Pregnancy Loss, Bereavement, and Conscientious Objection in Perioperative Services

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CASE STUDY: "I CANNOT GET anyone to assist with this surgery."

One weekend the Manager of Perioperative Services called the Ethics Co-Chair at home. "I have a problem," he said, "I have a patient with a fetal demise and no one is willing to provide pre or post op care or scrub in to remove the fetus. They are all conscientiously objecting."

I could see that the range of problems here was more than one. And my manner of addressing ethics emergencies is always "We may not be able to solve this emergent case, but we will teach and try to write policy so that we can prevent it from happening again." In this case study, I will attempt to show my thinking on pregnancy loss, bereavement, and conscientious objection in the perioperative services.

I could see several specific problems when examining this ethics consult:

1. Nurses seemed unaware of the *social contract* we have with the public.
2. Nurses were unaware of the exact *policy for conscientious objection* per the American Nurses Association (ANA), the Association of periOperative Registered Nurses (AORN), and the American Society of PeriAnesthesia Nurses (ASPAN).
3. Our *contracted nurses* have the right to conscientiously object but in the case of an emergency or no other nurse available, they must provide care until relief may be found.
4. Nurses should be aware of the position of the *State Board of Nursing*.
5. There is a *difference between a pregnancy termination* in which the fetus comes to the operating room with a heartbeat, and a demise or miscarriage, in which it does not. In the case of an ectopic pregnancy, there may or may not be a heartbeat.
6. The *vision and mission* of a secular hospital differs from that of a religious-based hospital. Directors of a secular hospital may choose to have the system provide access to all services that a patient requires. A religious-based hospital system may delineate which services it wishes to offer based on religious tenets, and this should be respected by personnel.
7. The pregnancy *dyad* according to the American College of Obstetricians and Gynecologists (ACOG) has two parties. The ACOG Code of Ethics states that maternal wishes and needs take precedence over fetal needs. In this case, the maternal party may be at risk of death when demise occurs and products of conception are not removed from the uterus.
8. Women and families who lose a desired pregnancy within the perioperative services deserve the *same dignity and evidence-based bereavement* support given in other sectors of the health care system, such as in maternal child services.

The Social Contract

As nurses, we exist in a unique place in society and work within a specific social policy.[1] We are trusted by the public who understand that we are here to safeguard them. We step in, at times, without extensive knowledge about how their condition may affect us (eg, caring for patients with human immunodeficiency virus early on before understanding the need for standard precautions) or when caring for others might put our own selves

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in danger (during hurricanes and fires, when our own homes or families may be at risk).

Whether the nurse is a member of the ANA, the ANA Code of Ethics[2] governs nursing practice and is used as a landmark document to judge nursing performance and liability. The American Nursing Association Code of Ethics, in Provision 1, directs us to "practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person." Provision 1.2 continues, "Respect for patient decisions does not require that the nurse agree with or support all patient choices… Respect is extended to all persons who require and receive nursing care." Provision 1.4 instructs that "Respect for human dignity requires the respect for recognition of human rights, specifically the right to self-determination."

The Code of Ethics guides nurses to safeguard patient autonomy, regardless of gender, illness, ability, socioeconomic status, functional status, proximity to death, age, ethnicity, condition, or health decisions. We show no "preference, prejudice, bias, convenience, or arbitrariness." In summary, unlike other professions, nurses do not choose their patients and are required to care for *all* members of society, with a specific set of guidelines should they wish *not* to do so.

The Conscientious Objection

The ANA supports the nurse's right to conscientious objection in Provision 5.4 of the Code. The nurse may object, and this objection is to be respected, to participation in certain procedures or forms of therapy that have been ordered for a patient. Conscientious objection is allowable when the procedure is one that causes the nurse moral distress. The nurse must "make this known in a timely and appropriate manner, in advance and in time for alternative arrangements to be made. Nurses are obliged to provide for patient safety and to withdraw only when assured that nursing care is available to the patient."

Catlin et al[3] worked to define conscientious objection for nurses. Historical military and religious documents were reviewed. Objections have most often been religious based and derived from a long-standing pattern of behavior based on personal values and beliefs. Often conscientiously objecting soldiers became medics or ambulance drivers rather than fight in military battle. Using the Schwartz-Barcott[4] method of concept analysis, a definition for nurses was offered.

> "For the nurse, conscientious objection may occur when the nurse interprets that the specific treatment that has been ordered for a patient is harmful or causing suffering. The nurse does not wish to provide this form of therapy and feels sincerely and has felt for some time that this situation warrants a conscientious objection. The nurse objects to the nature of the orders for treatment, willing to assist in other forms of treatment and not wishing to abandon the patient."[4, p103-104]

Using this definition, an example of how conscientious objection is used might be in choosing not to participate in male infant circumcision. The nurse finds the process of circumcision to be morally distressing and has for some time. The nurse has notified her manager well in advance. Another nurse is available and willing. The objecting nurse still cares for the infant before and after the procedure as he or she would care for any other patient. He or she assists in dressing, bathing, putting the infant to the mother's breast, or bottle feeding the baby. A sucrose pacifier might be offered before or after the procedure. The nurse objects, and this objection to participation in circumcision is respected, to a specific therapy. The nurse does not refuse to give care to the infant patient receiving health care services in his or her facility.

Using Conscientious Objection in the Perioperative Area

When perioperative nurses wish to conscientiously object, as in this case of a woman with pregnancy loss, several components must be considered. What is the process of objecting? What exactly is being objected to? How will the patient receive care? Each of these questions will be answered.

What is the Process?

A nurse may wish not to participate in pregnancy termination. Section"What Is a Therapeutic Abortion?" will explain further which conditions in pregnancy are considered to be a termination. The nurse, such as the scrub or circulating nurse, may object to