Colibri Healthcare

Podcast Transcript

Conscientious Objection: Balancing Beliefs and Patient Wellbeing

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Host: Candace Pierce DNP, MSN, RN, CNE

Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Episode 1: Conscientious Objection: Balancing Beliefs and Patient Wellbeing

Transcript

CANDACE PIERCE: This is Dr. Candace Pierce with the Elite Learning Library for Healthcare, and you are listening to our Elite Learning podcast, where we share the most up to date education for healthcare professionals. Thank you for joining us for this podcast series topic on conscientious objection and patient care. I'm joined by Dr. James Stowe, a registered nurse and a juris doctor from Samford University's Cumberland School of Law. Thank you so much for joining us for this topic.

JAY STOWE: Excited to be here. Thanks so much for having me.

PIERCE: Yes, absolutely. I really want you to start us off with the why. Why do we need to talk about conscientious objection and understand it? And why do you think it really became a big topic, or a bigger topic through the COVID-19 pandemic.

STOWE: As we think about ethical decisions, I would classify conscientious objection as an ethical decision in healthcare, and we have to consider where is that coming from. Why today versus years gone by. And I think it all has to do with where our ethical foundation has kind of come from, right.

Where has it transitioned from? If we think back years ago, we had the Hippocratic Oath, right. So Hippocrates of around 400 B.C. developed the Hippocratic Oath, and it basically said for physicians, and I'll paraphrase it, pledge to prescribe only beneficial treatments according to that physician's abilities and judgment, refrain from causing harm or hurt, and to live an exemplary personal and professional life, like it really extended outside of just the confines of an office. And we kind of know it best today as the oath our medical students take. Well, when you look at it and you look at today compared to years gone by, the oath has really been chipped away. It's really been amended. Well, 98 or so percent of our medical students still take an oath. And we even have an oath for nurses. There's a Nightingale oath.

PIERCE: Yeah, I was going to bring that up while you're talking about it. And that one was written in 1838, and was named in honor of Florence Nightingale, but it was actually written in Detroit, Michigan. And that one has also been changed multiple times. But our nursing students still take an oath, a pledge.

STOWE: They did. They took a pledge. And when you look at these things together, you know, kind of all these disciplines are taking this oath and we think, hey, do no harm. You know, I guess that's three words. It's easy to remember. And that's not necessarily the foundation of these oaths anymore. It's really interesting. We've taken things out of them. The original oath, for example, has a comment in there or a phrase in a quote, and it says in a like manner “I will not give to a woman of pessary to produce abortion”. That was in the original Hippocratic Oath. Do you think a hospital, or a university or college is going to allow their students to take a stand or a pledge one way or the other regardless of your belief on such a contentious issue, they're just not.

PIERCE: No. Not at all.

STOWE: Not at all. And so, then you look at that and you think, well, what about legally? Well, take this oath, we all have this belief, doctors, you take a Hippocratic oath, nurses, you take this oath. When you get into court, it's really simple as an attorney to say, hey, look, you pledge to do no harm and you did harm. So even this do no harm language has been amended. So I say all this to say that the ethical foundations that we have, that we used to have this collective belief has really eroded. And I think COVID-19 has brought that to the forefront where our personal beliefs now more than ever dictate our ethics. And it's not so collective anymore. It's very individualized. And that's impacting how we provide healthcare, and it's impacting whether or not our health is truly patient centered or not.

PIERCE: Right. Is it patient centered or is it or is it we centered? But I think that also highlights why this it seems like it's such a gray area. Conscientious objection to me seems very gray. And I don't understand where the line is drawn between my personal beliefs and my duty to take care of, to provide care.

STOWE: Well, that's a great question. And the answer is not very many people know that answer either, because it's a very difficult situation. So, you take a look at it, and our country, which was founded on religious principles, right? It's very difficult to disagree with that point. So, our court system, our country founding, had all these religious principles, and you look today. It's hard to judge who is still religious today, that's a difficult question. Kind of an oversimplified way of looking at that is church membership. You look from the 1930s to roughly the year 2000, and while it fluctuated up and down, about 70% of the U.S. was a member of a church, one church or another. Since 2000, that number from 70% has fallen to 47%.

PIERCE: Wow.

STOWE: So, in a very short period of time, we've kind of gone away from a collective belief to more individual beliefs. And why is that important? When we talk about the healthcare professionals personal beliefs, it's because those healthcare professionals have their personal beliefs now. They no longer have that collective belief. From a healthcare standpoint, our oath has deteriorated. Our religious foundation, we've stepped away from that. And so now we really look at things as our experiences? What's the ten-minute YouTube? What's the TikTok, the 5 seconds Snapchat, what does that teach us and tell us, and we're forming our beliefs from there. We are a very influenced society. So, when you look at this and you try to go, hey, how do I correlate my own personal beliefs with the legal system? It's very difficult, very, very difficult. You know, we recently had a huge decision in 2022 when the US Supreme Court overturned Roe v Wade. I haven't heard that much outcry over a US Supreme Court decision in quite a long time. As an attorney, it's very interesting to me, because what the court system did is it said basically, look, we don't believe the federal government has the right to decide this. We don't think that's under the federal court's purview. We think that's a state's right for a decision. So, many people said, Roe v. Wade, it banned abortions. It didn't do that. It actually kind of more follows the Constitution that said, hey, if the powers aren't expressed to the federal government, they go to the states to decide. And so, the states decided, and some put very, very constrictive bans on it. I live in Alabama. We collectively as a state, have such a ban that we had laws just in the waiting to kick in, you know? So, they were ready and willing to stop it from the get-go.

