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START AUDIO

Interviewer: There’s that one, yes, they’re both going. To begin with, can you tell me a bit about the work you do as a health professional please?

Respondent: As you know, my main role is in [area of job role] at the moment. Part of that is that you have to stay active in some kind of association with clinical practice to maintain a position on the register. Some years ago… I think, when I moved into this job, I found it very difficult to stop being a practicing midwife and health professional in terms of clinical contact. I did bank midwifery at a small maternity unit. That, again, became quite arduous, just the balancing of it.

I’ve done various activities. I trained a yoga teacher and did yoga in pregnancy, just to really keep that face contact, really, with women and pregnancy and everything. It is part of the role that you miss a lot.

I took over the contraception course, the family planning course as it was called then. It was supposed to be a caretaker role because they’d employed somebody to take it on, so I suppose I was the interim. Somehow I… I was told to keep it.

In family planning, as it was called, and in contraception, they kind of… It had all changed dramatically from when I did the course myself. I thought, “If I’m teaching it, I really need to be more than reading the books to see what it was.” Very, very, fortunately, I’d asked the local contraception services if I could have a role, like an honorary contract. They were reluctant to give me an honorary contract, which was very, I suppose, foreseeing at the time.

They said that they’d employ me three hours a week. It was really handy because it was nearby. I’d got the foundation course, I’d done the family planning and society, about two years before that. Even then, that had changed dramatically going in. From that point of view, I suppose, I had more recent and probably more pertinent experience in termination referrals.

When I first started in the service, the… When we came to clinic, there was always a doctor. I would say, apart from the odd exception when the… Sort of service shortage- Generally, the clinics were organised in lots of GP practices and that type of venue around the city. There’d always be a doctor and two nurses attached to them.

Women would come and, if they had an unplanned pregnancy and they didn’t really want to continue with it, we would be able to take them through the process. I suppose, my role then was just to discuss and advise. Then we’d go to… The doctor would see them and do that first signature for taking them forward in the process. Then we would contact the… I suppose the local unit would be [name of local abortion service] or the BPAS, depending on the gestation of the pregnancy. Then fax the forms through then. That system has changed now anyway.

I suppose my role there was, really, just advice and options and making sure that they had somebody to talk to and if it was the correct decision. Making sure that- If they wanted time to think, then you could look at the dates and advise them along those lines. That’s changed quite a bit now. Now, if somebody came, you could just give them a card and they’d contact BPAS, who organise… I think it’s pretty much a national helpline now. The system behind it fits in with the government’s drive that, if women want terminations of pregnancy, they get it sorted, more or less, in two weeks.

Interviewer: Right, so quite quickly?

Respondent: Yes. I suppose, from health & safety point of view, the earlier terminations can be done medically and it’s less problematic for the woman’s future health and condition.

I still get involved with women coming. They will… Some don’t want to make the phone call. My role would be to use the helpline and then just give the details and, usually, hand the phone over while the… They talk through medical conditions or, “Do you smoke?” and all of that-

Interviewer: Take a bit of a history?

Respondent: Yes. Then they make arrangements for a time that suits them, in a venue that suits them or fits in with the law and the licencing of individual clinics. I suppose it’s changed in that way.

Prior to that, I think, when I was working as on the antenatal ward, the hospital that I was in, it was the maternity hospital and the gynaecology hospital, two separate sites.

A senior registrar asked if we could take a woman from the gynaecology side for an induction of pregnancy, which really was a termination for congenital anomalies. That was really quite… It seemed to be like a, almost, one-off. I would say that it was… It was more or less, from my point of view- I was a sister at the time, on the ward. From my point of view, it was more or less it had been arranged and it happened. We had this lady in. She only spent a limited amount of time on the antenatal ward before she went to the delivery suite. Then, from there, there was more and more…

When the senior registrar was challenged, his view was that if she came to midwifery then she was being treated as a mother.

Interviewer: Oh right, rather than a patient?

Respondent: Than a patient. You know, rather than a surgical condition. I suppose, really, from his point of view, it was… Although it was a termination of pregnancy, it was done because of problems with the baby. Usually, incompatibility with life. They decided to do that. That was difficult because, I think, the whole thing is… You’re working towards making sure that their baby comes out healthy, whether it’s preterm…

As it became more custom and practice, I found it quite difficult. Not necessarily, even from a moral or an ethical stance. As you do read, where women are in gynaecology services, you could have a lady in an early pregnancy where everybody is battling to save a baby and then another situation where somebody is actually… The end process is there should be no way that this baby comes out alive. You even start to want to change your terminology from the woman with the baby coming out to the woman with the foetus, for the pregnancy to be terminated. It’s like there is an instinct to change your language.

Interviewer: I wonder what you thought on that. Is that, maybe, just a way for you to keep your professional head on, almost, and stop the ethical arguments pushing into that?

Respondent: I do think there might be a bit of an element of protection in it, because it’s quite… Even though you are trained and your whole professional code is to be non-judgemental and treat everybody equally and value, certainly in midwifery, the autonomy of the woman and… There is the whole debate that the woman’s body is her own. I think it is still quite difficult, particularly when you’ve got the juxtaposition of the two cases.

It’s almost like, if you were in a setting where your main remit… Say, for example, if you were on the termination ward, for want of a better description, you could probably… You’d be building up certain skills and a frame of mind, I think. I’ve never been in that situation. Compared to where you’ve got to see these two very, very, conflicting things.

