**File: fi54c5b5 -- Nurse - Natasha pt1.MP3 & fia4330d -- Nurse - Natasha pt2.MP3
Duration: 0:48:54
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Typist: 677**

START AUDIO

 [Start of fi54c5b5 -- Nurse - Natasha pt1.MP3]

Respondent: Oh, have you done it? A red light comes on.

Interviewer: Yes, a red light comes on, we’re in business.

Respondent: Oh yes, that’s like the ones they’ve got at-

Interviewer: Cut all that crap, I’ll have to transcribe this.

Respondent: So, no crap did you say?

Interviewer: No crap in this interview, please. I’m not transcribing that bit. We’re starting now.

 Thank you very much, as always. We’re a good help to each other, I think. So, I know, because we have done work in the past together, that you are an objector.

Respondent: Yes.

Interviewer: I believe you’ve always been that, am I right?

Respondent: Yes. I’ve never thought it was alright.

Interviewer: Can you tell me why?

Respondent: Well, I don’t like the idea of killing what is a little individual. Now, my first degree, as you know, is biochemistry, so I did other life sciences with it. Certainly, in biology, as soon as the egg and the sperm join together it is considered you have another potentially viable being. After all, not all pregnancies all come to fruition, for one reason or another. So, I’ve always thought, from that point of view, it’s a life.

 I do believe in God, and one of the commandments distinctly says… I can’t name all the commandments so please don’t ask me, [name of interviewer].

Interviewer: Don’t make me choke on my tea. (Laughter)

Respondent: Thou shalt not kill is one that sticks in mind. As a nurse, I think thou shalt definitely not kill, whether it’s a little individual or a big individual.

Interviewer: Okay. So do you, whether it’s, as somebody said in our previous research, half-an-inch long or a six foot man, it’s still an individual?

Respondent: It’s still an individual. As soon as that egg and sperm join together. We’ve got a potential individual because I do believe that it’s not always successful, is it?

Interviewer: No, and they generally sort themselves out somewhere along the way.

Respondent: And we wouldn’t know about it.

Interviewer: Exactly, yes.

Respondent: When I started my training, well, the question didn’t arise until I was allocated to my stint in theatres. Student nurses used to do, and you must’ve as well, a stint of four weeks, or something like that, in theatres. I happened to be allocated to Gynae theatre. Now, some of it was really interesting as it happens, and I learned a lot. But one of the first things I was asked, after what my name was and was I happy with my off-duty was: was or would I be happy to take part in terminations, because they happened on Wednesday mornings in that theatre? I said, “I’m really sorry, I really wouldn’t like to take part in that.”

Interviewer: You were actually asked that by the person in charge?

Respondent: Yes, I was asked definitely, on my first day, and it was early in the shift. But, it didn’t feel formal or anything, because I was asked things like, “Are you happy with this week’s off-duty?”

Interviewer: Wow, that was nice.

Respondent: Which was very nice, but they were desperate to attract staff so they did try to be nice to student nurses. Then I was told various things about where the toilet is, where you make your coffee and so on in theatres. Then the question just… I didn’t feel as if it were a formal question, but it obviously was a formal question, [name of interviewer]. But, it wasn’t done in a formal manner, “Oh, would you mind taking part?” and I said, “Oh, no I really wouldn’t like that. I don’t like the idea of termination.” “Oh, that’s fine, the question won’t arise then. Wednesday mornings you’ll be in orthopaedic theatres.”

Interviewer: Well, a different experience for you.

Respondent: A different experience. So, I was asked and it wasn’t made an issue. In fact, the only time the question re-arose was when I was participating in a D&C with a gynaecologist, and I’d been allowed to be all scrubbed up and everything, and it felt such a big important role… I know now, or I knew very soon that a D&C was a very minor procedure, and that’s why I was allowed such responsibility.

