0.2-1.9)	1.0 (0.2-5.2)
Importance of religion in life			
Not very/not at all important	Referent	Referent	Referent
Fairly important	1.0 (0.6-1.7)	1.0 (0.6-1.7)	1.0 (0.4-2.3)
Very important	0.7 (0.4-1.2)	0.7 (0.4-1.2)	0.6 (0.3-1.3)
Most important	0.4 (0.2-0.7)*	0.4 (0.2-0.7)*	0.3 (0.1-0.7)*
ACOG Member	1.2 (0.7-2.1)	1.2 (0.7-2.2)	1.1 (0.5-2.1)
Percent Urban	1.4 (0.5-3.7)	1.1 (0.4-2.9)	1.1 (0.4-3.2)

Table presents results of multivariable logistic regression analyses that adjust for all variables in the table.



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