Professional Ethics in Unintended Pregnancy and Prevention Care
Caring for Sara
(Patient Situation #1)

The Patient
Sara is a 22 year-old woman with a complex medical history. She is 10 weeks pregnant. Sara is obese (BMI of 35) with a previously diagnosed bicornuate uterus and a history of severe anemia.

The Setting
Dr. Houston is a physician in a small rural community who runs an office-based practice with admitting privileges to the local community, nonprofit hospital. This is not a religious based institution. There are no family planning or abortion clinics in the community, so several private doctors offer abortions at their offices to their own patients to ensure access to these services in the area. These services are not advertised so the doctors and their patients do not have to deal with harassment from members of the anti-choice community.

What Happened
Sara comes to Dr. Houston requesting an abortion. After performing an ultrasound, Dr. Houston decides to perform a first trimester aspiration procedure for Sara in the hospital setting. While this is not always necessary, Dr. Houston thought the procedure would be easier if she were able to use anesthesia to relax the musculature, which would make the procedure easier for her and more comfortable for the patient.

The nurses are surprised by the presence of an abortion case on the operating room list. Dr. Houston had not thought to discuss the case in advance with the nursing staff, assuming that there would not be any issues. However, the nursing staff have not previously encountered this type of case and are uneasy about how to care for a woman seeking abortion care. One nurse states that she does not believe in abortion and thus should not have to care for this woman. She tells Dr. Houston that she cannot participate in Sara’s care. The other nurse on duty decides to act similarly.
American College of Obstetricians and Gynecologists (ACOG), 2007 Statement on The Limits of Conscientious Refusal in Reproductive Medicine states that health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient’s health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained.

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Can the nurses refuse to care for Sara?

Dr. Houston cancels the procedure because she had not foreseen problems with treating Sara’s case in the hospital. Over the next several days, the Clinical Nurse Specialist assigned to the unit initiates individual discussions with nurses about invoking conscience clauses with the goal of understanding this particular incident and to better understand each nurse’s ethical stance for future situations that may arise.

It is necessary for nurses to have opportunities to engage in self-reflection and values clarification regarding the intersection of personal beliefs and professional responsibilities. Staffing dilemmas such as this one are more likely to occur in a unit that does not frequently provide abortion care.
Providers with moral or religious objections should either not practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. There are biomedical ethical principles, which are widely accepted in health care:

1. Respect for autonomy of patient decision-making
2. Beneficence states that positive steps must be taken to help others
3. Non-malfeasance principle refers to do no harm
4. Justice, also referred to as fairness, describes equity in the distribution of medical resources (Beauchamp and Childress, 2001; Beal and Cappiello, 2008)

In addition, the Code of Ethics for Nurses serves the following purposes:

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

The Code of Ethics states the nurse will practice with compassion and respect for every individual with any health condition. Various parts of the Code of Ethics provide guidance in this Patient Situation:

1.1 Respect for human dignity
   A fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual. Nurses take into account the needs and values of all persons in all professional relationships.

1.2 Relationships to patients
   The need for health care is universal, transcending all individual differences. The nurse establishes relationships and delivers nursing services with respect for human needs and values, and without prejudice. An individual's lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient. Such consideration does not suggest that the nurse necessarily agrees with or condones certain individual choices, but that the nurse respects the patient as a person. (Note how the
Code states the nurse does not have to agree with a patient's decision but must respect a patient's needs and values without prejudice).

1.3 The nature of health problems
The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by disease, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying.

1.4 The right to self-determination
Respect for human dignity requires the recognition of specific patient rights, particularly, the right of self-determination. Self-determination, also known as autonomy, is the philosophical basis for informed consent in health care. Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment; to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or penalty; and to be given necessary support throughout the decision-making and treatment process. Such support would include the opportunity to make decisions with family and significant others and the provision of advice and support from knowledgeable nurses and other health professionals. Patients should be involved in planning their own health care to the extent they are able and choose to participate.

2.2 Conflict of interest for nurses
Nurses are frequently put in situations of conflict arising from expectations from patients, families, physicians, colleagues, and in many cases, health care organizations and health plans. Nurses must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and health care decisions, as well as those of patients. Nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient’s best interests and preserve the professional integrity of the nurse.