 But sister was standing beside me and I can remember her saying to the surgeon, “And this lady definitely isn’t pregnant?” The female consultant said, “She told me she hadn’t had sex.” Anyway, that’s the point at which a little arm with a hand came out. I actually felt physically sick, [name of researcher]. A little arm with a little hand means there’s other bits and there was a baby in there. Sister said, “Oh, do you want to go?” I said, “Well, it’s started now. I think I’ll just sit there because it’s happened…”

 Anyway, the procedure finished and sister said, “I’m really unhappy you’ve been exposed to that.” I said, “I’m absolutely horror stricken,” because even though I was against termination I hadn’t quite pictured that when a termination occurred you would be able to identify identifiable bits. I know that’s a bit childish, because of course you would be able to identify bits [name of researcher]. I don’t know what I thought. I thought it would just be sucked out and it would be mush.

Interviewer: Well, if it’s early it would be but it sounds like it was post-12 weeks, at least.

Respondent: It definitely sounds post-12 weeks. It was reported to the School of Nursing because I’d said that I’d had an objection to taking part. I can remember my tutor seeing me at the next block, and I said, “Well, it happened. Sister had made it clear I didn’t need to take part, but once it started I thought there were more risks than if I got up and left.”

Interviewer: Interesting point, and it’s a really topical point.

Respondent: So, I have taken part in abortion [name of researcher], which is awful, but I hadn’t meant to take part. I didn’t feel as if I could walk out. Even though I was given the choice.

Interviewer: It’s obviously had a lasting effect because that wasn’t yesterday.

Respondent: Oh no, it was a long time ago, but I can actually still see it.

Interviewer: Okay, let’s not dwell on it.

Respondent: No, let’s move on. Thank you.

Interviewer: But, what you said was, “It had started.” Now, as you’re well aware, I think, most terminations now are a medical induction of labour, be it early on in the pregnancy or later on.

Respondent: I learned that in the small study I took part in with you, because I still had a picture in my head that whilst there were medical abortions that a large number would still be done surgically.

Interviewer: I’ve looked at the stats recently, but I can’t quite remember what they are. But definitely, definitely over 90% are medically induced.

Respondent: Well, I learned that from our study.

Interviewer: So, with that, and with your knowledge of physiology, obviously, that’s not going to be the five/ten minute job that the suction terminations were.

Respondent: We weren’t there long.

Interviewer: And more and more people are involved. So, if you’re in the clinical area now, what sort of part of that procedure people should be allowed to object to?

Respondent: It’s done with drugs, isn’t it, [name of researchers]? I’ve not seen it or read the protocol for it. If it were me, I don’t think I would want to be involved in preparing the drugs to give the lady or administer the drugs, because that’s doing the deed, that’s doing what the surgeon was going when I was inadvertently sat on the stool handing the equipment. So, I really feel strongly that no one who has an objection should be involved with the drugs, whatever they happen to be.

 Once they’ve been administered, I think, you shouldn’t have to- When I say, you shouldn’t have to look after the woman I don’t mean the woman shouldn’t be looked after, please believe me.

Interviewer: I do believe you.

Respondent: But, for the routine care I think it should be someone who doesn’t have an objection. I appreciate that’s putting on to someone something I don’t want to do. However, I do know if there was an emergency I would help. I think if it was the woman’s life and I was called for help, or a call for help went out and I was the only one loitering…

Interviewer: Chance would be a fine thing. (Laughter)

Respondent: Yes, chance would be a fine thing in a labour ward… I would have to answer the call because I couldn’t put her life at risk. However, I would still have a problem inside me thinking, “The reason her life is now at risk or she’s had a big bleed is because she’s undergoing a termination, which I object to.” So, that sounds a bit twisted.

Interviewer: That’s an interesting take on it. No, it’s not, but can we pad that out and tease it out a little bit more? Yes, you would help… I think what you’re saying is, yes you would help with the immediate first aid measures, but at the same time there’d be a feeling, “This should never have happened”?

Respondent: Yes, I would be feeling that. I hope that wouldn’t come over to the person, because I’m not sure I’ve got the right to make my views known to someone in that very vulnerable situation. I hope I would be able to keep my behaviour professional, but I think it would be professional rather than warm and caring.

Interviewer: Oh right, okay.

 So, given your own research, if you like, one of the key things that came out of your PhD was about communication.

