

UNE ANALYSE RÉFLEXIVE SUR LES AVORTEMENTS EN SALLE D'OPÉRATION

Auteur : Hubert Murray, baccalauréat spécialisé en soins infirmiers généraux, infirmier en service interne et infirmier anesthésiste, Hôpital St-George, Londres, R.-U.

RÉSUMÉ :

Cet article traite du concept de l'objection de conscience relativement aux interruptions chirurgicales de grossesse. Il se penche sur le devoir de vigilance de l'infirmière en service interne non seulement envers le patient, mais envers elle-même et souligne

l'importance d'être consciente de ses propres réactions morales et émotives face aux avortements en salle d'opération. Cette prise de conscience permet à l'infirmière/ODP (praticiens en salles d'opération) d'exercer de façon professionnelle et autonome et d'offrir des soins périopératoires de qualité supérieure tout en respectant ses droits personnels.

Réimpression tirée du *Journal of Perioperative Practice*, Volume 24, numéro 6, pp. 147-150. A reflective study on abortions in theatre, H Murray Droit d'auteur 2014, avec la permission de The Association for Perioperative Practice.

KEYWORDS: ABORTION, CONSCIENTIOUS OBJECTION, ETHICAL REASONING

A REFLECTIVE STUDY ON ABORTIONS IN THEATRE

Author: Hubert Murray BSc (Hons) in General Nursing, Scrub & Anaesthetic Nurse, St George's Hospital, London, UK.

Reprinted from *Journal of Perioperative Practice*, Volume 24, Issue 6, 147-150. A reflective study on abortions in theatre, H Murray Copyright 2014, with permission from The Association for Perioperative Practice.

ABSTRACT:

This article discusses the concept of conscientious objection in relation to surgical terminations of pregnancy. It explores a scrub nurse's duty of care not only to the patient but to themselves. It highlights the importance of being self-aware of one's moral and emotional attitude towards abortions in theatre. Doing so enables the nurse/ODP to practice professionally and autonomously, and to deliver the

highest level of perioperative care whilst respecting their personal rights.

INTRODUCTION:

As there are various methods of abortion, in this article I will use 'surgical terminations of pregnancy' (STOP) to refer to abortions. The operating theatre has become a crossroads at which vast cultural and ethical standpoints meet. At some stage theatre nurses and ODPs will

Conscientious objection is a very real ethical dilemma in perioperative nursing (AfPP 2011).

come into contact with an operation that will question their ethical viewpoint of what is right and wrong. Abortions are one example of this. In order to practice professionally we must know our rights and those of the patients. We must do everything we can to promote our work, strive for better care, act autonomously and be accountable for our actions.

With this in mind, how can we participate in abortions if we believe they are morally wrong? Can we object to participating in abortions and is it appropriate or even legal to object? Is there a guide for making difficult decisions like this? Will I be the recipient of criticism from other staff if I object? These questions bring challenging topics of discussion to the surface of our practice.

Conscientious objection is a very real ethical dilemma in perioperative nursing (AfPP 2011). In 2011 the number of abortions of resident woman in England and Wales was 189,931 (DH 2011). The potential amendment of the Abortion Act 1967 would mean that nurses and ODPs could be permitted to carry out surgical abortions (Lipp 2008) within the first trimester (TSO 2007 p8). Therefore, it is clear that at some stage in our career we will come into contact with STOP.

Two themes arise from this: how do we respect the decision of the patient if we believe that it is morally wrong, and how do we participate in a procedure if we are emotionally and religiously not comfortable with it? I believe that we can only answer these questions by reflecting on the scenarios of others or ourselves. I chose to use Gibbs' cycle of reflective practice which consists of six elements: description of the scenario, my involved feelings, evaluation, analysis, action plan and conclusion. Like Schoen (1991) I believe this to be the best model because it is easy to apply and can be applied both in-action and on-action, after an event has occurred.

Description of the event

The allocations for the day had been made and I was to work in general

surgery. However, I was informed by the floor manager that I was reallocated to day surgery because one of the scrub team had become ill. I asked what the list consisted of and was informed that it was STOPS; the manager then went about his other duties before I could enquire what a STOP was. At this point I handed over to my colleagues what I had prepared in my theatre and what needed to be done in my absence. I went apprehensively to day surgery, not knowing what a STOP was.