4.1 Acceptance of accountability and responsibility
Individual registered nurses bear primary responsibility for the nursing care that their patients receive and are individually accountable for their own practice. Nursing practice includes direct care activities, acts of delegation, and other responsibilities such as teaching, research, and administration. In each instance, the nurse retains accountability and responsibility for the quality of practice and for conformity with standards of care. Nurses are faced with decisions in the context of the increased complexity and changing
patterns in the delivery of health care. As the scope of nursing practice changes, the nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning activities to others who carry out nursing care. For example, some advanced practice nurses have the authority to issue prescription and treatment orders to be carried out by other nurses. These acts are not acts of delegation. Both the advanced practice nurse issuing the order and the nurse accepting the order are responsible for the judgments made and accountable for the actions taken.

4.2 Accountability for nursing judgement and action

Accountability means to be answerable to oneself and others for one's own actions. In order to be accountable, nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of patients. Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of health care organizations’ policies or providers’ directives. The Standards apply to registered nurses who provide preconception, antepartum, intrapartum, postpartum and newborn care and to women’s health. Registered nurses who provide care across the woman’s life span or targeted to specific ages and stages of development.

Invoking conscience clauses

Nurses engage in values clarification to sort their personal ethical stance on a variety of issues. Each nurse invokes his/her right to refuse an assignment based on their ethical beliefs, their understanding of nursing professional code of ethics and their understanding of their right to invoke conscientious objection. What if the nurse is unsure or confused about his/her convictions?

In terms of the patient, her procedure is delayed. Sara had arranged for her sister to spend the day with her and drive her home from the hospital. Her sister, Marie, took the day off of work with short notice and is uneasy about asking for another day off so soon with little notice. It was difficult to find a colleague to change shifts with her. She is not sure that she can be available to accompany Sara when/if the procedure is re-scheduled. Sara’s partner has recently started a new job and he is unable to take time off during the day. Sara is upset with the cancellation of her procedure. She had been NPO (which was difficult for her because of the nausea and vomiting), had arrived at the hospital by 7:00am and was sent home. Dr. Houston told her there was a nursing staffing problem but Sara heard some of the nursing staff discussing the issue. Sara felt ashamed of her situation and very angry that she does not know what will happen.

After reflection, a nurse determines that she can ethically provide care and respect the woman’s decision to terminate her pregnancy. Sara’s case is re-scheduled and she has her abortion without any problems.
The history of conscientious objection

The right of conscience emerged as the responsibility of professionals to refuse to follow immoral institutional or governmental directives. These discussions were heightened in post-World War II discussions regarding the responsibility of physicians not to conduct immoral and cruel treatment ordered by totalitarian regimes as in Nazi Germany.

Discussions have moved from a framework of duty to refrain from harm and protection of human rights to framework of protecting the provider. The provider is invoking conscious clauses to protect themselves from providing legal treatments or assisting the patient to access a treatment of the patient’s choice. As a result, at times, patients have been unable to access legal health care of their choosing (Beal and Cappiello, 2008; Charo, 2005).

Debates about conscientious objection surfaced again in 1973 after the ROE vs. Wade court decision. Church Amendment was the first federal legislation passed (1973) and declares that a health care worker cannot be required to perform or assist in the performance of abortion (or sterilization) procedures that conflict with religious beliefs or moral convictions. (Health Programs Extension Act of 1973. Pub L No. 93-45, 401, 87, Stat 91, 95). Effectively, this act does the following:

- Prohibits discrimination against health care workers who refuse to provide care based on ethical grounds.
- Protects health care workers (prohibits discrimination) against health care workers who perform lawful sterilization or abortion procedures.

Providers who wanted to provide abortion services have used the concept of conscientious objection. Before abortion was legal in the U.S., some doctors in the country quietly provided safe abortion care as they saw the health risks experienced by self-induced abortions. These doctors did so because of their deeply held ethical conviction that women should have access to safe care and not risk complications or death from unskilled providers. They were conscientious objectors in order to provide the service.