I think, as well… I suppose the nearest I can come… When I’ve worked as a midwife on the labour ward, depending on what the women are going through, it’s sometimes very hard to make that connection anyway. If somebody… I’ve looked after women who’ve had a fresh stillbirth or an in utero death, or a premature labour. Really, the viability outcome is not very positive. Some of those women deal with cutting it off.

I think, as a practitioner, it makes it quite difficult because if a woman is labouring away, depending on pain relief and all the other factors that go with it and how they feel themselves and how they handle labour… You know, sometimes you can be sat there and you can be talking about soap operas and curtains and all sorts because it fits. Then, other times, you could be quite silent and you’re just encouraging and supporting. Some people, really, just want you to pop in and out and… So you try to be like a bit of a chameleon as a practitioner.

If you’re in that situation where there is like… As I say, where the outcome may not be positive and a live baby at the end of it, sometimes you’re kind of like, “What do you converse about, is it respectful?”

Interviewer: Yes, yes.

Respondent: It’s hard enough that they’re coping with what they’re going through. In some respects, in termination, how do you deal with it at that level, as well? The woman has made a choice. I think my belief is that they’re making the choice in a very short space of time, because… Not just because of the legal aspect of 24 weeks, unless there is a really good rationale for going up to the 28 weeks, but the whole turnaround, it’s like… The optimum is to make those decisions in 12 weeks. Is it time? It’s still a stigma, can you really freely discuss it? It’s not something that people set out, necessarily, to plan to do.

Interviewer: No, no, no.

Respondent: It’s almost like, “How much choice do people have, and how much support do they have?” It makes it quite… If you talk about some things in a certain way, are you actually making them feel you’re undermining the decision? Are you making them think about the decision and things that they don’t really want to? Really, is that just the frame of mind or are people not wanting a conversation?

Interviewer: Yes, it’s like their mind is made up.

Respondent: Yes.

Interviewer: It sounds like you’re very supportive of the woman and you… It sounds like you’re taking an approach where it’s, almost, patient choice. Would I be right in saying that?

Respondent: I think I’d have to say that, really. I think it’s a sad choice. My own personal opinion is, I think it’s really sad. I get angry, in other ways, because… Certainly, coming from that contraception experience and life’s lived experiences, there is not enough done for people, both male and female, to really look at reproductive choices. There is still a lot of-

Gosh, it’s still almost like puritan society. You can see it with cervical screening and the HPV… When that was introduced, the reaction of the majority of parents… Even though, I think if they… The people who were rolling it out tried to put it forward as positively, health-consciously, as possible, but the flashback was, “Are you saying my child is promiscuous? You’re encouraging early sex.” That was despite how the-

Interviewer: Huge campaigns, yes?

Respondent: Yes, how people put it forward. I think there is more of an acceptance of it, but it’s still like a little snippet of it. You know, school nurses still battle to actually provide a supportive sex education. There are an awful lot of myths that go on. I think that’s the aspect of running the course, you do get practitioners coming from a whole host of environments and clinical areas. They keep you up to date with some of the myths.

Interviewer: Like a benchmark of what people are feeling out there?

Respondent: Yes. Young people, in a relationship, they’ll have genital contact and intercourse but they won’t kiss because kissing is seen as a more intimate act by some young people, compared to actual sexual intercourse. Then we’ve got the age group as well, life doesn’t end at 30 or 40 or 50. I suppose… Some people are increasingly going into second and third relationships or just, you know, having the years of teenage freedom that they didn’t really do-

Interviewer: Catching up?

Respondent: Absolutely. They haven’t got the skills to say, like some young people don’t, “You have to wear a condom.” In their age group- Hopefully, it’s dying out a little bit now with the generations and fertility ending. They haven’t got the skills to say, “You know, we’re not having sex if you haven’t got a condom. It’s like that’s seen- If you’re prepared, you’re a slut or you’re a man on the make kind of thing. So you get accidental pregnancies, then you get women who misinterpret their body changes. They think, “I’m old enough now, I’ll be in the menopause.”

Interviewer: Yes, you still get pregnant. (Laughter)

Respondent: Quite often, they’re the more intelligent, academic, career type women that you would think wouldn’t be thinking like that. There is, like, a street intelligence that it doesn’t happen to. Then women who think they’ve planned their lives, they don’t really understand the biological set-up of menopause. It’s almost like- At the end of it, it’s their life isn't it? I do think it’s sad.

I know they’ve done quite a bit of research, haven’t they? Some of the studies have come up and said, “Actually, women don’t… It doesn’t affect them.” Then I think, equally, there are a lot where it does affect them. Then that tends to be anecdotal, because they’re not the type of people that would necessarily be included in the research study or maybe wouldn’t even want to participate. I know I’ve looked after women, in the past, where if something has gone wrong with the pregnancy, they’ll be like, “It’s my fault, because I had an abortion.” It’s just like, “Well…” Subfertility or infertility, you think, “Well, it could be a reason because of an infection.”

Interviewer: Yes, the risks involved.

Respondent: “But that’s not necessarily…” That could be to do with anything, couldn’t it? Yes, having intercourse could cause an infection. An ascending infection gums up your tubes, pelvic inflammatory, it’s just… It’s life, really.

Interviewer: Just so I can get an understanding of where you are at, are there any limitations on abortion that you would place? Say, for example, a woman coming in for her 15th abortion, early abortion, late abortion, is there a position that you’re on or a stance that you would take towards that?