PIERCE: And Texas, I saw they just finished the first lawsuit where as a pregnant person sued to try to have an abortion because they found out that there was something wrong with the baby and they said no. So, she had to go out of state in order to get the abortion.

STOWE: You know, and that case is interesting. I was listening to that case, and from a legal perspective versus healthcare. So, let's say that states, and Alabama does not have this. Texas does have this, and this is part of the issue. Texas said, you know what, if the mother's life is at risk and we need to do life-saving measures, then abortion is okay. No one will define what is a life-saving measure or when the mother is at risk. So, we don't have clear guidelines. There are no clear guidelines. In this particular case, and forgive me, I don't have all the facts in front of me, but in this particular case, I believe the mother did some testing and the child, will not be viable or there will be some severe effects on birth. So, is the mother's health truly at risk?

PIERCE: Mm hmm.

STOWE: Is her life in jeopardy and available? It's debatable. I'm not a physician, so I don't know. But that's part of the problem is we all have this feeling of, oh, you know, I mean, from healthcare providers, hey, I want if the mother's life is at risk, absolutely. Save her life, right? But legally, where is that line? And we don't know. The bottom line is we don't know. And we've got to figure that out. And unfortunately, that's when it goes through many, many lawsuits and many, many judges interpretations until we get there.

PIERCE: So how many physicians and nurses are going to say, no, I'm not going to be a part of that. I'm going to object to that, because, and not even necessarily because of ethical and moral issues, but because I don't know where the line is. So, I'm going to object so that I don't cross a line that I didn't know was there.

STOWE: If you if you take a step back and you look at it, the smart answer is many of them.

PIERCE: Mm hmm.

STOWE: Because and I say that not for a patient-center focus. I say that we're a very litigious society and there's no individuals that are sued more than OBGYNs. If we are under this concept that every child is going to be born without any issue. Right. I mean, it's going to be perfect. Baby boy, baby girl is going to be perfect. If there's anything at all wrong. It's an automatic lawsuit. And so, you have that already. That's that is that is pure numbers. You can research that. So, you have that already. And now we bring this on. If I'm a nurse operating in that area, I have to seriously consider what I do. It's my livelihood, it's my license. And physicians as well. What happens when they start saying, I'm going to take my conscientious objection and I'm stepping out.

PIERCE: I'm going to go to insurance over here. I know, OBGYNs and that have stepped out and went to insurance. They stepped out of the field completely.

STOWE: It's very difficult when you work six months of the year just to pay your malpractice premiums and to feel good about your work. And at the same time, we need more physicians and nurses than ever. There's a very big shortage. And while all of these things are being brought to the forefront, we have people leaving the field, leaving the practice, and it just makes things more and more complicated. A recent study that I read stated that there's going to be a 20% shortage of nurses by 2025. And I thought, well, that's a that's a tremendous impact. There are different numbers put with it, anywhere from 200,000 to 500,000 nurses. But either way, it's a huge impact. But the number that I didn't or had not heard before was that there was roughly a 12% increase in demand for care, more acute, more sick patients, so fewer staff, more patients getting sick. It's a double whammy, and it's really going to affect decisions and how we approach healthcare going forward.

PIERCE: Absolutely. Is there even a way, and I know we touched on this a little bit, to really differentiate between the individual belief as a healthcare worker, as a nurse, and trying to give that patient-centered care?

STOWE: It's very difficult. It's very difficult.

PIERCE: Well, let's talk about the COVID-19 vaccine with individual all believes versus patient centered care.

STOWE: So COVID- 19 vaccine is an interesting one. We get this massive scare across country, this pandemic. The COVID-19 vaccine was produced to save humanity. And so, we started giving this vaccine. And there's all kinds of issues with it I mean, the rollout, it's brand new. We're trying to do as much as we can as fast as we can. We are trying to give it to as many people as we can to save lives as fast as we can. And the normal steps are bypassed. It's under emergency use authorization. So, it gets out there because it's an emergency. There's a pandemic. So now that it's passed us, we have all these questions, and I think it's natural for those in the healthcare field especially to ask questions and say, well, let me think about this. What was done, what was done right, what was done wrong? And then it's a very natural progression to go, hey, look, well, I've got to get this flu vaccine, right. There's a flu vaccine that is from, the flu season in the hospital is October 1st through March 1st. And so, with that, now what most frontline healthcare people don't understand, and what most patients and families understand is there's actually financial compensation tied up into administration and documentation of

this one thing, along with many things. So, if the nurse says, look, hey, if I'm the nurse leader, I'm the nurse manager, nurse director, frontline staff, nurse comes to me and says, look, after this whole COVID thing, I'm just really, I've got a lot of questions. And I think if I could just see a safety study of this annual flu vaccine, I just would feel a whole lot better about getting it. There's all this controversy with the COVID-19. I don't understand it, but I know there is controversy, so I could just see this. So, you have to sit there and look and say, wait a minute, there isn't a safety study. There hasn't really been a safety study on vaccines in 40 years. But even if you did, how do you do a long-term safety study on a seasonal flu vaccine that changes year after year?