Respondent: Yes, I hope my communication would be professional, “It’s okay Mrs Smith, there are four of us here now, we’re getting that bleeding under control, the surgeon’s on the way.” But, I’m not sure… I think I would find it hard to do the hand-holding and brow mopping. But, of course, if she grabs my hand I would hold it.

 But, I would find it hard because I know I would be thinking, “The only reason we’re in this situation is because that baby is being aborted.” I really do have an issue about that.

Interviewer: Well, clearly you have an issue from conception onwards.

Respondent: Yes.

Interviewer: Other people might say, “Right, I don’t think I could do a late termination, but I’m alright with an early termination.” How do you feel about the ethics about taking that sort of stance?

Respondent: I couldn’t, simply because I think once fertilisation has occurred the biological processes that form a baby are already underway, because the cells start dividing as soon as the sperm and the egg join. You know, the actual processes don’t wait for a period of time.

 How early would be early?

Interviewer: Yes, where do you make that cut off?

Respondent: Yes. I’m already sitting and thinking, if you want to identify guidelines when you have something like that… That already puts a grey area in. If the guidelines said, “Participation in early termination up to week whatever was decided…” would then someone be able or try to apply pressure to someone like me, who really doesn’t want to be involved in such a thing at all? Would there be pressure, “It’s only at eight weeks…”?

Interviewer: When it’s maybe 12. (Laughter)

Respondent: Yes, when it’s maybe 12. Again, you can’t always identify exactly when that point of conception takes place, and that’s why we have problems with due dates and things, isn’t it? It’s not exact.

Interviewer: It’s pretty good these days, but it’s never going to be exact.

Respondent: And babies grow at different rates and develop at different rates.

Interviewer: I’ll come back to that.

 You said a minute or two ago that you wouldn’t want to be involved with the drugs or anything. Now, pharmacists these days are being asked to prescribe the morning after pill. Is that something that you think they should be allowed to object to?

Respondent: I think so, because they would be handing over a pill, but that would be the same as me mixing up the intravenous drugs and putting up the drip. Yes, it’s quicker and easier. They’re opening the bottle with the pills in them and handing it over. I’m not a pharmacist, obviously, but if you were asking me, as a nurse, to administer that pill I wouldn’t want to administer that pill any more than I would want to mix up the drugs and administer them intravenously. It’s still the drug you’re giving, isn’t it?

Interviewer: Yes, absolutely.

 I think, for me, the grey area in that is that if you’re a woman that’s eight weeks pregnant, or whatever, comes to the abortion clinic and the nurse hands over the drugs, at that point they’re pills and later on they become intravenous… But, at the morning after pill, how many are actually pregnant? We’re never ever going to know that.

Respondent: That’s a good point. Here was me just assuming the morning after pill, because they’d had sex they… Well, they could be pregnant.

Interviewer: Of course they could be pregnant, yes.

Respondent: But you’re right, how many actually are? Some people are married for, say, three years before they conceive and they haven’t been taking contraception, and are wondering why they’ve not got pregnant.

Interviewer: Yes, for me it’s a grey area and it will always be a grey area.

Respondent: That’s a good point. I didn’t even think of that, and yet I do know that it’s not 100% record.

Interviewer: Either way. (Laughter)

Respondent: Either way. Oh dear. But I wouldn’t want to be the one…

Interviewer: That might cause the…?

Respondent: That might cause it because she might be pregnant. Actually, even if she’s not pregnant, [name of interviewer], I’m not sure I would want to be giving those drugs, because they really are quite nasty drugs, aren’t they?

Interviewer: Oh yes, I think so.

Respondent: So, there have to be risks to her health in giving that drug anyway, apart from the fact that if she has conceived it’s going to remove the product of conception, as I dare say they would be used at that stage.

Interviewer: It’s an interesting one, isn’t it?

Respondent: Oh dear, now I’m starting to think, “Is it really a problem because it’s likely they’re not pregnant?” I’m still thinking they might be.

Interviewer: Yes, they might be, exactly.

 It’s not a judgement, it’s just a thought. For me, I was saying that this is a kind of grey area. I’m with you all along, if I were a pharmacist in the middle of nowhere, I’m sorry, I still wouldn’t be giving it, but…

Respondent: Yes. Are they expected to give it at the moment? Is this one of the jobs that you do if you’re working in…?