Respondent: Again, I think it’s the separation between personal and professional and acting within the law and the code. Whatever they call it for a decade… You know, professional standards really. I, personally, wouldn’t like to be involved in actual late abortions. I suppose, in some ways, it’s a bit of an oddity because, if you think about it, a caesarean section is a termination of pregnancy, isn't it?

Interviewer: Yes, yes, I suppose. Yes, I never thought about it like that actually.

Respondent: A lot of people don’t. When I’ve done my job] with students, it’s that… I think it’s that confusion around it all. Medical staff and the parents can make a decision to have an elective section. It’s the outcome that’s different.

You’re doing an elective section or you’re inducing labour early, and you’re outcome is to give the baby the best chance of survival. You wouldn’t necessarily do a section unless the condition of the baby affected the wellbeing of the mother. You’d certainly do inductions to get- The outcome is not to have a baby. It’s almost like… When I’ve thought about it and broken it down to that, it’s almost like I have participated, really, except the history of it is that you would just make damn sure that baby didn’t come out alive for one set of circumstances and do your upmost that it did come out alive in another.

I think that’s what people, I don’t know, don’t appreciate really. It isn’t just, “Oh…” For whatever belief system I have, I don’t agree with abortion. You wouldn’t participate, absolutely. If that were the case, I shouldn’t be doing the job I’m doing.

I know, in… Certainly, in the past, in, say, the contraceptive clinics, there was a practitioner. A nurse, a GP nurse, she wouldn’t even interview… If somebody came in and they were asking for a termination, she would pass it on to somebody else.

Interviewer: What’s your opinion of that, do you think that’s okay to do?

Respondent: I’ve worked with enough people… I don’t know really. I think, in a way, it was okay in the system because she was the only one person out of a number. She wasn’t stopping people’s choices. Also you wonder, if people are doing it reluctantly, are they giving the best advice, are they giving the best support? Therefore, are they really fulfilling the role as a practitioner?

I do think the honesty of it was good. I do respect the organisation, that they were able to uphold that really.

Interviewer: Yes, accommodate it for them?

Respondent: Yes. I don’t think there’d be many organisations, nowadays, that would do the same. Again, we had… One of the doctors, he would give advice. You know, he’d say, “These are your options.” In his role, he would need to be the signatory. He wouldn’t sign the form. That was always left to another doctor to do. I don’t know. I suppose, in a way- Again, it’s all mixed feelings really. I think conscientious objection is just a minefield of mixed emotions if you’re not in either end of the spectrum.

For example, if you were working in gynaecology and that was part of your main work, really you’d have to… If you were wanting to conscientiously object, but it’s beyond that, to really not participate at all, then you’re in the wrong place really.

Interviewer: Do you think, maybe, health professionals, if they are conscientious objectors, they should maybe give a little forethought to what their role should entail, or do you feel that there is a place for conscientious objectors in the work that you’ve done in clinics?

Respondent: Again, I suppose… In the development of services to date… Going back, historical debate… I came from a Catholic education, convent-type education. There was an awful lot… SPUC lectures figured a lot. There was a lot of information there. I don’t think it did any good, to be honest, because I don’t think it was thoughtful enough for the… It wasn’t biological, there was just… It was like, “This is what’s happening.” I don’t think it really did us a service.

I have to say, we were all… At the time, we all passed the scholarship. We weren’t an unintelligent group of young women. I don’t think it really had the effect that they wanted.

Very much, brought up in the sanctity of life and God’s gift and all of this but none of it really, in that generation… It didn’t touch anything, I don’t think. It was all outward. Not a lot of opportunity, I think, to internalise the information that you were given. I, very much, came from that background. I think, really, my first experience was in midwifery. I suppose, for me, I would never…

I lived through the David Alton changes to the Abortion Act and all of the debate. That was part of my political youth and interest in things that were going- So I’d followed all of that, but I had never really had to form an opinion. I could have thoughts on it, I could think, “Oh…” Whether I would or wouldn’t do it, it never entered the equation really. I never knew any of my friends, acquaintances, who had actually undergone termination or thought about it. It was, kind of, outside-

Interviewer: It’s like a moot point almost?

Respondent: Yes. Everything that went on in school did diddly-squat, really, for that whole formation. Everything was outside of it.

When I was in… In my nurse training, I never experienced it either. I did mental health, instead of gynaecology, as a speciality. That might have impacted me earlier. It wasn’t until, I suppose, I was in midwifery when this senior registrar started bringing the women in that I had to think about it. It just wasn’t…

Interviewer: You’d never had the opportunity to, almost?

Respondent: Yes. As a midwife, the majority of women that came to you, even when they did early bird bookings, they’d decided that- It might have been an unplanned pregnancy but it wasn’t… They’d decided they’d want it or they’d keep it, for whatever reason, and just get on with life. In midwifery, it was always people who had decided they would keep the pregnancy going.

Interviewer: Do you think that… You mentioned, there, about the religious background that you had or the religious teachings and how you almost didn’t get an opportunity… It sounds like you’re saying you didn’t quite get an opportunity to form a view, and then you went into midwifery. Like you say, predominantly, the business is delivering babies. Do you think your views have changed, at all, through your experience? As a health professional, I should say.