In 2008 the Bush Administration extended protections under the Church Amendment to workers who chose not to participate, even indirectly, in care that violated their moral beliefs. The working was so broad that discussion at the time speculated that many issues might arise, for e.g., that a hospital staff that cleans the OR suite could object to do if an abortion procedure occurred in the OR. The extension of rules was rescinded in the following administration (Obama).

While nurses have the ethical responsibility to implement and adhere to nursing practice standards, there is increasing evidence that political and institutional restrictions on our duty to provide the best care possible are jeopardizing patient health as well as our ability to adhere to an ethical standard of care. Furthermore, the standard of care most often restricted based on ideology and personal
beliefs are those related to reproductive health and sexual activity. More health care providers are refusing to provide services to which they have personal and religious objections. Restrictions have expanded due to the growth of large religiously controlled health care corporations. These organizations often impose contractual limitations on the health care the clinicians in their systems can offer, essentially preventing health care professionals from delivering the care they were trained to provide. Imbuing health care institutions with religious ideology allows those beliefs to supersede those of the health care professional and/or patient. However, the importance and nature of health care, and the nature of the relationship between a health care provider and his/her patient, render that justification inadequate.

Recent political trends have favored ideology over science. When ideological restrictions are imposed, patients may be denied access to quality health care and may not even receive appropriate information or referrals for the care they need. Despite the threats to patient health, the leading quality monitoring and enforcement agencies have failed to incorporate any quality measures related to these restrictions.

Currently, doctors and nurses that provide abortion care often describe their dedication to their work as providing a needed and legal procedure. Although they do not often use the term of conscientious objection to their work, the article by Lisa Harris makes the point that current laws provide minimal protection for “conscious bound providers” to offer abortion information, care and/or referrals. This leads to additional stigmatization for professionals involved in direct abortion care. Bioethicists rarely make the ethical argument for protecting the conscientious provision of care. “Moral integrity can be injured as much by not performing an action required by one's core beliefs as by performing an action that contradicts those beliefs” (Wicclair, 2011).
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What Happened (continued)

The nurse who decides to proceed with caring for Sara shares that she remains uncomfortable caring for Sara as she does not know the post-procedure care involved. This nurse administrator contacts the nursing education department to assist the nurse with understanding the appropriate care for Sara. The other nurses decline to be involved in Sara’s care. However, with one nurse to provide care, Sara is able to have her abortion procedure scheduled four days later.

How did this nurse conscientiously provide care?

The Association of Women’s Health, Obstetric and Neonatal Nurses uses standards that apply to registered nurses who provide preconception, antepartum, intrapartum, postpartum and newborn care and to women’s health. The standard on ethics says the following:

Caring for a woman who has chosen the option of abortion can be seen as an act of conscience for the health care provider (Harris, 2012). Harris makes the argument that current bioethical frameworks do not address ethics with respect to positive acts of conscience, which is protecting health care workers who chose to offer abortion care.

The registered nurse’s decisions and actions on behalf of women, fetuses, and newborns are determined in an ethical manner and guided by a sound framework for an ethical decision-making process. The following measurement criteria are used. The RN:
1. Uses the ANA Code of Ethics for Nurses with Interpretive Statements to guide practice.

2. Seeks available resources that are necessary to help formulate ethical decisions.

3. Maintains confidentiality and protects the privacy of patient information consistent within legal and regulatory parameters.

4. Acts as a patient advocate in appropriate ways and assists patients in developing skills for self-advocacy.

5. Delivers care in a nonjudgmental and nondiscriminatory manner that is sensitive to patient diversity and patient preferences whenever possible.

6. Delivers care in a compassionate manner that preserves patient autonomy, dignity, safety, and rights.

7. Reports and strives to protect women and their newborns from incompetent, impaired, unethical or illegal healthcare practice.

8. Contributes to resolution of ethical issues for women and their fetuses or newborns or family members, and within health care services or systems appropriate to her or his role through participation in activities such as ethics committees.

According to Magelsson (2012), conscientious objection should meet the following criteria:

1. Providing health care would seriously damage the health professional’s moral integrity by constituting a serious violation of a deeply held conviction (usually a strong religious or longstanding moral perspective)

2. The objection has a plausible moral or religious rationale – this means that the nurse must articulate a deeply held belief. For example, it would not be sufficient for a nurse to refuse to care for a morbidly obese patient as the nurse has no tolerance for habits of overeating.