Interviewer: Some of the chains are quite open to conscientious objectors, others less so, from what I’ve been reading and what I’ve been hearing about. The pharmacists are as divided as everyone else on it.

 Interestingly, in the new Irish law there are named people that are allowed to be objectors, doctors, nurses and midwives, and pharmacists don’t come into it.

Respondent: Oh, well if they’re expected to give drugs I would’ve thought that should be extended to them as soon as possible.

Interviewer: You know how in hospitals these days it’s a bit different from our day, remember the days…

Respondent: I’ll pop your Zimmer in the corner there. (Laughter)

Interviewer: A lot of the drugs get made up centrally, the combo drugs, you know, like for instance IV antibiotics are often done…

Respondent: Or chemotherapy and things for cancer.

Interviewer: Likewise with some of the abortifacients.

Respondent: Oh right.

Interviewer: So, a pharmacist may be asked to make up this drug but not for a specific person. They’ve got a supply of the drugs made up… What would be your thoughts on that? Not you personally, but should somebody- Well, use yourself and example if you want. Should somebody be allowed to object to that?

Respondent: I think they should be allowed to object to that because I can remember saying just a little while ago that I would have an issue making up the drugs. So, I don’t think I should then say, “Oh, but it’s alright for the pharmacist to have to do this.”

Interviewer: Even though they don’t know it’s for Mrs X?

Respondent: But they know it’s for Mrs Somebody.

Interviewer: That’s going to do the deed.

Respondent: Yes, because they are drugs that are only used for causing an abortion, aren’t they?

Interviewer: Yes.

Respondent: It’s not that they could say, “Oh, that could be chemotherapy.” No.

Interviewer: Some of them could be for postpartum haemorrhage, but, yes, I mean it’s…

Respondent: So, if I’ve got an objection to doing that… I would know who it was for but I’m not sure that’s a big difference. Expecting someone to make up the drugs knowing what they have to be used for, even though they don’t know, the lady hasn’t been admitted yet, but someone could be admitted this afternoon and be giving that. So no, I think they should be allowed to say, “No, I’m not making those drugs up.”

Interviewer: Right, okay.

Respondent: At present, what is the situation, [name of researcher]? Are they just expected to make up…?

Interviewer: That I don’t know because I haven’t read the transcripts, but I’ll tell you at the end of the study. (Laughter) I don’t know actually. I know somebody’s talked about it in an earlier transcript that I did read, because I read a couple of everyone to start with. I’m supposed to be reading through them all in two weeks’ time.

Respondent: Oh right, and then you’ll let me know?

Interviewer: I will. I’ll try my best to remember. (Laughter)

 The other things, even perhaps a bit further removed, in your day, when you were a student nurse, I guess, and that woman in theatre that you saw, others that you didn’t see, where obviously booked in to come for the appointment, they’d seen the doctors and they’d got the pharmacy-

Respondent: And they were admitted to begin…

Interviewer: What about taking them through the admission process of even booking them into be admitted?

Respondent: I don’t think I would want to book them in or admit them. I wouldn’t have a problem answering the phone to someone and saying, “Yes, your appointment is 10:00,” because it would be in the book. I think it would make life very awkward if I said, “I can’t take this phone call, it’s from [name of researcher] and she’s coming in for a termination.” (Laughter)

 No, I would take a call but I would rather not have to be the person who admits them, because I think it should be someone who is 100% on their side. I’m not on their side, [name of researcher].

Interviewer: So, again, with that sort of warmth and being with them.

Respondent: I do hope, like from my own PhD that my communication skills would carry me through, and I’d be polite, communicate well, give them the information they needed, assure them that a midwife would be caring for them throughout the process, which she would be. But, I wouldn’t want to be that person. I would like to be allowed to object to that, I would rather not have to do it. I don’t have a problem taking the calls and saying, “Yes, come in at 10:00, a midwife or nurse will admit you when you arrive,” but I wouldn’t want to be that midwife or nurse.