Respondent: Yes. I suppose, really, I’ve… If I’m brutally honest, when I first had that experience of women coming into midwifery with, basically, a termination, I really didn’t know how to think. As I say, it had never entered… People who went into midwifery, although the Abortion Act had been going for a number of years, we never had to think about it. You never had to think about conscientious objection. Then, suddenly, the woman was there and… You’d still care and go through with it but a lot of midwives, at the time, were like, “I don’t know…”

Interviewer: “I don’t really know why I’m doing this,” maybe?

Respondent: Yes. It’s almost like, “What’s this conscientious objection, how does it affect me? Do I conscientiously object?” I think, certainly, at the time, it was very much interpreted that you didn’t have to do anything at all. If you conscientiously objected, never the twain meet really. I think, for a lot of us- I only had a small part in it, because of being on the antenatal area at the time and not on the labour ward, but there were a lot of midwives who really didn’t know what they thought in that time. I do feel quite resentful because I don’t think anybody gave us that space to work it out.

Interviewer: Do you think, because it was sort of sprung on you, almost, overriding feeling was, “Well I’ve got a professional obligation to do this, but I don’t really quite know how I feel about doing it”? Do you think that might have been the case?

Respondent: Oh. I think, very much, so. Even midwives who probably didn’t have any personal background… It’s hard to express correctly the phrases and the words for it because it’s almost like it was never discussed. That was gynaecology, it wasn’t midwifery.

If some of the midwives had worked on a gynaecology area, they may be a little bit more aware of it. I do know some midwives would volunteer because they’d had gynaecology experience. Whereas other midwives who, eventually, were like, “At the end of it, it’s the woman’s choice.” They may not have thought it was the most appropriate area, because of the nature of other women and… Part of that, I think, as well was there was no training. You were just expected to transfer your skills and everything. There was no downtime discussion. People just gave the best care they could.

Interviewer: It sounds quite similar, actually… I’m sure you are familiar with the case of the two midwives up in Scotland.

Respondent: Yes.

Interviewer: They were working on a delivery ward, senior midwives. No terminations were done, then they were introduced. They decided to invoke their right to conscientiously object. Long story short, I think they originally won up in Scotland. Then it was taken to the Supreme Court, that’s where they lost.

In the Supreme Court case, they developed a list of 13 things that they perceived to be participation in abortion. They took quite a broad perspective of what participation took. They included things like answering emergency buzzers, taking telephone calls to book women in, supporting midwives who may be under them. Although they wouldn’t be taking any actual active participation, they considered supporting other midwives who were involved in abortion as being complicit in the participation side of things.

Ultimately, they lost the case because the judge ruled that when the Abortion Act was envisaged it was envisaged that it was only hands-on activities that constituted participation in abortion. I’d just be interested to hear what you have to say. Do you take that broad perspective, as those midwives did, that participation involves all the acts that lead up to the ultimate abortion? Or do you feel that it is the hands-on activities? The woman has come, she’s made a decision, this is what it involves.

Respondent: I suppose their approach to it was very much like that nurse in the contraceptive clinic, wasn’t it?

Interviewer: Yes.

Respondent: She would just be like, “I’ll pass you onto somebody else.” She took that totalitarian, total, view. I don’t know, I think…

I have a lot of sympathy for them. It would be… I suppose it very much reflects my experience from that emotional, personal, side, going back to the ‘90s. I think the law is… I don’t know. I think refusing to take telephone calls, I’m not sure that’s really the termination as such. To me, it’s more the actual procedure itself. I suppose, if I were to look at it in the different decades, there would be nothing that would’ve stopped me caring for that woman because, even in my unformed thoughts of how I should be reacting, I still think I couldn’t not help somebody.

Not answering an emergency buzzer, I don’t know. I would say, in some ways, they’re not… I don’t know how they could, really, justify that extent because part of that is administrative. If you didn’t answer that emergency buzzer, because of a woman’s decision and not really knowing why that woman made that decision, then… For example, she could bleed to death. It’s almost like you’ve actually not provided care.

Interviewer: Do you think, in that instance, they took, almost, a too broad perspective of what constitutes participation in abortion? Would you see it as, more, a narrow perspective? The booking in and actually, “Here is your medication…” You know, giving the woman the medication, would you see that side, more, as being participating in abortion?

Respondent: Yes. I think, if it’s got to that stage, they were very much let down by their employers. For them, personally, it’s… If they don’t agree with terminations whatsoever, then that’s their right. It’s when you put the professional aspect to it, I think that’s- It’s very muddied because, I think, society has just got a very muddied view over the whole situation.

I could be facing something like this in my contraceptive experience, because there is a huge push that now medicines are, kind of like, being in the process for a while… For example, some people will go for drugs to initiate and maintain the effects to terminate. Sometimes, the women go to hospital, they’re given some of the early drugs there, the tablets. Some of them, the women are given them to take home. Some nurses are giving them, in some sites, under patient group directions. It isn’t just a medical thing. That’s, sort of, on the edges of whether- It has been suggested, through the faculty, and touched on in discussion as to…

Whereas, if women come and they’re wanting a contraceptive pill, I can issue the pill under patient group directions. If they came and they wanted the medical termination, it would probably be a time in coming but it could eventually devolve down to my level of responsibility to issue those tablets as well.

Interviewer: Would you see that as you participating?

