**File: fid5141e -- Nurse - Nerida pt 1.MP3 & fi242590 -- Nurse - Nerida pt 2.MP3  
Duration: 0:32:54  
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START AUDIO

[Start of fid5141e -- Nurse - Nerida pt 1.MP3]

Interviewer: That one’s on, yes, and that one’s on.

So, to begin with, can you tell me a little bit about the work that you do as a health professional, so as a nurse what do you do?

Respondent: I work in the [name of unit] and [name of unit], I go from one to the other really, so that’s quite hard. With the [name of unit] I see six patients every morning, who are wanting to have a termination of the pregnancy. So they’ll see the doctor first and then they’ll see me afterwards and I give the medication and go through everything else with them, what will happen, and then they can go home. Or if they’re over a certain term gestation they go for a surgical termination and so we book that in.

Interviewer: How long have you worked as a nurse for?

Respondent: Six years.

Interviewer: How long have you worked in the area that you work in?

Respondent: I’ve worked there for about 15 months now, before that I worked in the gynae ward, so I didn’t really do the clinics there but I worked on the ward where the patients would come if they were staying in.

Interviewer: Would that be patients who have sought abortion or would that be general gynae?

Respondent: In that hospital?

Interviewer: In that hospital I mean, yes.

Respondent: So everything really. At the hospital they did do a later gestation. Where I work now, for medical termination pregnancy they have to be under nine-plus-six, and they have the medication, one tablet with me and then they take the other medication home, which is a new thing. Anything above nine-plus-six to twelve-plus-six they have a surgical termination. Anything above that we refer them back to BPAS and they have to go somewhere else.

So in the hospital they’d only do surgical to twelve-plus-six, anything later they would do on the ward, up to about seventeen weeks.

Interviewer: It’s quite a big hospital, isn’t it?

Respondent: Yes.

Interviewer: I was going to say, is abortion something that you come across quite often, but I suppose, as you say, you have women come to you almost on a daily basis as part of your role.

Respondent: Yes.

Interviewer: So, as you know, this project is looking at conscientious objection to abortion. What do you think conscientious objection to abortion means?

Respondent: I’d say it was people who don’t believe in termination so they won’t do the clinics that I do or they won’t sign out medication for termination.

Interviewer: What are your thoughts on that?

Respondent: I think everyone’s got the right… One of the questions on my interview when I started there was, how would I feel about looking after someone who was having a termination of pregnancy? So, that was one of the questions. I don’t know what would’ve happened if I would’ve said no, I’m not sure.

There are a couple of nurses who won’t sign out the mifepristone. When the doctor does their first bit we have to then go and find another doctor to do a second signature, they’ll have a read and sometimes it can be quite difficult to find a doctor, depending on what rotation of doctors we’ve got at the moment because quite a few more doctors than nurses will object, I’ve found.

Interviewer: It sounds like you’ve got some experience of people who do object?

Respondent: Yes.

Interviewer: But am I right in assuming you don’t object yourself?

Respondent: No I don’t, no.

Interviewer: Can you tell me a little bit about your experience with nurses who have objected and maybe what reasons they give?

Respondent: Religion is mainly one thing that I’ve come across and then another girl, she’s only young but I think she’s having fertility problems, so I don’t know whether that’s the reason why she won’t, which is understandable as well.

Interviewer: How do you feel about that? Do you think it’s possible to work in your area and be a conscientious objector?

Respondent: I think one colleague is a great nurse, she objects to doing the clinics or signing out certain medication, the mifepristone, the misoprostol she will sign out because I think the mifepristone stops the pregnancy hormone so she won’t do that, but the second part she has done on the ward, if she’s had to.

Interviewer: Do you know why that might be?

Respondent: I think the mifepristone really stops the heart beat type of thing.

Interviewer: Oh right, so that’s the one that ends the pregnancy maybe?

Respondent: Yes, and then the next one is just, sort of, expel it, so I think that’s probably why.

Interviewer: Right, so it’s almost like she feels she has no part in the actual abortion?

Respondent: Yes.

Interviewer: I see that.

Respondent: I think that no one would object to looking after someone who’s come in with complications, to the ward, and who’s unwell. No nurse or doctor would really object to looking after them then, it’s just the initial treatment, I’ve found.