Interviewer: Now, supposing you were the sister in charge and it was a crazy morning… I know you’re not a midwife but imagine you’re a midwife on the labour ward.

Respondent: I’ve been on the labour ward as a student nurse. I had a lovely midwife that I always worked with, and we did have some very crazy mornings, as it happens.

Interviewer: So, your midwives are all allocated, they’re all doing their stuff, and this woman comes for her termination, booked two or three days earlier, she appears and you don’t have the resources to deal with her. What would you see as your involvement and how would you get round your own scruples, if you like?

Respondent: I would ask her to wait, obviously. I would see if I could do a spot of reallocation. If I was in charge of the labour ward I would hope that I would know the views of my midwives and any nurses that were giving supportive care. If there were any, and I would assume that there would be a number, who really didn’t have issues about abortion or anything else that happens on the labour ward, I would take over their role until they could admit her. She’s got to be admitted, but I’m sorry, I’d rather not admit her myself.

 If I couldn’t reallocate I think it would have to ask for some help, to have someone sent down because we needed someone admitted and no one was free. Once she was admitted, well, I wouldn’t be proceeding with the procedure, like administering the drugs or whatever, I would say, “I’m sorry, we’re extremely busy this morning, as you can probably see. I know that’s not your problem, but as soon as the midwife is free to get things started with you and explain exactly what’s going to happen she’ll be along.”

 So, I would ask her to wait.

Interviewer: There are two important things you said there.

Respondent: Oh dear, right.

Interviewer: No, it’s good.

 You were saying you would hope that you would know the views of your midwives and nurses, your staff.

Respondent: Yes.

Interviewer: Do you think that sort of thing should be made mandatory?

Respondent: Oh, what do you mean, [name of researcher]? That I should…?

Interviewer: I mean, nice to know and you might know informally that Nurse Smith is an objector, but do you think Nurse Smith should have to declare that she is an objector?

Respondent: That’s actually quite a hard question because-

Interviewer: Sorry, I know. You’re up to it though. (Laughter)

Respondent: Because when I worked in theatre as a student nurse I was asked on my first morning and I didn’t even feel that it was formal. But, sister must’ve been taking note and she must’ve asked every student or staff nurse who came to the area, “Do you mind taking part in terminations or have you an objection?” She didn’t bat an eyelid when I said I had an objection, and just said, “That was fine, it was Wednesday mornings and I would be allocated to another theatre.”

 So, she must’ve known her staff members and she must’ve asked every single student nurse that strolled through the door that question. And I didn’t even feel as if I was… Of course I was being asked a question.

Interviewer: It’s a nice way to do it, actually.

Respondent: It just felt perfectly naturally. It was part of, “The toilets are there, when you’re sent for a coffee it’s here, and we do the full gamut of gynaecology work, from very minor to very major here, I hope you see most of it. And, do you have an objection to terminations, because we do them on Wednesday mornings?” So, it didn’t feel like an issue.

Interviewer: I think it’s a very, very nice way to do it. I was more meaning, when somebody comes along looking for a job, as a midwife or as a nurse in a gynaecological area, should they be asked this? It’s a really difficult question.

Respondent: It is, because…

Interviewer: One of the more divisive ones, I might add.

Respondent: My concern, if it had to be asked like at an interview… I wasn’t just being-

Interviewer: No, it wasn’t an interview for you.

Respondent: No. I feel it could be used to select or deselect candidates. Just say it was, even inadvertent or not purposefully, but if sister, who would be one of the interviewers because it’s her area, was thinking, “I’m having a real hard job staffing this place. I need everyone to be able to do everything,” and it was asked, you could end up with a whole labour ward with everyone willing to do everything.

 I think you need to have objectors as well, because it gives a balanced view. I didn’t mind people knowing that I wasn’t going to do this, and there were others who didn’t participate as well. And it wasn’t an issue. But, I feel if the risk was raised, and as soon as you ask the question at an interview the risk is raised, that they won’t take someone who is not willing to do all aspects of care in that area, you could end up just with it being done in an unthinking way. It’s just routine. Whereas, if you have individuals who don’t do this and other folk know when you’re working there, it raises the issue to them that this isn’t just routine, some people do have an objection to it, and it raises awareness.