Respondent: I think that’s probably where those midwives find themselves. For me, I have no… I have a sadness about anything where I feel people aren’t given enough time to choose, but I would see… I choose to work in that area, and that’s the nature of it. For me, giving information for that person to make a choice, making a phone call because they don’t feel up to it is part of it. If I was working in a clinical area then I, personally, would feel okay to monitor their vital signs, to provide support, to feed them, to make sure that they are hydrated, to change the pads. I would see that as me caring for that woman, not necessarily the procedure.

I don’t want to trivialise it, but it’s almost like some people having breast augmentation. It’s not a choice that I think is rational, in a way, but the care that goes with it is not my decision, in a way.

Interviewer: Yes. It sounds like you almost… In terms of how we identify you for the purpose, solely, of this study, we’d identify you as a non-objector. Although personally, like you say, you do feel quite a sadness that someone finds themselves in that situation given the life… It is a life and death aspect, isn't it?

Respondent: Yes, so-

Interviewer: That’s the warts and all of abortion, isn't it?

Respondent: Hmm.

Interviewer: Actually, your professional obligation would still override those feelings that you have?

Respondent: Yes. If I were to be in that situation… It has to be hypothetical, doesn’t it, because my main role is in [are of job role]. For that study, the cases that you said, I think the little bit I’d heard where they’d turn up the drip rate and things. I could see that, if you were under conscientious objection, that would be participating in a termination, which would be similar. I’d have to question, “If I give these tablets, is it my views and my morality that I’m struggling with in conflict with the professional role?” It is the end of a life, isn't it?

Interviewer: Yes.

Respondent: If you end a life, under the law, it’s either manslaughter or murder. I suppose, I’ve not dipped my toes in the water to that extent so-

Interviewer: Is there anything that’s stopped you doing that, or is it that you’ve never had to almost think about it? This project… I remember saying to you, way back when, when we were discussing it, I always felt that I had an opinion about abortion. Actually, those opinions have been challenged. I’ve not necessarily changed my opinion, but it does make me think about what I’m saying by saying what I say. I’m just interested to know, “Have your views changed at all?” You say you, sort of, don’t go there almost.

Respondent: I suppose… As I say, I don’t think my school education side of it prepared me for any of this at all. I think it was very poor. These issues in life, it’s sort of… You’re having to… I’ve not always had that forethought to prepare myself. I found myself in things and then having to internalise it and almost, in retrospect, decide what I thought having done it. I think I would be a non-objector, from what you’re saying, but I couldn’t… I don’t think…

If, for example, the medications came in, I am of the opinion that I couldn’t do it. I suppose my thoughts have changed in so far as, if I was to think of how I would’ve thought from SPUC coming in, I’d have probably been totally anti-abortion. My life experiences have… Maybe my personality has been that- Yes, then, I probably have changed my views. I don’t know if I could actually administer medication though, because that is…

I think that’s where I find… From what you’ve said about the two midwives, I do have a lot of sympathy from there… In their situation, they probably were asked to put a drip rate up. That, I would see, would be being very instrumental in it.

Interviewer: Related to that, what elements of the abortion process do you think conscientious objectors should be able to refrain from? Do you think they should just be able to say, “Right, I’m having nothing to do with the patient,” and walk away, or do you think-

Respondent: I think that was… Wasn’t that the spirit of the act, that if…

Interviewer: It’s open to interpretation-

Respondent: Yes, yes, but I think it was the naivety of putting the act together. Having lived in the political discussion at the time, that was the whole… That was the sell-out- Well, or the sell-

Interviewer: Concession?

Respondent: The selling. Yes, to get it through, wasn’t it? It’s always about compromise to get the law through. To get it through, to meet… Like the 24 weeks, they kind of compromised on… Because viability was 28 weeks, that fitted in with the law so they’d have that. For the objection lobby, then they put the conscientious objection- In the naivety, it is vague. I just think that people have become… I don’t know, maybe more accepting of it.

I would say… Although I would do it differently, I would say that conscientious objectors should be able to not do anything. I do think some of those things, like not answering a buzzer and not writing down somebody coming in for it… I don’t think that’s participating as such.

Interviewer: It’s almost like you see that side as caring for the woman?

Respondent: It’s administration, in a way, isn't it, and caring. You’re making… It’s almost like you’re making assumptions about what these things are for… You could book somebody in for a termination of pregnancy, and they never turn up because they’ve changed their mind. I think, where it gets- Actually, you’re in that situation where the mechanisms for the termination take place. The person is actually there, you’re setting them up. Then, when it’s that personal interaction, I would say that would be where the conscientious objection can kick in. Everything else is just paperwork, in a way, isn't it?

Interviewer: I see what you’re saying.

Respondent: But then it’s sort of like that’s… It’s the respect for beliefs, isn't it? I do think it’s a difficult position because, then, they’re not fulfilling their role. If part of that shift leader, managerial role, is to do this type of thing, and they’re not doing it, then should they stay in that role? People have… In my experience, where they’ve conscientiously objected, if they’ve not been able to do the job and the job is a big circle of everything, then they’ve moved. They’ve come out of gynaecology and gone into orthopaedics, and things like that. You do have those two aspects, don’t you, of working in a job role?

Interviewer: Yes. It’s almost like you have to consider what it entails to be able to do it properly, really.

Respondent: Yes.

Interviewer: Do you think that it’s possible to be an objector and work in this area?

Respondent: I think it’s increasingly difficult, I would say. Society has changed. Things are taken for granted that, really… I don’t know. When I trained as a nurse, if you were… When I was a student nurse, at 3:00 o’clock they used to have a mass on a Sunday. If you were on shift, you could go and still fulfil your duty of holy obligation. If you were Jewish, then people would try to do the off duty that you didn’t work at dusk. All of that has just gone by the board now.