Upon arrival at the new theatre, there were a few familiar faces and I asked what each case involved, what equipment was needed and if the patient had been sent for. I was given a brief overview of the list by the other scrub nurse. The list was four cases, all of which were surgical terminations of pregnancy (STOP). A STOP involves a woman being admitted to hospital for suction evacuation of the uterus at 14 to 16 weeks of pregnancy (RCOG 2011). I was not asked if I had any objections towards working in the list nor did I raise any concerns. With the other scrub nurse and assistant theatre practitioner we prepared for the procedures and successfully completed the list.

Feelings

At first, when my manager approached me about being reallocated to a different theatre I felt apprehensive about joining a new theatre team that I may not be familiar with. When I found out what the cases were I felt worried as I had no previous experience in obstetrics and gynaecology. I was concerned that I would not have the appropriate scrub skills. Secondly, I felt somewhat confused because my religious background (Roman Catholic) does not permit abortions and here I was, participating in them. Thirdly, I felt that if I raised my concern about working in this theatre I would be seen as a burden to the department. Finally, I did not feel empowered or supported by the floor manager to raise any objection, therefore I doubted myself and my skills.

Conscientious objection is a term that describes a nurse's refusal to be involved in some or all of the patient's care (RCN 2008), and it is enshrined in the Abortion Act section two (HMSO 1967).

Evaluation

During reflecting on-action later that day, I began by evaluating the situation from a positive perspective: all care given to the patients on the list was delivered professionally, efficiently and safely. No personal prejudices were imposed on them. Dawkins and Ingram (1998) found that it can be very difficult to respect the cultural and religious beliefs of a patient whilst in theatre because we have become blind to inherent diversity.

The WHO safer surgery checks were completed and there was a strong sense of cohesiveness and effective communication between the theatre team. Vats et al (2009) stated that, in stressful situations, we are prone to error. Having safety checks in place is only effective if there is a strong sense of cohesiveness in the operating team.

Due to my religious background I felt confused about working in this theatre, however I did not feel strongly enough either for or against participating in the abortions to make my feelings known. Therefore I decided that I needed to experience it to form my own opinion. As a result of this I learnt new skills and information about the procedures. The backbone of personal growth is to have the confidence to put oneself into new learning experiences (Woodhead 2000) so that we can increase our skills and knowledge base.

Looking at it from a negative perspective, I believe that the floor manager did not show a duty of care to me as he did not ask if I was comfortable with going into the theatre. On the other hand I felt as though I was not assertive enough to my floor manager. According to Woodhead (2000) if a leader or manager wants to promote an effective working team then they must meet the needs of the team members and ensure that they feel valued. This promotes an open environment for communication. Finally, I felt it would be unprofessional of me to object to work in the theatre; I

did not know if objecting was acting outside of my code of conduct and jeopardising my duty of care to the patient.

Analysis

In perioperative practice we are faced with difficult decisions every day that must be made quickly. To guide us in making the right decision we are influenced by the ethical standards that govern our profession; we have a duty of care to our patients (Kennedy 2004). This implies that we must act to protect the autonomy of patients and must respect their decisions in order to:

'Make the care of people your first concern, treating them as individuals and respecting their dignity' (NMC 2008)

These points enshrine caring for the patient, but in my scenario there is still an ethical conflict present. Pirie (2012) believes that we must respect patients' decisions even though they may not be in conjunction with our own. Although this author agrees with Pirie, I also believe that our own rights must be respected. AfPP (2011) stated that it is best practice to respect not only the values of our patients but also our own values.

Conscientious objection is a term that describes a nurse's refusal to be involved in some or all of the patient's care (RCN 2008), and it is enshrined in the Abortion Act section two (HMSO 1967). According to Pirie (2004) there are two distinct areas in which one can conscientiously object to being a part of a patient's care:

- participation in abortion as detailed in the Abortion Act 1967; and
- the right to refuse to be involved in technological procedure to achieve conception and pregnancy (Human Fertilization and Embryology Act of 1990).

The objection may be based on personal, moral or religious beliefs which can have an impact on the patient (Pirie 2004).