Interviewer: I think it’s a big thing in nursing and midwifery, to come back to the WHO term, we’re mid-level professionals. The doctors, once you get to registrar and above you can opt out very easily. Whereas, for us it’s not so easy.

Respondent: No, because you’re right there and you’re face-to-face. I wouldn’t have an objection if the lady has arrived in the ward, I would show her to her room and get the midwife who was going to care for her. But, I really couldn’t be the person that did it.

 So, I haven’t really answered that question, [name], that you asked.

Interviewer: I don’t think there is an answer, [name of respondent], to be honest.

Respondent: I would just be worried that if it were asked, that even if it was stated, “Oh no, this isn’t used to make the decision as to whether you get the job or not, the decision is on have you got a good reference, from the school if you’ve just qualified, or if you’ve got good references from previous places you’ve worked.”

Interviewer: I personally, if I were in charge of a hospital, I wouldn’t be asking the question at interview. I don’t think that’s fair. I would maybe take a census of my staff once every two or three years so that you know, but by that time they’re on the staff.

Respondent: Which answers my suggestion earlier, if I were the sister in charge I would hope I would know the views of my staff so I wouldn’t be asking you to do it because I know you don’t want to do that and you wouldn’t do it. I would hope I would know who is happy to offer care to that lady.

Interviewer: And also for rostering purposes.

Respondent: Yes, absolutely. But that’s different. I wasn’t anticipating it being done before they arrived, it was getting to know the staff as they came and were working with me.

Interviewer: I don’t know anywhere where it is done at interview, but remember the case of the Swedish midwife, she couldn’t get a job because her views were known.

Respondent: That’s right, so the judgement had been made and not only had she got the views she had had the courage to share them in an article. So, is she going to be trouble?

Interviewer: Probably, yes.

Respondent: But actually, she probably wouldn’t be because she probably was an excellent midwife and could deal with all other aspects of the work.

Interviewer: Of course.

 I mean, looking at the stats we got so far it’s like 0.33% of people are objectors, so it’s not a big deal.

Respondent: Oh my goodness. Which makes me think, “Why has it become such an issue then?”

Interviewer: Well, it’s good question, but before we get to that I might pick up on something else you said, it was you saying you felt you could do A, B and C but not D and E. Is that what you see as referring or…? Do you feel there’s a duty to refer, I guess?

Respondent: Yes, if I can’t do it… I can’t do it…

Interviewer: (Laughter)

Respondent: No, I couldn’t do it, but I think I have a duty to know of someone or to get someone to care for the individual.

Interviewer: Is that because, of something else you just said, they’re physically present, the woman is there, she has her appointment and she has come in? It’s very rarely an emergency procedure. She’s there and you’re there, you’re the nurse and therefore you have to deal with that immediacy.

Respondent: Yes.

Interviewer: Right. But, if you’re the doctor, and in this country still two doctors have to sign the form, and you physically can’t sign the form, do you think you, at that point, have a duty to refer her to somebody else or just say, simply, “No, I can’t”?

Respondent: One side of me thinks, “No, I can’t.”

Interviewer: (Laughter)

Respondent: But, I’m then thinking, “She’s probably pretty desperate if she’s sitting in front of me asking for such a drastic procedure, although she might not know it’s a drastic procedure…” I think, professionally, there is some duty to refer her. If it’s GP’s, GPs in a practice do know who does what, like who looks after most of the pregnant ladies, who deals with diabetes most often, apart from the practice nurse…

Interviewer: (Laughter) Yes.

Respondent: But, they do know what each other’s specialists are, and their interests, and I would’ve hoped they would know their views on things like abortion. It’s going to happen in a GP practice, a patient is going to come in and say, “I’m pregnant and I don’t want to be, I wish to be referred.”

Interviewer: Yes, I know in my GP practice it does happen because one time I went along and this woman in her 50s, I guess, was the doctor who was there. I didn’t know her from a bar of soap but she called my name and she said, “I want to congratulate you on that article on conscientious objection.” I’m going, “Right.”