We’ve got two students- Well, we’ve got a student who is a practicing orthodox Jew. She requests the Sabbath. She’s been told it’s not possible, she just has to take it off because they can’t make those allowances for staff. In another HEI, there is a nun who has asked for some days off to- You know, or late shifts anyway, to get to mass. That’s been told no.

Interviewer: Oh right.

Respondent: So society has moved, very rapidly, to not respecting the activities of daily living, the whole spirituality side of it so-

Interviewer: Which, I suppose, is quite important because that’s where your compassion, almost, brings…

Respondent: Yes.

Interviewer: You mentioned, a bit earlier on, about an objector that you’ve encountered. They said, “This is not what I do, go and see someone else.” Referral seems to be quite a crux point, almost, when it comes to conscientious objection. There are parties that see referral as participation, because the end result is potentially still abortion. Other people don’t, they actually say, “It might be or it might not be.” I was just interested, do you see referral as participation in abortion?

Respondent: No, I don’t, because it’s… There was a case, some years ago. There was a GP and a consultant, married partnership, at a local hospital. They were both practicing Catholics. When the women in the GP practice went to this particular GP, he would always refer them to his wife who was the consultant. She blocked their process so that they’d be too late for a termination. That went on quite a lot, really. In that respect… This is part, I think, of where Health Education England, and all its predecessor titles, came up with this two-week referral with the faculty, the Royal College of Obstetrics and Gynaecologists, because you’d get that kind of blocking.

In some ways, they were using their personal belief system to take away a woman’s choice. Again, I suppose, that’s like with SPUC. They got aimed at them so often that, you know, “It’s alright, but if I’ve got a child that I can’t cope with then who is helping me?” Then they set up things like [Name of centre for terminally ill children], didn’t they, and whatever to try to address that.

Usually, my experience has been that there are referrals but it won’t necessarily be a formal process. Say, for example, on a labour ward, if you know that somebody really can’t do it, other midwives will step in.

Interviewer: It’s like everyone has got each other’s back almost?

Respondent: Almost. Yes, that’s a good way of putting it.

Interviewer: Do you think people talk about conscientious objection where you work?

Respondent: No, I don’t think it’s considered at all.

Interviewer: Why do you think that, maybe, is?

Respondent: My impression is that it’s not seen as important. It’s almost like you just go with the flow. I suppose, if people were to conscientiously object then you’d be seen as… I don’t know, like a dinosaur maybe or… I just don’t think people think about it.

Interviewer: It’s not really on the radar, type thing?

Respondent: No. In some ways, it’s a little bit like… I suppose, my passage through all of this to date is that it’s not seen as a thing you can do. It remains visceral, really.

Again, a couple of years ago… In one of our programmes, we used to put students in gynaecology for eight weeks, even if they were doing midwifery, for the women’s health. Part of that rotation would be to the abortion clinic as an experience. The staff were very good, in that they said the students could do as little or as much as they want. It was really interesting. One particular group, it’s like the juxtaposition really.

In one particular group, we had two students. One was very young, came from sixth form, and had done an awful lot of work in the health education sessions, over and above their A Levels, to look at the whole of… You know, really, really, did loads on termination. She was absolutely red hot, 18 or 19-year-old, “Every woman has got the right to choose.”

Then we had another student who, when we were talking about it, she had totally the opposite view. She’d had children. She couldn’t understand why on Earth anybody would have a termination, and looked down on people who made that choice.

When we were having one of our tutorial sessions, it became a bit of a debrief. Just the sheer involvement in it had changed the way they thought. The red hot woman with the choice was like, “But, you know, I saw all of these photographs and all of this.” She said, “I didn’t know what it was really like.” She, kind of, was probably at that process, really, of thinking, “How far would I get involved?” Then the other student, actually, she said when she’d met the women and listened to… You know, talked to them. She actually changed her views. It’s almost like conscientious objection would be… Gosh, what’s the word? It’s like too remote, you know.

Interviewer: It’s almost like that experience-

Respondent: Too abstract.

Interviewer: Yes, it’s almost like that experience has shaped their views. That hands-on experience has managed to shape their views.

Respondent: It did, and that was dramatic. I suppose it’s like students who hold back from care of the dying, but that’s their personal… So when they went to gynaecology, they were like, “I don’t want to lay out a dead person.” Because that wouldn’t, thank God, necessarily be part of the midwives’ role because we don’t… We might have baby deaths but it’s, certainly in this neck of the woods, very rare to have a maternal death, so we’re not geared up for something that is part and parcel of nursing. They didn’t want to do that, but there was not consequential affect with that, was there?

Interviewer: No.

Respondent: It was to do their… I think that’s where termination gets muddied really.

Interviewer: Yes, yes, until you see it, the nuts and bolts of it, it’s like you can’t quite form a view, really, because you don’t understand what it is until you see it.

Respondent: No, no, that’s… I don’t know. Even thinking about our programme, I don’t think we actually talk about conscientious objection in a very meaningful way. They might mention it in a law lecture. So you might talk about the Abortion Act and… You know, I know I have mentioned it as such. I think, probably, in midwifery we don’t see it as part of the role, you know.