PIERCE: Yes. Every year.

STOWE: It's just that it's pretty unfeasible to ever.

PIERCE: And COVID-19 vaccine continues to change. They're continuously putting out boosters. They're like, oh, we're adding new strains to it. It is a continual change between COVID-19 and the flu vaccine every year.

STOWE: It is. And so, you look at that, and as the frontline nursing personnel, it's a very valid question. I want to see a safety study because, again, if we go back to this oath of do no harm, it's hard to marry the two. Because we don't have evidence that we're not harming.

PIERCE: I just want to point out, too, while you're talking about this, as it's almost sometimes in some facilities you get like the scarlet letter. You didn't get your flu vaccine, or you didn't get your COVID booster, so you're going to get fired, or you're going to have to wear this and a mask so that everybody knows that you made a decision following your conscience.

STOWE: Yeah, it's really tough. The hospitals are, any healthcare facility, really. It's really twofold. We want you to take the flu vaccine, for example, because we don't want you to get sick one, so we care about your health. But at the same time, we also need you here to take care of these patients. And if you're not here, we can't accept as many, and the revenue goes down too. And where is the line? Are the hospitals really altruistic or are they just worried about the bottom line? So, what do they do? They say you have the choice. You do have the choice to take it or not in most situations. However, if you don't, I'm going to need you to mask up and do all these things that other people aren't. And you need to stand out. So is that really a fair allowance of being able to choose for yourself, and be able to consciously object to something, or are you able to do it with an asterisk of, well, we're going to make fun of you and browbeat you into doing something. And so, it's a fine line out there. And I think that's why this thing still persists, is because no one really knows how to really appease all sides. But at the end of the day, if the science says that flu vaccines do well and help people and the nursing staff is deciding not to get it, what about the elderly, immunocompromised in the hospital? Grandkids are going to come to see them. And kids are little petri dishes. They bring everything from daycare and school home. And so, we now share all this with grandmother. She gets the flu. Could we have avoided that? So, we have to go back at some point and consider what that patient-centered care really looks like. In light of all of this personal, ethical issues that are before us.

PIERCE: Right. I want to bring up a couple of examples that I can think of that I've seen happen or heard talked about within our profession. And I just want to throw those out there to see how these might be within that gray area of conscientious objection. And one of those is you're working on a floor. The House supervisor says that you have to take an immunocompromised patient, but your floor is full of

the flu. The flu is hanging out on your floor, and you have an immunocompromised patient. You don't have enough nurses to make sure that this person is just dedicated to this immunocompromised patient. And so, you decline to care for that patient maybe because you have a flu patient and they're trying to give you this immunocompromised, and you don't want to share the flu by accident with this patient, Is that is that something you can conscientiously object to? Do you have the right to stand up and say, I can't do that?

STOWE: So, it's very interesting. The ability to conscientious object is pretty protected by law, right? The foundations are our religious freedom, our freedom of speech, our freedom of choice. It's really embedded in our constitutional rights. So that's pretty supported by most states in their constitutions. What happens, though, is the hospital says, hey, we understand that, but we still have to provide care. So, what can we do? So, most hospitals have policies that say, you know what, you can object, but I need you to come to H.R. I need you to list all of your objections down, and we're going to keep that on file. And when you have a situation that arises, we're going to take what you have written down and cross it and make sure that they meet. That's a pretty intimidating thing when you take the average healthcare worker to go down formally right out. And what if you don't include every little situation that arises?

PIERCE: Right.

STOWE: I mean, you know, topically, examples here. We know topically. Okay. I don't want to participate in abortion, for example. Texas situation comes up. Well, did we list the mother's choice and the mother's belief that she has a terminal situation in front of her or not? Where's that line? So, what happens is when we get a patient in and we say, what this looks like, smells like feels like that situation where I want a conscientious objector. We do, so the nurse manager, nurse, and director call H.R. They pull the list, they come back and say close, but no cigar. This doesn't fall into that exception. You need to do this task. You, ethically and morally, based on your religion, are like, wait a minute, I don't feel good about this. So, you do have the right to conscience to conscientiously object. However, in this instance, you didn't list it, you didn't follow the hospital policy, so you actually are violating hospital policy, and you have to decide whether you're going to keep your job and do the act. So, it's very difficult. The other thing is, on the flip side, if you accept the patient, if you accept the assignment, you accept the care over the patient, you accept that duty, then you've accepted care, and you've assumed that you will do what the patient needs. So now how do you object? It's very difficult. And there's gray lines there, right? You didn't know about what the patient was asking before you got to assign the patient. You do now, so what do you do? It's very gray. It's very difficult. But if you accept care for that patient, and you decide halfway through the care, you're doing an action, halfway through, you go, wait a minute, I don't know about that. It's going to be very difficult to defend that, because you've accepted the duty. You started it and now you're stopping and refusing.