 It turned out she was an objector so she got talking about it and said, “When they employed me here they asked me,” and she said, “I said I couldn’t and I wouldn’t.” And they said, “That’s alright, we can cope with one and we haven’t got one at the moment. So, fine.” So, they actually asked her before they took her on. She was a locum… So, there are ways.

 It’s a thing I struggle with, the referral, are you condoning the act by referring it? I think that’s what you’re saying.

Respondent: That’s right, yes. Half of me is sitting and thinking, “Maybe you are condoning the act by referring,” but if I say, “No, I can’t do it,” they’re desperate already and they are going to go somewhere else.

Interviewer: Yes, they’re going to do it anyway and maybe kill themselves, which is not the…

Respondent: Which is not the purpose of…

Interviewer: That’s why the Act was passed, wasn’t it, to try and prevent these maternal deaths.

Respondent: That’s right.

Interviewer: Okay, now you just said something else that slipped my mind, what was it?

 It was a minute ago.

 We’ve talked about referral. We’ve talked about… Something you said and I said, “We’ll come back to that.”

 No, I can’t remember.

Respondent: Not about answering the phone?

Interviewer: No, no.

Respondent: Or taking the woman to the room and getting someone to come and care for her?

Interviewer: No, it was something much more deep and meaningful.

 Never mind.

 [End of fi54c5b5 -- Nurse - Natasha pt1.MP3]

 [Start of fia4330d -- Nurse - Natasha pt2.MP3]

 [0:00:06]

Interviewer: It was just before we were talking about referring, and should they be allowed to be objectors. What would you say, in the future, like the NMC and certainly the RCM to some extent have been trying to do, not so much the RCM, but, “You shouldn’t be objectors.” Would you say that, in the future, and given our high termination rate in this country it’s a strong possibility, that we should not allow conscientious objection?

 They’re talking about changing the law. Do you think that would deprive us of quality staff or do you think, “Right, that’s the nature of the beast, you have to do it”?

Respondent: Oh no. I thought it was one of the human rights to be able to refuse to take part in something that you were morally against?

Interviewer: It is.

Respondent: Not just that you didn’t fancy doing that wee job but that you had moral objections to it. I did think that that was one of the human rights.

Interviewer: Indeed it is, and that’s the grounds that the Swedish midwife is now fighting it on at the European Court of Human Rights.

Respondent: I think if you make statements like, “If you want to do midwifery or nursing you cannot have a conscientious objection to termination or other medical procedures,” for example, if they stopped a conscientious objection to abortion, and I’ve got a big issue with that, I would also have a pretty big issue if they said, “You can’t object to taking part in euthanasia.”

 I wouldn’t be taking part in euthanasia either, on the same basis of thou really should not kill.

Interviewer: Yes, and that’s one of what we said the study would do, inform that debate, hopefully, for the future, one way or another.

 Right, you’ve raised a point that was the final one I was going to ask you anyway. That’s a sort of, for want of a better word, absolute objection. Yes?

Respondent: Yes.

Interviewer: Life is life, from natural conception to natural death. Okay, fine. What about people that may object in some circumstances, like say they object to social abortion but not abortion on grounds of a severely deformed foetus, or something like that? Should that be allowed? Not, should it be allowed but you know what I mean.

Respondent: Yes, but again I think if I were the sister in the area I would want to know that there are some, like us, who will not take part in abortion full stop. But it would be very beneficial to me, or whoever was organising the rota or the care, to know that certain members of staff, whilst they object to social abortion, if a lady is carrying a severely handicap child they’re happy to take part in that case, I would want to know. It’s a very pragmatic issue. That would allow me to know who is happy to do what in what situations, and I can allocate them appropriately.

 I wouldn’t want to be taking part in that abortion either, but if someone was happy to do so, but normally they would not be happy to take part in abortions, if I knew that then I could allocate appropriately and not cause them anxiety in their workplace.

Interviewer: Yes, exactly. Or anyone else.

Respondent: Yes, or anyone’s else anxiety. (Laughter)

Interviewer: And you’d want a nice mixture?

Respondent: Yes.