Interviewer: You mentioned, there, when the Abortion Act was envisaged and conscientious objection was included, there was almost a bit of naivety in that compromise that came in with it. If the conscientious objection part of the act was to be scrapped, what do you think should replace it, if anything? Do you think that it should, maybe, remain the same to allow that interpretation, that open interpretation?

Respondent: Being realistic, and considering the different aspects, I do feel there should be… That is an area of practice that… You should be able to conscientiously object to it because it is about life and… I feel what they should do is to make it a lot clearer. I know they have redefined it, on a pragmatic working level, to say… You know, the code and different… Sort of like the, kind of like, register body and everything has talked about it. The conscientious objection is really only about the actual act of procuring the termination, for want of a better… So the care of the person shouldn’t come into it.

I would say that- If they were going to make any changes, I would say, “Yes, keep conscientious objection in but be very, very, clear what you mean about that.” I think it’s like- Part of it- With later terminations, you have to make sure… Again, there have been cases where there’s been a baby born. I remember, historically, this has…

There was a young practitioner… They went into… The woman gave birth, the baby was alive, and she actually resuscitated the baby because that was her professional instinct. She didn’t agree with abortion, as well. I don’t know, did it muddy the waters, did it just give people more of an argument? From there, then, you actually have to practice foeticide. You have to make sure… You’ll inject saline to make sure that the baby starts to decompose. You give potassium so its heart stops. I just don’t think that people who talk about conscientious objection and how it shouldn’t be there…

Yes, you should answer the phone, you should do the bookings. It’s that whole ethical slippery slope, isn't it? Do people realise that by saying… You know, going from, “Sorry, I want nothing to do with it. I’m invoking the conscientious objection clause.” To, sort of like, my situation where, as I say, I was just on the perimeter… Yes, I’ll care for that person because it’s the person I’m caring for, not her choice. Possibly, you know, then, “Yes, a couple of tablets, they’re harmless, aren’t they?” You know, “Just give the tablets.” It’s all nice and clinical, it’s all done, but it’s the whole remit. People don’t say it.

Then they say, “Oh well, yes, but then they’ll reduce it from 28 weeks.” There are two conflicting laws going on, there is the Infant Preservation Act and…

Interviewer: Yes.

Respondent: Unless they did a whole revamp, which we’d get nowhere with anyway… Not all babies of 24 weeks survive.

Interviewer: It sounds like, for… One of the questions that I was going to ask is, “What’s your understanding of conscientious objection?” It sounds like you’ve actually thought about it an awful lot.

Respondent: Yes, I’ve lived it.

Interviewer: Yes. It sounds like you take a broad perspective of conscientious objection. Would I be right in saying that you feel that conscientious objection is very personal to each individual?

Respondent: It is, isn't it? Conscience is… I think, partly, it’s your spiritual beliefs, partly it’s your religious beliefs. For some people, it’s fear, it’s your personality. All of those things go into it. Really, if it’s conscientious objection, who is anybody else to say, “Your conscience is wrong”? We do, don’t we, if somebody is psychopathic or narcissistic, we’d say, “You’ve got no conscience.” Do you say to people, “You’ve got too much conscience”? At the end of the day, you have to live with yourself. I think, where the difficulty is being employed to do a job that you can’t do. It’s almost like you could make reasonable adjustment if it was a physical disability or something.

Interviewer: Yes, if it was a disability or something.

Respondent: So you’ve got a reasonable adjustment for there. I think what’s changed is employers are not willing to make a reasonable adjustment for what makes up a person, which is your belief systems. You’ve got a right to those, as much as anybody.

I’m pleased it’s in a debate, I’m just not quite- I think people, in a way, are getting hung up with some of the mechanisms that go round it.

Interviewer: That’s coming to the end of the interview. Is there anything more that you want to add at all?

Respondent: I don’t think so. Except, “Watch this space, because it’s an ongoing challenge.”

Interviewer: I know. Well this is it, will we ever get guidelines? I’m not entirely sure. Is there anything more that you’d like to add that, maybe, I’ve missed?

Respondent: I can’t think of anything.

Interviewer: I’ve skirted over? I’m just going through my questions. You’ve been great, you’ve just… I’ve not had to ask much. You, sort of, answered my questions before I-

Respondent: That’s good.

Interviewer: No, it is. It’s really good, it makes my job a lot easier. Before I’ve answered them… No, thank you very much. I think…

Respondent: Yes. I think, probably, a lot of conscientious objection goes on under the parameters from if you’re working in an area with supportive individuals. As you put it love, “Well, they watch you’re back.” Along with a whole host of procedures… If somebody didn’t want to look after a stillbirth, other people would step in to do it unless it was absolutely essential. I think the thing, with conscientious objection, is your absolutely essential is your day-to-day living, isn't it?

Interviewer: Yes.

Respondent: It shows a lack of respect, really, for professionals.

Interviewer: There was just one thing that I didn’t ask, but you’ve sort of… I think you’ve answered it without me asking it. Whose rights come first, do you think the patient’s rights override the rights of the health professional or do you think the health professional’s override the patient’s, or do you think it should be equal?

Respondent: I think it’s equal, I really do believe everybody has their own personal rights. I think what you have to do is look at what you’re doing to make sure that you expressing and working on your rights doesn’t conflict with another person’s rights, so knowing when to step back.