PIERCE: Right?

STOWE: There's a great chance that you'll be held liable in court for failing to complete the task or failing to help the patient.

PIERCE: Right. So, I saw another example out there. We have a patient who is basically end-of-life care. Physician writes for morphine. But you know that if you give this amount that it's written for, it's not a sliding scale morphine. It is an amount of morphine, that it's going to continue to decrease those breaths. And she is going to pass on. So really what is happening is that morphine is helping to end the

life, not on purpose, but you know that is what's going to happen from experience. And you're not comfortable with participating in that. And you've checked with the physician, and the physician, that's what he wants you to give. So that's what the order is. What do you do in that instance? Do you have an option?

STOWE: You always have an option, right? As a nurse, you always have options. Now, the truth is you have to weigh your options, because your options, or the repercussions I should say of your choice, can be several things. One, you can just simply be, okay, fine, take this patient, swap with somebody else, report off. We'll move on. We're busy. Let's just swap people. Second is you're going to get yelled at a little, harassed, hazed. What does that mean for the future? Are you going to continue to get? Does the physician that rounds the next day go, yes, there's the obstinate nurse. There's the one over there that won't do anything. Won't even take care of our patients and patients. The families are hearing this. Does that happen? Or three, do you just get fired, and can you afford to be fired? When is your mortgage due? When is your car payment due? It is wintertime right now. It's cold. Do you keep your children warm or not? So, these are not easy questions to answer for the healthcare practitioner, especially when you're in the middle of it and you have mere seconds to think about it. And when we think about this whole ethical dilemma, you got to slow down. And that's one of the hardest things. We mention the difficult situation is difficult patients. But also, there's fewer staff during more acute patients, more need out there, which leads to less and less time to simply think. So yes, you can is the answer, but you just have to know the repercussions for it. And are you okay with it?

PIERCE: I know that you have an interesting background story and where you went to school to be a registered nurse and then decided to go be an attorney. You worked with, I'm assuming, medical issues within the law for a while, and now you do hospital administration. So, I love that you see both sides of this. You are seeing the legal side, but then you also see the hospital from the inside out. So, you're able to pull those together. And what is your perspective? What have you seen inside the hospital when it comes to conscientious objection, and how most places might treat conscientious objection?

STOWE: It really boils down to the executive leadership. And I mean that from not only the hospital staff, but also the physician staff. Hospital staff, I say that because the chief nursing officer, most of the staff, 50 plus percent of the staff in a hospital reports up to the CNO because, again, nurses and LPN and aides and techs are at the bedside and that's their line of authority and in reporting. So, if you have a strong chief nurse, you have a strong CEO or a strong COO, where the physicians typically report up to that are all lock stock together and say, okay, look, anybody can stop the line. Let's figure out what we can actually do here to fix the situation, to keep it patient-centered. So long as you have that, if I object to something I just don't feel comfortable with, hey, next man up, next lady up. Hey, who's okay with this? I am okay with this, great, you all report off. Let's move on. Everybody wins. If you don't have that strong leadership that works together, and it's more of a complaint where so-and-so's complaining they didn't do this, so-and-so's complaining they didn't do that, and it just escalates, and the tensions rise. And you lose that teamwork, you lose that environment. The whole culture falls apart, right? People are standing by their ethical decisions. We all have different ethical and religious beliefs. So, it's okay to stand by them. Just express them clearly, and let's figure out a way around that. And I think if we were to stop, and we had supportive environments from top down that would address these changes in real time, we can bypass the hazing, the harassment, the belittling of people who decide to speak up. Because unfortunately, in so many instances today, we kind of resort to name calling and belittling and hazing versus keeping the patient in the center and moving towards, “okay, you object let's figure out how to take care of the patient. Who can do that?” And we miss that. We miss that a lot today.

PIERCE: And I think that really erodes the workforce that we do have. We're seeing a rise in suicide for healthcare professionals, especially nurses, too. And we saw that through COVID. And I know, we attribute a lot of that to PTSD from the things that they saw it. But also, how about the fact that they weren't able to follow the things that they ethically and morally believed and felt? I worked with a nurse who was in the ICU, and she didn't want her patients to die alone. So, she would sit in a room, she would hold their hand, and you wouldn't see her until that patient passed away. But not every nurse was able to do that because, hey, I need to talk to my charge nurse. I object to someone dying alone. I can't have that happen. Can you watch my patient? You know how many people weren't given the ability to uphold their ethical and moral values as to the reason why they even went into healthcare in the first place? And how does that affect them mentally? I mean, do you think that?

STOWE: I think it's greatly impactful. You know what, I would even offer so much as the first step to this whole conversation is do we tell the healthcare workers that they have the right to do this?

PIERCE: Now, I've never had somebody tell me, if you don't believe in something, if you are not comfortable. Now, I've had them say, if you're not comfortable, come get me. We'll do it together. I've never had somebody say, if you firmly do not believe in assisting and giving this medication that you know is going to assist somebody in leaving this world, that you don't have to do that. I've never had someone tell me that I didn't have to overstep the values and morals that I have.