Interviewer: Just to go back to what we were saying earlier about not asking people at employment, supposing you found that… Say you worked in a gynae theatre- No, they’re not doing it.

Respondent: In labour ward.

Interviewer: Yes, and you couldn’t roster sufficient non-objectors to deal with the workload coming through. How do you handle that issue?

Respondent: I really don’t know. But, you said there’s only 0.33%?

Interviewer: At the moment yes, but that’s nationwide.

Respondent: But, there could be 22% in Glasgow, for example.

Interviewer: Yes, in the Queen Elizabeth where they’re doing the bulk of them.

Respondent: Actually, the percentage could rise in areas where they’re doing lots because people start to see and think about what they’re actually doing, and could change from being non-objectors to thinking, “I really shouldn’t be doing this, or we shouldn’t be doing this.”

Interviewer: Yes, and what happens now? It’s a very, very good question. I think I will go back to the Head of the [name of abortion clinic] that deals with the terminations, because she’s very tuned in to conscientious objection, and ask her what would happen in that instance. Because people do change, in both directions.

Respondent: Oh yes, they do.

 I can’t actually answer that. What sort of participant am I? Oh dear…

Interviewer: Oh, you failed. (Laughter)

Respondent: Failed.

Interviewer: No, not at all. There are no right answers to these questions.

Respondent: That’s what makes it so difficult, isn’t it? But surely if the views of staff are obtained in a nice, friendly, open manner, not at interview because how awful would that be? If views were known and shared… I don’t mean sit and discuss them, but just it’s known that these two girls don’t participate in abortions, but my goodness they do everything else… And in normal circumstances there shouldn’t be a problem with the rota.

 The situation you suggest is exceptional, but I appreciate it could happen.

Interviewer: I hope it never does happen, but…

Respondent: I can’t think how on earth I would deal with that. I’d be thinking, “Uh-oh, we’re in real trouble now.” Would that be the situation when you would have to do what they do in general surgical areas, or cardio thoracic areas, and I’ve worked in both of those areas, when the patient is sent home because there is not the staff to care for them?

Interviewer: Yes.

Respondent: And a new appointment made.

Interviewer: I think it possibly would have to be. I’ve never ever seen it happening, but then I’m not in the clinical area.

Respondent: That’s the only thing I could think of, because it’s done in surgical areas all the time.

Interviewer: People get cancelled three or four times.

Respondent: That’s right. Admittedly, you can’t keep cancelling someone for an abortion because the baby is growing all that time.

Interviewer: Well, if some people get their way you’ll be able to do it right up to term, so you can keep cancelling them.

Respondent: Oh dear.

Interviewer: I know, we won’t get into the morals of the abortion process itself.

Respondent: No thank you.

Interviewer: Is there anything I haven’t asked you that you felt I would be? It’s like an interview for a job, isn’t it?

Respondent: It is, isn’t it? I don’t think so. I think your questions have let me express my views.

Interviewer: I think so.

Respondent: I can’t think of anything else.

Interviewer: I’m trying to think of the Doogan and Wood case, and their 13 criteria. I think we’ve covered all of them, and more.

Respondent: I think we have, because one of the things in the case, I remember I was sympathetic for a lot of the things but not for not taking phone calls, for example. That’s like a receptionist in a GP’s surgery, “No, I can’t book you an appointment with the GP because you want to talk about termination.” No, the GP will deal with that when the lady gets in his office and the midwife will deal with the lady when I’ve booked her in, you know, on the phone. I’m not doing more than that. Just say you are in the office and you’re taking the phone cells, simply because you’re say in the office, it would be very disruptive to the work, if you’ve got loads of ladies in labour at the time, to say, “I can’t take this call, can you come out and take it?”

Interviewer: Yes.

Respondent: No, I just… And it’s not a direct part of the procedure.

Interviewer: No, it may never result in the procedure itself anyway, so…

Respondent: Yes, well it might well not result in the procedure.

Interviewer: So, okay, let’s quite it. I’ll turn the thing off. Thank you very much indeed.

Respondent: Thank you for giving me the opportunity to talk about it.

 [End of fia4330d -- Nurse - Natasha pt2.MP3]

END AUDIO

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