If I was looking after somebody, and I felt I couldn’t be non-judgemental… You get it on other levels, don’t you? You know, people who smoke. Really awful social conditions where you think, “You’re living that life, and you do have choices.” If I found I couldn’t deal with that, then I should recognise that and step back. Then, sometimes, you can’t. I think that’s the difficulty, isn't it? I wouldn’t say one group of people have rights over the other, at all.

Interviewer: It sounds like your experience has shaped your professional… Your duty of care, almost, it’s like-

Respondent: Yes.

Interviewer: I can’t think of the right word. Your professionalism, I suppose…

Respondent: Yes. Otherwise it’s not your job, is it? I suppose, more in nursing than midwifery, I’ve looked after some pretty horrible people.

Interviewer: People are like that, though, there’s good, bad, and indifferent in between.

Respondent: Yes, yes, it is, you know… As a student nurse, I had experience in mental health in orthopaedics. You know, you kind of have what my grandmother would’ve called the underclass. You’ve got to… Sometimes it’s an effort, but that’s the role you take. That’s what you aspire to, isn't it? If you’re lucky, you can go into your little coffee room and go, “Oh my-”

Interviewer: “I’ve had enough.”

Respondent: And brace yourself. That’s… It’s hard, but if you can’t do it then…

Interviewer: You shouldn’t be in the kitchen?

Respondent: Yes, yes, almost. I know it’s different, isn't it? You train for something, you’ve got a job, you’ve got a mortgage, and you’ve got the other things that go on. It’s not exactly that you have to suck it up but you make judgements on it. I would say everybody’s rights should be respected. I suppose that’s where I feel conscientious objection should be seen and it should be individual to the individual.

Again, I do know in the history of it all being processed and going into areas where… If you were in a Marie Stopes Clinic, you know why you were there. If you’re working on a labour ward, you’d be like, “Woah, where did this come from?” It could be then, you know, community midwives. That’s been discussed, that they go and give this medication-

Interviewer: Really?

Respondent: Oh yes. The whole remit has been… It may not be formally, but it’s been mooted in different forums over the time. You could find yourself in situations where you’re doing it. It’s acceptable by society, and seen to be okay, but it’s like if you… If you don’t honour the conscience side of it then… Yes, refer on. That’s where I would say, if you conscientiously objected…

I wouldn’t have very much patience for people who would say, “I just don’t have anything to do with it.” Rather than say, “I can’t help you, please go there.” That, to me, isn’t human, because you’re not making any decisions, you’re not initiating anything, you’re just signposting.

I don’t know. I do think it’s very important, and I don’t think people realise how important-

Interviewer: Yes, it’s almost like-

Respondent: It’s a sense of your identity for some people.

Interviewer: It sounds like you’re saying that, almost… How can I put this? I’ve got a really terrible example that’s in my mind. I’m trying to think of a better way to put it. It’s almost like these changes are being implemented but those changes aren’t being challenged because people’s… Maybe… Do you think people are scared to conscientiously object or feel daft conscientiously objecting? So these changes are happening and it’s becoming looser, I don’t know whether that’s the right word, but-

Respondent: Yes, it is. Yes, I do think you’ve got something there. If you think about it over the time- At one time, if you were… I’m not even sure about the licensing of it. The current situation is the government licenses certain places, don’t they, to do terminations at certain gestations. If you wanted a late termination, you’d probably end up going down to [name of city in England] for it.

When people talk about conscientious objection and… I think… I don’t know. It’s not my knowledge, it’s my thoughts on it. We’re looking at this stage of it. I’m somebody who goes in. Then we’ve got this initiated by medical staff and it fits in with induction of labour for anybody else, it’s a couple of tablets, and we do that.

In the discussion, what they’re not going towards, and I think that’s possibly a bit squeamish because they don’t want to upset people… The end point is we’ve got a baby that is at a gestation that would be viable unless, when they took the breath of life it didn’t happen or they had severe syndromes or something. We’ve got it at this end stage. Basically, what we’re doing there is a foeticide. Making sure it’s not viable, despite everything. I think that part of the discussion doesn’t happen because people don’t want to know about that, do they?

Interviewer: No, no. That’s the dirty side, if you like, of it.

Respondent: It is, it is. It’s right. It’s like, “This is the clean side because it fits in with a miscarriage, a heavy bleed.” It’s clean, isn't it?

Interviewer: Yes, yes.

Respondent: Whereas, when you go down there, you’ve got somebody that’s in the full throws of labour and worse because it’s just…

Interviewer: The baby has got to come out.

Respondent: Yes. Generally, because of the way the licences are, the people who work in that situation accept it. They know what the job entails in its entirety, so they do it. They’re not going to be conscientious objectors, are they?

Interviewer: You’d like to think, maybe, not.

Respondent: They’d have to participate fully, wouldn’t they? They’d have to be the nurse that goes into theatre and scoops up the remains and things like that. I don’t know how far their role evolves into actual… You know, potassium injections or if it’s still a medical role or something. I don’t think it’s seen in that entirety.

Interviewer: I think I’ve asked everything that I needed to. Like I say, you’ve been great. You’ve answered my questions before I’ve even had to ask them, which makes a nice change to be honest with you.

Respondent: It is something that I’ve thought about over time, from all the different aspects. It’s not something... You think, if you go into contraception, all you have to do is make a phone call and somebody else deals with it. Now it’s sort of like… I’ll probably have retired by the time that comes in, so I mightn’t have to come to that debate.

Interviewer: Thank you very much, that’s been brilliant.

Respondent: I’m glad-

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