STOWE: And I think that's one of the first things that we have to consider. How far does that go for a healthcare institution to empower its staff to say I care enough about your beliefs and opinions, to ask you in advance what you're good at doing? Because the truth of the matter is there's not that many things, if you really sit down and think about it, there's not that many things that people are going to object to. And when you make that short list, how often do those come up actually on a day to day basis? It's truly rare, and we talk about these kind of extreme examples that happen daily across the U.S., abortion and end of life interventions. But when you narrow it down from 5500 hospitals across the US to one specific floor, to one specific unit, to that one bed where you're working, it's not frequent. I wonder how far does that go to creating a workforce in an environment that I as a healthcare worker want to work in? If someone cares enough to ask me what are my touchpoints, what are my objections, I think it would go a long way.

PIERCE: Absolutely. I think that's a really good point too, especially for leaders to kind of think about when they're trying to build their floor. They're trying to build their team. Just to let them know that there is an out when something is not something isn't following what I believe. So, unfortunately, we've come to the end of our time for episode one, but please join us for episode two where Dr. Stowe will continue this discussion and we're going to really break down some of this individual beliefs versus patient centered care and some strategies to help us navigate this gray area. Thank you so much for being here for episode one, Jay. This has been so informative. I'm really looking forward to continuing this conversation with you on episode two.

STOWE: Great. Thank you.

Episode 2: Conscientious Objection: Balancing Beliefs and Patient Wellbeing

Transcript:

PIERCE: Welcome back to our series on conscientious objection and patient care. Joining me to continue this discussion is Dr. James Stowe and episode one, Jay, you walked us through some ethical tensions of our beliefs versus patient-centered care and what patients may need or request from us as healthcare providers. Through this episode, we're going to continue where we left off, and we're really going to hop into institutional policies, informed consent, consent, and autonomy and hopefully throw in a few of those case studies and examples in there. So, Jay, let's really start looking at institution policies. Is their protection, not even just through the institution that we work for, the organization we work for, but also states? I know every state is different in their government as far as protection. So, what is it that we should know in how these play together?

STOWE: Absolutely. You know, this is really an interesting question, because if you asked the bedside healthcare worker what sort of policies, rights, and protection do you have, I dare say anyone could give you an answer. You know, it's not something that we consider and think about. And truthfully, we actually have some decent protection out there. When you think kind of top-down from a state level, most states, and it differs from state to state, the language, but most of them have something where they've passed, where we protect your freedom to choose, and your rights to stand by your beliefs. So, most states have this this out there. Right?

PIERCE: Right.

STOWE: And it's really easy to follow that when your opinions corroborate or go along with the laws that have been passed that allow X, Y, or Z. What happens so frequently is our ethical and moral compass as a society has moved from this collective belief to more personal beliefs. Now we have this state saying, hey, we protect your right to believe. But now we go into a healthcare institution and the institution itself says, wait a minute, I can have ten people act in ten different ways. So now the institution says, you know what? I know there are collective opinions now, but now the hospitals are in healthcare. I use hospitals interchangeably with institutions, clinics, offices. So many of them are putting out these are our values. This is our mission.

PIERCE: Mm hmm.

STOWE: And they're stating very clearly what they believe in. So, one thing I would suggest is that if you are going to work for a company or are interested in a company, have you pulled up their values their mission, and what they believe? And does that match yours? If it doesn't, then maybe during that interview you ask them what happens if I don't believe this, and just put it on the table, because you're going to have an issue down the road because sometimes they're kind of broad. So, you have these, and then you kind of get to more specific policies within the healthcare institutions that will guide what can be done.

PIERCE: Right.

STOWE: So, what happens here is hospitals will have policies. And we mentioned earlier where it will outline maybe a framework of if you object to something, come over here and list it and let us know.

PIERCE: So how to do it. It'll tell you how to do it when you already know that this is something you object to. But I do, and you can keep going, but I do want to throw out there that sometimes I feel like you might not know what you object to until you get there.

STOWE: And there's one of the problems. So, what's not always clear is when you're at the bedside, and there's an emergency that happens, because of Murphy's Law. Nothing is going to happen ethically and morally unless it is at 8:00 at night or a Saturday afternoon or whatever when no one is there.

PIERCE: Yes. When no one is there.

STOWE: No one's in the hospital, right? So, you have a house supervisor over all the nurses? No risk manager. The chief of staff isn't there, and no executive is there. So, it underscores this idea that what are the actual steps? Is there clear communication? Do we have policies and procedures that guide us, that tell us exactly what we need to do? And unfortunately, we don't always have the case. Now, we do have some support that is given to frontline staff that is generally in an ethics team. Many hospitals have an ethics team that you can call. And I think these are really great. I really do. I've had to call them a number of times. I will tell you the issues with them. And we can bypass the nights and weekends where you can only imagine the difficulty of getting in touch with people. This ethics team is designed or reviewed at the first of the year. To go over everything, we review it. We designate people to be on. It's not used for six months.

PIERCE: Yeah.