Interviewer: You spoke about a couple of nurses there who object, what impact does that have on your colleagues, for example, if any?

Respondent: The nurses? Not really, you just find another nurse to sign out with. But, as I say, the doctors can be quite frustrating because then you’ve got to find out where other doctors are to get this second signature.

Interviewer: What impact does that have the patient, people’s refusal or conscientious objection?

Respondent: You see, they wouldn’t really know. They’d probably just have to wait longer in the waiting room for me to get another signature, but we wouldn’t say…

Interviewer: “We don’t want to give you an abortion.”

Respondent: (Laughter) Yes, some do feel quite bad, you know, some people feel guilty anyway, or upset, so it would just add to it.

Interviewer: Add to the stress, yes.

You mentioned there that the doctors have a read through the patients case notes and that. Do they ever give a reason why they won’t sign or are there doctors that you know not to ask if they’re rotation? How does it work operationally almost?

Respondent: If they’ve read it and then they won’t sign? Sometimes there have been times where, the doctors who’s done it initially at the appointment, they’ve not thought that their reasons for good enough that were written down, so they’ve gone back to the first doctor and said, “Can you elaborate a bit more on why?”

Interviewer: You mentioned that you think predominantly the reason is around religion, that some people object, does that also apply for the doctors?

Respondent: Yes, some but not everyone. There’s a doctor now who hasn’t made his mind up yet whether he wants to sign, so for the moment he’s not signing.

Interviewer: Oh right. (Laughter)

Respondent: He says he doesn’t know if he feels comfortable with doing it, and he’s not religious so I don’t know what…

Interviewer: I suppose that is a battle of his conscience then, if it’s not particularly based on something maybe there is a conscious debate doing on in his head. It would be quite interesting to see what his thoughts are.

So, you said it has an impact on the patient in terms of you have to run round and try and find another doctor…

Respondent: Yes, so what would happen is the doctor will see the patient first and then the patient would then go into the waiting area. I get the notes, get everything sorted and get everything signed before having the patient in to see me.

Interviewer: It’s just a longer wait for them.

How do you feel about that? It sounds like it might be almost a potluck as to which doctor you know is going to sign or on which day, how does that make you feel?

Respondent: Sometimes there will be two doctors doing it, on a Friday there tends to be and on an afternoon there tends to be two doctors doing it, which is much easier for me. It is a pain, I do think the doctors should get their own signatures, to be honest.

Interviewer: I suppose if they did they’d be a bit more organised. They’d organise themselves, so it’s not your organisation - because it would impact on them…

So, how do you feel about participating in abortion?

Respondent: I think every woman’s got their own reasons and it’s their choice, at the end of the day. It’s actually quite a hard thing for a lot of patients to do, so it’s helping them through that as well. I wouldn’t say I enjoy it, but I feel I’m fine with it. I just think I want to help patients through a difficult time, and that’s what I do.

Interviewer: That must be quite rewarding really?

Respondent: Yes. I think sometimes it’s frustrating when you get the same people and they still don’t want any contraception or they say they’re going to get the contraception and they don’t. That gets a bit frustrating.

Interviewer: Do you see that often, at all?

Respondent: Yes.

Interviewer: Do you? How often, would you say, out of your caseload in a week, would you see somebody that you’ve seen? Or would, if that’s the case?

Respondent: I’ve had a patient who was in last year it was, she was in the January or in the March and then she came in in the August. Then again she was on the list for November. And I was thinking, “Oh my God.” But she went and had the scan it actually worked and she was 20 weeks.

Interviewer: Oh…

Respondent: That would’ve been her third time in a year, and…

Interviewer: That’s quite a lot, isn’t it?

Respondent: I think a lot of people don’t realise what they’re doing to their bodies, especially young girls.

Interviewer: So, there’s almost like a lack of education that actually this is a major procedure. It might be as simple as a tablet now but it’s still an assault- Well, not an assault, that sounds terrible. It has an impact on your body.

Respondent: Yes. I think one of the things with people that have a few terminations, when they find that they get to a certain gestation and miscarry because their body is so used to-

Interviewer: Expelling the baby.

Respondent: At that point, at so many weeks.

Interviewer: I wouldn’t know that, as I said earlier, I’m not a nurse so I wouldn’t have known that either.