3. The treatment is not considered an essential part of the health professional’s work.

4. The burdens to the patient are acceptably small
   • The patient’s condition is not life-threatening. If the patient’s life is in danger, a nurse is obligated to provide care regardless of his/her ethical belief.
   • Refusal does not lead to the patient not getting the treatment, or to unacceptable delay or expenses.

5. The burdens to colleagues and healthcare institutions are acceptably small. The nurse invoking a conscience clause should not do this so frequently that it becomes burdensome to their co-workers. If it is burdensome, the nurse must re-evaluate if he/she is working in the appropriate practice setting for their deeply held beliefs.
EXAMPLE: A nurse took a position in a Title X funded clinic which provides affordable contraceptive methods to women in need, the nurse should not expect to have their conscientious objection to contraception accommodated. The nurse with such strong held beliefs should not seek employment in a clinic that provides contraception as one of the main services.

In addition, the claim to conscientious objection is strengthened if:

6. The objection is founded in nursing's own values.

7. The nursing care situation, nursing or medical procedure is new or of uncertain moral status. Since abortion has been legal since 1973 in the U.S., it is difficult to make the case that abortion care is not new or of uncertain moral status.

What happens when one nurse decides to care for a patient having an abortion when other nurses are making a different choice?

The culture of a work environment can have an impact on a nurse’s decisions to participate or not participate in the care of a patient. In some settings, the nurse who agrees to provide abortion care may experience negative comments from her/his colleagues. A 2008 review of the literature by Lipp on nurses who participate in abortion care reports that nurses who participate in abortion care, as well as those who refused, had been criticized by their co-workers. A small qualitative study by Kade et al. (2004) showed that more than one third of physician respondents reported that they had to postpone abortion services due to a lack of nurses willing to assist. Gallagher et al. (2010) suggests that the support of the team is essential in providing abortion care, and that is just what happened in this scenario.

In Sara’s case, she was able to have the procedure she needed, however, postponements due to staff unwillingness to participate in care, or lack of knowledge, can be extremely detrimental to patient health.

Nurses who choose to not participate in abortion care can support the beliefs of nurses who choose to exercise their right of conscience to provide abortion care.

Nurses continue to face ethical dilemmas in reproductive health care that challenge their personal beliefs, their role as patient advocate and their belief in and respect for patient autonomy in decision-making and right to care. Professional nursing organizations can provide guidance and opportunities for nurses to discuss the application of ethical frameworks to complex ethical cases.
American Nurses Association articulates the nurses’ duty to patients. Nurses must not abandon their patients: “Once a nurse begins treating a patient, she or he is legally bound to care for that patient until another nurse is available to assume responsibility for the patient” (Lachman, 2014).

In the case scenario, the nurse had not yet begun to care for Sara, however, the hospital had begun to care for Sara. This complicates the situation for the patient. In an ideal world, any nurse with a conscientious objection to caring for a woman having an abortion would have communicated this to her nursing colleagues at the time of her employment. In addition, in an ideal world the physician would have communicated with nursing staff prior to scheduling Sara’s case, since this was an unusual situation in that the physician has not previously scheduled abortion cases in the hospital.

Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience.

The nurse should communicate a conscientious objection in advance in order for patient care to occur uninterrupted. The nurse may not abandon the patient, meaning in an emergency, care must be provided regardless of the ethical perspective of the nurse. In addition, if the nurse engages in care with the patient, the nurse may not withdraw providing care until alternative nursing staffing is available. The patient must not suffer.

Values clarification work

*Exercise in Professionalism*

These exercises from the Medical University of South Carolina are designed to help learners tease out their values related to abortion care and how their values may impact the care nurses can provide to patients experiencing unintended pregnancy.

*The Abortion Option: A Values Clarification Guide for Health Care Professionals*

These exercises from the National Abortion Federation are designed to help nurses critically examine factors that might influence their beliefs about parenting, adoption, and abortion and, for some, their desire to become involved in abortion care. There are tools for clarifying values related to abortion, views about the role of health care providers, and case studies are used to identify and examine potential biases.
References

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