STOWE: We don't use it. Now, all of a sudden, we go, okay, let's call the risk manager or let's call the physician. The physician calls and says, “well, I don't know who to call.” The nurses says “I don't know who to call.” They go up the chain, and the nursing leadership can only think of two people. Let's call the CNO or let's call risk management.

PIERCE: Right.

STOWE: CNO hasn't had to deal with it in six months or more. Maybe not at all. They don't typically know, so they reach out to the risk manager as normal. So, we call the risk manager and the risk managers goes “Okay. Well, tell me all about what's going on.” They then have to reach out and touch base with all the members or attempt to. It depends on how big the team is. Is your team four people? Is it ten people? If it's ten I dare say you won’t get in touch with everybody. If it's four you, present the situation. Now, the physician that's sitting on this team has questions. Why wouldn't he? You know, he's got he's got legitimate health questions. So now the physician tells the risk manager, “hey, I've got questions.” A risk manager calls back to the department, calls me as a nurse leader, and says, “hey, the doctor wants to know this”. I have to get up, go to the nurse, and figure out what those answers are, and then turn around and start that phone chain again. It can be four, five, six hours before you get a response. So what happens when it's an emergent situation?

PIERCE: Right.

STOWE: Somebody has got to make a decision. And usually the risk manager, when they get enough pressure from the nursing leadership, will simply say, well, I think it's this, let's go with this.

PIERCE: Right.

STOWE: And so, when you think of that response and how you finally got there, and the delay, Are those ethical teams, is it lipstick? Is it really words on paper? Are the ideas good, or are they functional? And I think that's one thing that hospitals can improve on is better definition, better call

trees, better day versus night. Who's going to do it? If a doctor is not on call at night that's on this ethical team, are they going to answer the call from a hospital?

PIERCE: Right. You are not wrong. I'm not going in tonight. I am not answering the phone.

STOWE: My partners on call, not me. I want one night off, please. For the love, let me have a night off. And can you blame them? They haven't been called in a year for this. Well, two years for this. So why would they think that this would be a reason for the call? So, I think the ethical team, the decision, and the guidance you get from them when you do get that guidance is incredibly beneficial. I just think that as a collective group, hospitals generally need to do a better job of organizing those for a more timely response to take that pressure off of that frontline nurse, that frontline LPN, that frontline physician, because they have multiple other people that are caring for it. If they're calling you, it's a big issue.

PIERCE: Right? And I think that's part of if you're assigned to it. I mean, today we have text messaging, so it's like, “hi, I know I called you and you didn't answer. It's an ethical question”. Normally, they'll call you right back. But if they think you're calling them in, I don't know many people that are going to answer the phone to talk about that. Well, I think that having an ethical committee is great looking at it in retrospect. It's much easier to get people in there than it is in an emergency, when it's planned versus when it's unplanned. So, I think that it's a great idea. But you are right. How do we work it out? Because, you know, most things are available Monday through Friday, eight to five. But for those that are there at night, that are there on the weekend, you don't have a lot of resources.

STOWE: It's difficult. It's difficult at best. If you look at day shift versus night shift, in most places, you'll see the night shift has stereotypically much better teamwork, much better framework for providing patients in their care. It is because they have to rely on each other. They have to work as a team. Day shift, we do have the ability to call this department, call that department, to make some calls, and have other people do things. So night shift is generally a much better team and they have much better camaraderie and are able to call people quickly. It's just getting a response.

PIERCE: Yeah, that's so true. So, I know we talked a lot about end of life. We've talked about abortion, but there are also some cultural and religious, moral, moral, and ethical issues within the culture and within a religion in that healthcare provider space. So, can you kind of walk us through where those lines are and the support that you have for culture and religion?

STOWE: So, I think when you look at culture and religion, most of us, our culture and our behavior has a foundation on religion. I think it's very difficult to deny that when you look at the founding of our country, founding of our legal system, founding in so many core tenets of our society.

PIERCE: And I want to point that out, too, because I feel like when the United States of America was formed, it became, people were coming over. They really were the same religion, they had the same moral and ethical beliefs. And as people have migrated over here through the many, many, many, many, many, many years now, we have so many different religions and so many different cultures than we did when we were first becoming an established country.

STOWE: And it's really interesting. I'll give you a personal example. I was a travel nurse twenty, I won't say how many, years ago.

PIERCE: That many years ago, huh?

STOWE: Yes. I did a stint out in California, and this was a very highly populated Mandarin Chinese community.

PIERCE: Yeah.