Respondent: It does have an impact on the future really.

Interviewer: Thank you for that.

Can I ask, what has helped informed your views? You sound very patient-centric and sound very much for the choice of the woman, so pro-choice, I always get that one the wrong way round… (Laughter). What has helped inform those views of yours?

Respondent: I don’t know really. I don’t know.

Interviewer: That’s fair enough.

You know you mentioned religion, and that helps inform their views. For example, I’m a Catholic, a very lapse Catholic I’ve got to add. My mum’s not Catholic, she’s C of E, so my opinion around abortion, I think, has been very much informed from my mum’s experience, in terms of she grew up very much in the ‘60s and she had a very strong female dominance in her life, as in other women lived together because all the men were away at sea. So she would tell me the stories about the backstreet abortions and things like that, so I suppose that’s what helped inform my views really.

I was wondering if there was anything that you could think of that informed yours?

Respondent: I think it’s just pro-choice, everyone’s choice. As you say, if they’re not doing it in a safe way there’s stuff you can buy off the internet now as well, you can buy the medication off the internet and it’s so dangerous.

I always try and give a lot of safety advice as well, like drill it into them because it does worry. They go to nine-plus-six and then let them go home, I don’t think I agree with that gestation. I think that’s too far.

Interviewer: Is it?

Respondent: I think so, and I do worry. But you’ve got to just-

Interviewer: You can’t take them home with you. (Laughter) You’ve got a family as well so you’d be worrying about hundreds of patients, wouldn’t you?

Respondent: Yes, but I just think, if it’s what they want… I don’t know. There’s nothing really in my life that’s… Nothing like that.

Interviewer: So very much patient focused and the choice of the patient.

Respondent: Yes, I don’t think there’s anything that’s happened in my life that would…

Interviewer: Has your experience or your views changed? Has your experience as a nurse changed your views or coming into the profession you may have thought one thing and actually now you’ve arrived at this pro-choice sort of feeling?

Respondent: I don’t know really. I wouldn’t be against someone doing it, it is their body at the end of the day, but it depends what gestation. I mean, if you get to a later gestation… I don’t discriminate or anything like that, but it doesn’t really sit with me. I didn’t like it at the [name of hospital] when they’d be up to- I’d look after them, I wouldn’t treat them any differently and give them the best care I could.

Again, that’s even harder, isn’t it, to terminate at that gestation. Especially with the foetal abnormalities as well, that’s really hard as well, doing that to patients, because that’s not their choice, is it, that’s something that-? Well, it is their choice but it’s their only choice isn’t it?

Interviewer: It’s a wanted baby, isn’t it?

Respondent: Some of the doctors even then won’t get involved, and I don’t understand that at all.

Interviewer: It sounds like you disagree with doctors who wouldn’t get involved with therapeutic, is that what they call them, therapeutic terminations and those instances?

Respondent: Yes, so if they carry the baby to term the baby will die straight away, and I just think, “Why would you want to put someone through that at full term?”

Interviewer: It’s almost like you feel that, and correct me if I’m wrong, it’s better for everyone’s wellbeing that the pregnancy is brought to an end earlier and at that point?

Respondent: Yes.

Interviewer: I understand.

Respondent: But doctors who disagree tend to disagree on every aspect, even if…

Interviewer: Oh right, so whether it’s a social abortion… Just abortion full stop, they wouldn’t have a leeway, if you like, for special circumstances? They have a very black and white approach?

Respondent: Yes.

Interviewer: I see.

This might sound like a bit of a tricky question but, as you know, we’re trying to understand what the limitations and extent of participation in abortion is. So, in terms of limitations, what do you think the limitations to participation in abortion are?

It might be better if I give you an example, there was a case, and I don’t know whether you’re familiar with it, of two midwives, back in 2014, from Glasgow. Basically, they worked on a delivery ward and then abortions were introduced to their ward. They were practicing Catholics and they didn’t want to be involved because it went against their faith.

They created a list of 13 things that they felt constituted participation in abortion, and that included things like answering the telephone to people who are booking in for an abortion, supporting other midwives who may be treating or supporting the woman through the abortion, information giving, answering emergency buzzers… I can’t remember the exact list, but they’re the types of things. So, sort of the peripheral activities that all facilitate that abortion going ahead.