If a nurse/practitioner feels strongly about a situation and is aware of conscientious objection, their intuition would lead them not to participate. However, as I had no prior experience or enough knowledge regarding abortion, I could not make a truly informed decision on conscientious objection. Marshall and Raynor (2002) state that nurses must decide upon a course of action based on their intuition, and this may require reflecting on their own experiences or others in order to make this decision. Reflecting on this, I discussed how to manage this situation if it were to arise again. Two questions that further the discussion are: how could I have raised my conscientious objection?; and, how can I object in such a way that neither the patient's autonomy nor mine is disregarded?

Through researching these questions, I found that the code of professional conduct advises us to make known to the appropriate person any conscientious objection which may be relevant to our work (NMC 2008). Reflecting this, AfPP (2011) reinforced this by stating that a manager must be informed of a conscientious objection in sufficient time to manage the situation. If we voice our conscientious objection to the necessary people i.e. floor manager, and in a timely manner, alternative arrangements can be made, so that the patient's care is unaffected by our decision. This enables us to practice autonomously and to ensure that our duty of care to our patient is not compromised (Beauchamp & Childress 2009). The only time when

conscientious objection is not applicable is when the procedure is needed in a life threatening situation for either the mother or the foetus; this was not applicable in this situation.

The ethics of abortion create strong social debate and it can be difficult for the individual to form a decision that they are comfortable with. Having a good knowledge about ethical reasoning helps one make a difficult decision. It can encompass subjects such as exercising conscientious objection, cancelling a list due to lack of staff or lack of operating time. To make the best decision we need to have different methods for ethical reasoning. I believe that a better understanding of ethical reasoning would have helped me make an appropriate decision when deciding if I should partake in the abortions.

Fullbrook (2005) uses a principles' based framework to assist us in making difficult decisions in perioperative practice on whether or not to act:

- The first and second principles are to undertake a risk/benefit analysis of whether or not to act, and to reflect on what might happen if I do or do not act. In my case, if I chose to abide by my religious background I would not have participated in the STOPS. Therefore, the day surgery manager would have had to reallocate me and put somebody else into my position. Or, in the worst case scenario, under the local theatre policy my decision would have prevented the list from going ahead due to a lack of staff and the list may have been cancelled;
- Taking the third principle, what are the dangers of acting, or not acting? If I did participate in the list, did I have the appropriate skills, would I have been slower than other practitioners thus causing the list to overrun?;
- The fourth principle is: what is the cost of acting or not acting? My patients needed an abortion for reasons that I was unaware of, and by not proceeding, this could have been detrimental to their physical and/or psychological well-being; and
- The fifth principle is: what is the most

relevant current knowledge about the situation I am in? At that point, I did not feel I was in a position to look up the trust's policies on objecting to work in an operation list nor would I have had the time to do so.

I believe that applying Fullbrook's ethical framework to my situation would have been very beneficial for me in my scenario. Unfortunately, I was not aware of it when I encountered my first abortion and therefore I was not able to form a decision based on Fullbrook's framework. In view of this I decided that the best outcome would be to work through the list in the hope that I would learn from it. Pirie (2012) is of the opinion that a patient has a duty of care owed to them from a practitioner who has been allocated to care for them. Therefore, by simply agreeing to take the place of the sick member of staff, a duty of care was immediately established between myself and the patients on the list (Brazier 2003, in Pirie 2012).

The final aspect to this scenario is having the confidence to practice autonomy. If I was to exercise an objection would I have been subject to criticism by the theatre staff. This is understandable as the list would have been prevented from starting due to staff shortage and a reshuffle of staff would have been necessary thus causing a time delay to the list.

Reinforcing my views is a study of nurses' attitudes towards pregnancy and termination. Marek (2006) found that nurses were criticised by their co-workers for not participating in the care of women undergoing abortions. Griffith and Tegnah (2010) reflect this in their belief that, in some scenarios, our sense of autonomy can come under strain. I believe that this may be due to the multicultural society we are surrounded by at work. Any person being subjected to discrimination from other staff must remember that they have a right to exercise their rights and that we must all abide by our code, as set out by the NMC (2008), i.e. you must treat your colleagues fairly and without any

The ethics of abortion create strong social debate and it can be difficult for the individual to form a decision that they are comfortable with.

discrimination. If we are worried that we might be the recipients of criticism as a result of our decisions, we must have both good assertive skills and a firm understanding of our legal responsibilities in practice. We can then work both professionally and autonomously. Understanding the nature of conscientious objection and ethical reasoning enables us to promote the best possible care for ourselves and our patients.