STOWE: As I sound, I do not know Mandarin Chinese. I do not know their cultural and religious beliefs. I took care of an elderly woman in the ICU, and she passed. It was expected that she pass, and the ED was calling me, saying "Hey, we have a critical patient we need to get out of there." I worked with the house supervisor. We transferred that patient down to the morgue. Got the room cleaned. Well, I was unaware of a belief at that time that they needed to stay at least 8 hours in the place of their death spiritually. And it was a large issue, and rightfully so. That was their belief. And I disturbed their belief. As a traveler, if you've ever done anything like this, you know that the unit or hospital education is fairly minimal. You're expected to come in and practice to the standard of RN in whatever unit you are in. And that was not a problem. The competency was not a problem. The religious and cultural awareness of the community was a problem. I had no awareness of this. So, this is not specifically an issue that has arisen today, but it is something that I believe, to your point, can arise more and more as there are so many different belief systems that are coming into the hospitals, not only by our patients but our healthcare workers. So, what are we doing to educate individuals like me, when I go into the workforce to say, this is our population base. This is what you need to do to be cognizant of their religion. Look, I would want my beliefs to be respected, and I have no problem respecting someone else's. Right. It's eight hours in a room. Why would I have a problem with this? But I messed it up, and so I do think there are opportunities there that we miss out on educating. Finding out the population that lives in our community is not difficult, for at the very least, we take a census every ten years and it'll give us the specific breakdown of each population, and the languages, and all you have to do is look up those individuals' nationality or languages and backtrack a little bit and look for religions, the major religions in those areas, and find out the big tenants. It doesn't take long. We go to extensive orientation. It can be posted in break rooms. It could be all kinds of things. So, it's definitely something from a cultural, religious perspective that we know as a society very, very topical. This religion doesn't want blood administration. This religion doesn't want any intervention at all.

PIERCE: Right.

STOWE: But we don't get to the nooks and crannies of things. Why can't we reach out to those religious leaders and say, hey, can you develop me a one pager that would help?

PIERCE: What do we need to know? We can have it right here in this binder. I can flip to it when they come in, and I can see everything I need to know.

STOWE: We don't even really have to do the work. I'm pretty sure those religious leaders will do it for us. Which, in turn, from a business perspective, they announce, hey, look, they care so much about you that they want to get it right. If you have an option, or if you if something happens, maybe you want to go to this healthcare facility for care because they care.

PIERCE: Absolutely. I was just thinking as far as religion. There are some religions where if it's a female, then they don't want a male other than their spouse touching them or helping to bathe them. So, I feel like in cases, especially where that particular patient cannot speak up for themselves, maybe they're unconscious, maybe they're in a coma, maybe they're not there mentally like they should be, and they

can't speak out for themselves. You know, us being able to conscientious objector to say, I know that t I can't do this for this person. So, I need to be able to say I'm not going to care for that person. It needs to be blah, blah, blah. Maybe if it's a male, it needs to be a male. If it's a female, it needs to be a female, whatever the case is. But just some examples of us being able to not only conscientiously object based on our values and belief systems, but on theirs, because that should be a part of ours as well. We want to do no harm to the patient.

STOWE: You bring up a really interesting point. I'll tell you kind of a side story based off of that. Not too long ago, I was working with a hospital and a staffing agency trying to bring over some international nurses for staffing shortage. If you're in the E.D. or worked in E.D. specifically for a hospital across this country with COVID, and did not experience a staffing shortage, I'm coming to work for you. Because it was not a pretty sight. It was not fun. It was very disturbing. It was very difficult. And the truth of the matter is, a lot of people left, because of the difficulty in nature of it. So be that as it may, being diligent in trying to find alternatives, we started interviewing, or I did, some international nurses and to your point, some of the Middle Eastern nurses have phenomenal experience, really phenomenal. And if you look at some of the hospitals over there, they're phenomenal. I mean, you have to think about the money that they can they can use to build them, and the supplies, equipment and a training.

It really is second to none. But to your point, they segregate care, female and male. So, if I bring someone over to the United States and put them in the E.R. and say, you need to see anyone that walks through the door. Like we traditionally do in the U.S., they can't see half the population. They don't have the experience or the training.

PIERCE: Yeah.

STOWE: Then you take it a second step and say religiously, will they be able to? And then thirdly, do I bring them over if they can't truly take a patient load, as we have it just designed? So, it's a complex layer of how do I be respectful to religion, their beliefs, but how do I also accomplish the patient-centered care that I need it? It's all gray. There's no easy answer for that. What I found was, there are a number of international nurses working in the Middle East that are not necessarily of that belief system who have other experience, both female and male, that could come overseas to the U.S. and work. But it adds a layer of complexity when you do try to be cognizant and respectful, but at the same time, from a healthcare, from an institution standpoint, I've got a responsibility to provide care to everyone.

PIERCE: Right.

STOWE: So, it's very difficult.

PIERCE: Yes, that does have a lot of complexity to that issue. Plus, you'd have the environment of bringing them over here and it's like, well, why can't they see the patient? So, you start with the possibility of becoming more of a toxic culture for the internationals that would come over and offer to work over here. So that is tough. It's tough to navigate.

STOWE: Yes, very much so.

PIERCE: Another area where I see conscientious objection, actually, I think I got in trouble for this when I was a new nurse, is informed consent. I got to walk in, and I got to get this thing signed, but I never

saw the physician come in and talk to the patient. The patients tell me the physician's not been here, has not talked to them, but I'm supposed to go get them to sign something?

STOWE: Informed consent has been an issue for as long as I have been aware of it. And you would think that it would not be such a big deal.

PIERCE: You would! It would seem so straightforward.