I’m wondering what your thoughts are on that? Where would you place the extent of participation in abortion and the limits to participation in abortion?

Respondent: I think with the couple of nurses they won’t hand out, they mifepristone won’t do the clinic, and the doctors won’t do the second signature. I think that’s fine. But I think anything more than that, I think they should be doing really. Emergency buzzer… You can’t ignore an emergency buzzer. If someone phones up wanting to have a termination, you just have to give them the BPAS phone number.

Interviewer: Do you think that by doing that you are participating in abortion, by giving that information?

Respondent: No, because if you don’t give them that information someone else will anyway. I just think you’re not actively participating in giving a phone number. It’s not as if you’re making the appointment, it’s putting it in their hands, isn’t it, giving a phone number.

Interviewer: So, I suppose the flipside to that is they might not go and ring that number. You don’t really know what they’re going to do with that information.

Respondent: People change their mind. They’ll come for the scan and they’ll go away to think about it, then they’ll not come back and they’ll carry on with the pregnancy. Like that one at 20 weeks, she did.

Interviewer: Oh, did she?

Respondent: Yes, I kept an eye on her, just thinking… Because she could’ve still went somewhere else.

Interviewer: So, was the baby born safe and well?

Respondent: That was November…

Interviewer: So, a bit early.

Respondent: I don’t know if the baby’s born yet, but I knew she was going to her antenatal appointments and so I knew she was continuing. But then again, we don’t know what effects it would have on the baby, that she’s already had this medication.

Interviewer: Of course, yes. Fingers crossed everything’s okay.

Going back to participation in abortion, you said that you don’t see those peripheral activities as participation in abortion. But, it sounds like you understand where those nurses that you work with, where they won’t give the medication…

Respondent: Yes.

Interviewer: Just trying to understand, it sounds like you’ve got quite a narrow perspective on what participation in abortion involves, in terms of it’s the medication giving or if it’s a surgical procedure then obviously it’s being in that theatre, as such. Would I be right in saying that?

Respondent: Yes. I mean, the nurses would still check in for check list in theatre for those patients, they have done. It depends what your views are, doesn’t it? I would think it was.

Interviewer: That’s your view, it’s more a hands-on activity?

Respondent: Yes.

Interviewer: You mentioned before that you’ve had women come for multiple abortions, and also that it doesn’t sit comfortably with you with regards to later term abortions. So, you’d still support the woman through that decision?

Respondent: Yes.

Interviewer: Are there any limitations that you would place on abortion yourself? So, at any point would you go, “No, that’s enough for me, I don’t want to be involved?”

Respondent: When I worked at the hospital we did medical terminations up to about 17 weeks, I know they go to BPAS for surgical up to about 23, don’t they? There was one time that I think their surgeon or something couldn’t get in, and they’d already had part one of the treatment, so they’d spoken to our consultant about bringing them over to our hospital and them having medical. They were all 20-plus weeks and we all said no because we’re nurses, we’re not midwives. I think at that point it’s a delivery, isn’t it?

Interviewer: Yes, I understand.

Respondent: So, I wouldn’t do anything like that.

Plus, I think there are so many more risks involved when it’s above 20 weeks. At the hospital they’ve had the surgery at BPAS and because there are loads more rights they’ve ended up perforating the uterus at least five times, and the whole time, in four years that I was at that hospital. They’d end up getting blue-lighted over to the hospital, ending up for hours in theatre having a hysterectomy, and spending days in HDU as well, before they come back onto the ward. A lot of the time they’d travelled from Wales because they didn’t want anyone they knew or their family knew, and we’d have to phone the family to say they’re really poorly but not allowed to tell them why because it’s all confidential.

Interviewer: Oh, that’s really difficult. That is really, really difficult.

It sounds like your decision to say no was based more on clinical practice and clinical skill, but in the sense that you’re not a trained midwife, you’re a trained nurse, which is a different skill to delivering babies.

Respondent: Yes.

Interviewer: I understand.

But would you have ever considered refusing on terms of your conscience, so in terms of conscientious objection?

Respondent: I probably would because it’s different. I just feel like it’s very different gestation, it’s like a fully formed baby isn’t it. But then it must be something drastic why they’re making this decision, so it would be difficult being in that position.