CONCLUSION:

Using Gibbs' cycle of reflective practice I have discussed the concept of conscientious objection in relation to surgical terminations of pregnancy. I have explored a scrub nurse's duty of care, not only to the patient but also to themselves. I have highlighted the importance of being self-aware of one's moral and emotional attitude towards abortions in theatre. Doing so enables the nurse/ODP to practice professionally and autonomously, thus delivering the highest level of perioperative care whilst respecting their own personal rights.

Practicing conscientious objection is a difficult issue to manage, especially within current working conditions such as staff shortages and increasing workloads. There are a vast number of ethical issues that arise in the daily perioperative environment. Having tools to help us make difficult decisions are vital for our practice to thrive. Fullbrook's ethical framework can act as one tool to help us make these difficult decisions. Having a keen understanding of these ethical issues and ways to approach them ultimately improves our practice and promotes the

Duty of care is our primary purpose in healthcare, whether this involves caring directly or indirectly for our patients.

highest level of care possible for our patients. Partaking or not partaking in an abortion list draws upon our self-awareness skills, communication skills and demands high levels of assertiveness.

Duty of care is our primary purpose in healthcare, whether this involves caring directly or indirectly for our patients. I feel that duty of care to ourselves can sometimes be overlooked. We have a right to exercise autonomy and stand by our beliefs and values. Conscientious objection enables us to practice these elements safely without negatively affecting the patient's rights. This demonstrates that, if we have the appropriate knowledge, we can care for both our patients and ourselves.

Action Plan

My first recommendation would be to devise a questionnaire for both main theatre and day surgery staff to ascertain their personal or cultural views on abortions and their awareness of conscientious objection and whether they would feel comfortable exercising their right to object.

Secondly, I would like to devise a separate audit for team leaders to gain an insight into their perceptions of their staff's ethical and emotional views on abortion. Further to this, looking into staff perceptions about emergency abortions, where conscientious objection is not valid, would highlight any emotional or technical issues. This would demonstrate whether staff are being facilitated by team leaders to air any concerns about working in these procedures.

Next I would create a pamphlet about one's duty of care to oneself as well as to one's patient, emphasising conscientious objection, ethical decision making and assertiveness. I would present the results in a meeting to both day surgery and main theatre staff to highlight any areas of concern. I am of the opinion that bringing self-care and assertiveness to the forefront

of theatres could improve staff self-awareness on issues such as conscientious objection and difficult decision-making. This would create a more confident and skilled workforce. If we can uphold a strong self-value we can uphold a good morale and sense of leadership to make the right decisions for ourselves and our patients. Therefore, patients undergoing surgical terminations of pregnancy would receive the highest quality of care possible from our perioperative team.

REFERENCES:

Association for Perioperative Practice 2011 **Standards and recommendations for safe perioperative practice** Harrogate, AfPP

Beauchamp TL, Childress JF 2009 **Principles of biomedical ethics** New York, Oxford University Press
Brazier M 2003 **Medicine, patients and the law** London, Penguin

Dawkins M, Ingram D 1998 Ethnic and cultural awareness *British Journal of Theatre Nursing* 8 (6) 16-18

Department of Health 2011 **Statistical bulletin: Abortion statistics England and Wales** Available from: www.gov.uk/government/news/abortion-statistics-england-wales-201 [Accessed December 2013]

Fulbrook S 2005 The duty of care: an update. Current legal principles *Journal of Perioperative Practice* 15 (2) 78-82

Gibb G 1988 **Learning by doing: A guide to teaching and learning methods** Oxford, Further Education Unit, Oxford Polytechnic

Griffith R, Tengnah C 2010 **Law and professionalism issues in nurses** Exeter, Learning Matters

Her Majesty's Stationary office 1967 **Abortion Act** London, HMSO Available from: www.legislation.gov.uk/ukpga/1967/87/pdfs/ukpga_19670087_en.pdf [Accessed December 2013]