STOWE: An invasive procedure is going to occur, and you would think that the patient should have the right to hear from the expert as to what's going on and have the expert answer all our questions. But then you throw in this real-life workflow into it, and all of a sudden informed consent just goes haywire. And I'll tell you, a situation recently, I said recently, the last few years that I've come across. I started a position as director in the emergency department, and quickly observed, and pretty much about fell out of my chair when I saw this happen. But the ER physician, a lady came in, car wreck, MVA, needed orthopedic surgery. ED doc was right on top of it, great care, nurse was providing great care. I was very impressed. I was excited that this was the team that I was going to be leading. ER doc calls the surgeon. The surgeon says, hey, absolutely. We'll take him to the O.R. tonight. I'm in a case. Just go ahead, and knock out the consent.

PIERCE: Right.

STOWE: I'm sitting there in the nurse's station listening to this. ER doc gets up, goes in there, talks to the patient, comes back, the nurse is sitting in the nurse's station and says, hey, go ahead and get the consent sign. And I looked around and I thought.

PIERCE: Are you looking for that physician that was going to do the surgery.

STOWE: I was looking for the surgeon or the surgeon's PA. And so, then the nurse says okay. And I thought, well, I'm going to follow this trail. So, I watched the nurse. The nurse looked up online at the surgery that was ordered, wrote it out, went into the room, got the patient to sign, and signed after as a witness. And I was just astounded that the ER doctor was getting consent for all specialties that needed to go to surgery. The ER doctor is, number one not performing the act. Right.

PIERCE: Right. So they're not the expert.

STOWE: Two, They're not the expert. They can't tell you all the side effects and answer all your questions. I mean, that's a difficult hill to climb right there. Then they come back, and the nurse isn't even in the room with them to witness the conversation. So, the nurse goes in there and gets all this stuff signed. It has never heard the first question nor the first answer. So, I followed a couple of more of them and simply went in there, said, “hey, who's going to your surgery?” [STOWE] asked the patient: “I don't know”. [STOWE asked] “What do you having done?” [Patient] “I don't know. And it's fair for the patients to have that response, because it was very disjointed, right. The process wasn't a solid process, and it was very disturbing to me. So, I ran it up the chain of command saying, hey, we got to we got to straighten this out. Our patients deserve better. Our patients need to center of this and be able to be informed, of what's going on, and have proper knowledge in order to make a proper answer. And the COO instructs me “Hey look, stop right there. That throws a wrench in the practice. The surgeons don't want to have to come down there. Talk to families and all this kind of stuff.”

PIERCE: That is their job.

STOWE: Well, I about fell out a second time. So, I politely excused myself, then went and told risk management, let them chase that down and change procedure, and played like I didn't know what was going on. But at some point in time that underscores the complexity of your ethical, moral belief systems and standing up to change things, to allow the patient to be the center of care while everybody is on the same page. Administration, physicians, and nurses all have to be on the same page. And if we're not, we simply aren't going to keep the patient at the center of care, we just aren't. And that's a shame.

PIERCE: And if that goes to court, and we have signed something saying that all of these events have happened, but they didn't happen legally, that's not I mean, we did something wrong. We are signing our name saying we did something we did not do.

STOWE: It's a homerun in court from a legal standpoint of I've got you dead to rights. If anything happens untoward, heaven forbit, if it does, just go ahead and get your checkbook out.
PIERCE: So that is definitely a reason to conscientiously object to as a workflow a work process that is not going to hold up in court. We are going to go down for that.

STOWE: You know, objecting is not always bad. Objecting can still keep, and may very well be, well I have personal beliefs that may guide my actions. Objection can also be keeping the patient at the center of care and giving them the right care. And so, if we keep that at the forefront of our thoughts, hey, the patient wins, we win as healthcare workers, and it's just a win-win for all.

PIERCE: I love what you said that objecting is not always a bad thing, that sometimes we have to object to keep the patient at the center and that's so important. And the care that we give, that patient centered care, where we want to make sure they get what they need. And unfortunately, that has brought us to the end of our series. This is such a great conversation, and it was so eye-opening to be able to just walk through some of these gray areas. I think informed consent is definitely not a gray area. And I'm glad to hear that that is not a gray area. But I know that a lot of this is really going to depend on policies and procedures, and really what your state outlines as being okay for conscientious objection. And so, as we come to the end of this, Jay, what can you say to somebody who's trying to navigate and understand conscientious objection?

STOWE: At the end of the day, healthcare is a difficult environment. People don't feel well, they're sick. They're reaching out to you for care. They need help. And unfortunately, the art of medicine is that it's an art. It's not a defined science where we know everything that's going to happen all the time. So, while we practice this art, part of that art is knowing when to speak up. It's knowing when to be quiet. But if you ever have a question as a healthcare provider, we all put our pants on the same. Put them on, stand up, speak up, keep your patient at the center. And I feel strongly that at the end of the day, even if you have to meet with a lot of higher ups at a very intimidating room, if you are able to tell them, “hey, my patient needed this, I stood up for my patient”, you're going to win every time.

PIERCE: So good. Yes. And I love what you said about the art and science because we describe nursing as the art and science of nursing. So very good. To our listeners, I hope you also gain insight into this topic. We really encourage you to explore many of the courses that we have available on elitelearning.com to help you grow in your career and earn your CEs.