Interviewer: I suppose, as a nurse though, you’re not in the position to make that choice?

Respondent: No.

Interviewer: I see.

Have you ever experienced a woman who’s seeking an abortion and who’s been refused abortion?

Respondent: No.

Interviewer: We’ve already talked about when you’ve experienced objectors and the impact that has on working procedures. It sounds like, for you, as a nurse, it doesn’t impact on the patient, other than there’s a bit of a delay in them getting the medication.

I was just wondering what your thoughts are with regards to what elements of the abortion process people should or could be allowed to refrain from participating in?

Respondent: What they can say no to?

Interviewer: Yes. As a conscientious objector what do you feel-? Not you as a conscientious objector but somebody else, some of your colleagues, whether it be a nurse or a doctor, what elements of that process do you think they should be able to say no to?

Respondent: I think the initial, when you’re seeing the patient, with the scanning and the medication. I think what the girls do object to is probably the right thing to object to, so the medication, the clinic, the doctor consultation and the doctor’s signing if they don’t want to sign.

Interviewer: But they still deliver the care afterwards?

Respondent: Yes, they’ve still got a duty of care if she needed anything. I’ve never known anyone to object to caring for someone who needed it. It sounds like those midwives did.

Interviewer: I suppose your job commands so much compassion, doesn’t it, and, like you say, it’s in you to be compassionate. So it would almost jar against your being, almost, wouldn’t it?

Respondent: Yes.

Interviewer: There are some places in the world, like Sweden and I think Iceland, where conscientious objection is outlawed, so no one’s allowed to conscientiously object, and then there are places like Italy where whole institutions will evoke their right to conscientiously object. So, I suppose there’s a bit of a religious element there with it being a predominantly Catholic country.

I’m just wondering what your thoughts are on that? Would you support that, in terms of you’ve got two totally polar ends and opposite approaches to dealing with conscientious objection? What are your thoughts on that?

Respondent: I think, as a doctor, if you want to work in gynaecology or maternity it is a part of it. Like I had that discussion at interview, I think maybe the doctors should maybe have that discussion as well.

Interviewer: It sounds like you’re saying that you need to have a bit of forethought as to what you’re coming into really?

Respondent: Yes, I think it is a big part of it, really.

Interviewer: You mentioned that you were asked if you had to declare. Do you know of any other colleagues, have they ever been asked whether they’d be happy to go ahead and be involved in abortion?

Respondent: I’m not sure if it was only my interview. But one of the nurses who refuses has worked here about 25 years, so I don’t think that question was asked then.

Interviewer: I suppose things have changed dramatically, haven’t they, in terms of abortion and how it’s done.

Respondent: Yes. I think years ago though people used to go on the ward, I think the reason we only do medical to 9-plus-6 is because there are no beds on the ward now.

Interviewer: Yes, I suppose the NHS is under a lot of pressure isn’t it, really?

Respondent: But I knew they used to go on the ward. At the [name of hospital] they did go on the ward. We used to have quite a few. There is a whole ward there as well, the [name of abortion clinic], and all they do is terminations.

Interviewer: That’s right, yes. I suppose it’s just different operational procedures for dealing with a similar thing.

Do you feel that the rights of the patients override the rights of the healthcare practitioner? So, thinking about conscientious objection, you know, if somebody did object do you think that actually it’s the patient’s choice and beliefs that come first above those of the healthcare professional?

Respondent: I think if someone doesn’t want to have a child they shouldn’t have to have a child. You know, there are a lot of people who’ve got five kids already and they’re not going to be able to look after that child properly. You read all these stories in the paper about kids who… I’m not saying that that’s what they do, but I just think there is a lot of that in the world, and I think if a woman doesn’t want to have another child she doesn’t feel like she should have to.

Interviewer: So, in situations, would you say, that the patient’s rights override those of the healthcare practitioner?

Respondent: I do, but then I think if a healthcare professional is going to go home and it’s going to impact their life, if they were forced to be involved, I don’t think that’s fair either.

Interviewer: Do you think there’s a place for healthcare practitioners, in your area of work, who do conscientiously object?

Respondent: Yes, I think so, not for everything, not for emergency care. I think if it’s going to impact their life then, yes. If they’re interested in gynae and obstetrics but that’s a part they don’t want to do I think that’s fine, but you couldn’t have everyone like that otherwise you’ve have no one to look after them.

Interviewer: You’d have no service, would you?

Respondent: Yes.

Interviewer: So it sounds like you’re saying it’s about, yes, they can work here but we have to manage it, maybe in some way, so that it doesn’t impact on the patients and there’s some protection there for both parties, I suppose, your working colleagues as well.

As it exists the Abortion Act was introduced over 50 years ago, and the conscience clause is quite vague, so it just says along the lines of… And I’m sure it’s put in far better wording than I can put it, but along the lines of, ‘Healthcare professionals have the right to conscientiously object as long as it doesn’t put the life of the woman in jeopardy.’

So, if the clause was to be scrapped or gotten rid of, what do you think should replace it, if anything?

Respondent: What was the question again?

Interviewer: Conscientious objection, as a clause in the Abortion Act, is quite vague and it’s open to interpretation. What we’re finding is when healthcare practitioners evoke it, and there’s a disagreement between the organisation that they work for and the healthcare practitioner, it’s ended up in court to try and make a decision. I mentioned the case of the midwives, for example.

So if that clause, as a stance, was scrapped and gotten rid of what do you think should replace it, if anything? Or do you think it’s good to have that open interpretation of the clause?

Respondent: The clause says, basically, if you don’t want to look after them you don’t have to, type of thing?

Interviewer: The clause says along the lines of, health care practitioners have the right to conscientiously object as long as the life of the woman isn’t in danger, they have to intervene if the woman was to haemorrhage and an emergency situation was to happen, and that woman’s life was to be in danger, then it’s almost like those beliefs go out the window and you’ve got to intervene there.

[0:29:40]

[End of fid5141e -- Nurse - Nerida pt 1.MP3]

[Start of fi242590 -- Nurse - Nerida pt 2.MP3]

Interviewer: No, that’s working, okay.

So, as I was saying, the point I was getting at, before we were rudely interrupted, is if the clause was gotten rid of as it stands, for example, would you think it would be better if there was more subscribed, very individualistic guidelines, or do you think it’s good to keep it open to interpretation?

Respondent: I think maybe the medical termination, so the baby will have no quality of life or die at birth, I think you should have to intervene in that. That’s it really. I think it’s good to keep it open.

Interviewer: I’ve had those discussions with other people through the interviews, and some people feel it’s good to have that open interpretation because you don’t know what you’re going to come up against. Would you say that’s true?

Respondent: Yes.

Interviewer: I think that is actually the end. We were rudely interrupted there by that.

Is there anything more that you want to add, you know, thinking about conscientious objection and thinking about the extent of the limitations to participation in abortion?

Respondent: It’s just the medical ones really. A lot of the time in the [name of hospital] you’d have people travelling from Ireland because their baby’s not compatible with life and they had to travel to get here, and then to come across doctors who won’t sign for you is not really fair, and they’re having to pay as well, aren’t they, to come here and have the treatment done.

I think that’s it really, I think.

Interviewer: It sounds like that although that happens the patient would never really get to know.

Respondent: No, I don’t think they would.

Interviewer: Do you think people should think about what they’re coming into before they enter the profession? You know, have a thought that actually it might jar against your beliefs?

Respondent: Yes, because it is a part of gynae, so if it’s something you’re really against maybe it’s not for you, maybe? It is hard because sometimes I go from the early pregnancy unit where you’re dealing with ladies who are losing babies, and then I go straight into that clinic and you’re changing roles really quick. And I’ve got a friend who’s struggling with fertility as well, and that’s hard. But just because someone is terminating a pregnancy wouldn’t necessarily change anything for the other person. It’s hard. It is really hard.

Interviewer: I suppose it’s an individual choice, isn’t it?

Respondent: Yes.

Interviewer: I can see the contrast you, and for you almost flipping your head to almost protect yourself really because you can’t take it all home with you, can you? It must be a challenge.

Thank you so much. I think I’ve literally asked everything that I needed to.

Respondent: Great.

Interviewer: Thank you so much.

Respondent: Thank you.

[End of fi242590 -- Nurse - Nerida pt 2.MP3]

END AUDIO

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