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START AUDIO

Interviewer: And that one should be going.

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

Respondent: I’m a nurse in gynaaecology, so we deal with any gynae issues from women who are being sick because they’re pregnant, through miscarriages and terminations, to older women who have problems with prolapses and such like, and two gynae cancers that we do, primary surgery, palliation and death for those people.

Interviewer: How long have you been doing that for?

Respondent: Nearly 15 years.

Interviewer: So, quite a while. Do you enjoy it?

Respondent: Yes.

Interviewer: It sounds like quite a mixed bag.

Respondent: It is, a very mixed bag, very.

Interviewer: No two days the same. (Laughter)

 So, can you tell me in your role is abortion something that you come across often?

Respondent: It’s not very often, but it is often enough. We tend to do the later terminations because we have a ward here that does terminations, but they only do, I think, up to nine weeks.

Interviewer: Oh right, okay.

Respondent: So, after that they come to us. We don’t administer the first pill, the Mifegyne pill, that’s usually done in the emergency room or in the abortion service, and then they come to us for the pills that open the cervix and get rid of the pregnancy.

 Also, we do terminations for girls with foetal abnormalities. We do the occasional foetal abnormality here, but it’s not as much.

Interviewer: How do you feel about that? How do you feel about being involved in abortion?

Respondent: It’s something we have to do, but I don’t think it’s anything that anybody on the ward likes doing.

Interviewer: Can you tell me a bit more about that?

Respondent: Because we have this combination of women, we’ve got IVF ladies… We’ve got two ladies on this morning who’ve got in for egg collections for IVF, and then you might have, next door to them, someone who’s having a termination. So, you’re going in and out of these poor women who can’t have babies, then we’ve got women who are losing babies and then we’ve got these girls who… You know…

 It is difficult. I think it’s difficult because you think, “Why is it still like this?” In the ‘40s and ‘50s, when girls had no other way, they went to awful people who did awful things to them, or they did it themselves, they put coat hangers up to try and terminate themselves. But, it’s worse, I think, than it was.

Interviewer: In what way?

Respondent: In that it’s almost like it’s a contraceptive with some people. I don’t know how you get around that, because there are girls who get themselves into trouble, we know that there are always going to be those girls who, for one reason or another didn’t mean to do what they did and have ended up pregnant. Often they are late pregnancy when they actually come in the end because I think they’re not looking to be pregnant.

Interviewer: I see, so maybe shying away from it and hiding it from themselves?

Respondent: Yes, and maybe hiding it even. Especially the younger girls, they’ll be hiding it from their mums and stuff, you know.

 But, for the majority, it shouldn’t even be a necessity anymore. You know, there is that much stuff, it even comes on adverts on the telly now, doesn’t it, about contraceptives and stuff. So, they can’t say they don’t know. I think.

 For most of the girls I think they feel a bit, “Why?” You know, “Why is it even needed?” I know there are ethics around it and all that, but why is it needed the way it is? Some girls will have files this thick because they’ve come in that many times, and it is almost like a contraceptive.

 I think that’s distressing because you think, “The poor little baby,” because we have to birth them. They come in 10 to even 18 or 19 weeks, and you’re delivering a baby, maybe 2cms maybe 6cms or 7cms, but, none the less, they look like babies.

Interviewer: Really? When they’re that small?

Respondent: Yes. When they show you things on scans you can see that, you know, the little baby shape with the legs and everything. So, that’s what we’re delivering. That’s what we’re taking away from them. You can’t show your distress. You can’t show that you don’t like it. You know, you’ve got to go in and be nice to these people even so.

Interviewer: How do you do that? It sounds like you’re saying although you find it distressing you put your beliefs to one side and still give your patient care. How do you resolve that conflict, I suppose?

Respondent: I don’t think you do resolve it, really. You take a breath, you go in, you’re nice to the girl and to her fella. You say, “How are you doing?” and then we try to give contraceptive advice, that’s supposed to be part of our care plan, to give contraceptive advice, “What are you going to do?”

 Recently I’ve had two 16-year-olds, and when I’ve asked them what they’re going to do they’re very cocky.

Interviewer: Oh really?

Respondent: Yes, very.

Interviewer: How did you feel about that?

Respondent: I thought, “It’s not on that, is it? It’s just not on.” It’s like it was nothing. Like the child was nothing. Like it had no meaning at all. The little life that they’ve just got rid of because it didn’t suit them. “What are you going to do about contraceptive?” “Oh I’ll sort that out.” Sitting with their mums, mums don’t obviously… I mean, if she’d have been mine, one in particular was really bad, “If you were mine there’s no you would’ve just said what you’ve just said.”

Interviewer: It sounds like they don’t even quite understand the gravity of what they did?

Respondent: No, it didn’t mean anything. It meant nothing.

Interviewer: It sounds quite difficult really.

Respondent: Then you could have a girl who’s just lost a baby sitting next to her.

Interviewer: It’s like complete extremes isn’t it, of experience?

Respondent: Yes.

Interviewer: So, as you know, this project is looking at to conscientious objection to abortion. Sorry, I should’ve said earlier on, I’m going to be just referring to my little prompts.

 What do you think constitutes conscientious objection to abortion?

Respondent: I think it’s anybody who objects to abortions should be able to conscientiously object. I know they say it’s religious and all that kind of stuff, but I don’t think you have to have a particular religious view to have an objection to something. I don’t particularly like abortions, and I understand people who say ‘pro-life’ and that kind of thing, I do understand what they say. Sometimes the girls will say, “It’s better off, because what kind of life would it have had?”

Interviewer: Right, so the social circumstances that that child would be brought up in?

Respondent: What they call social circumstances, yes.

 If it’s for severe abnormalities and the mum and dad have thought, “We can’t really do this,” especially some things where the child is going to die either just shortly before or shortly after birth, I can’t see any objections to that. I really can’t. I can’t see how people could object to that. It’s distressing the mums, and the dads don’t want to do what they’re doing. To say, “I object to that,” I think that’s totally unfeeling towards what people are going through.

 But, for what they call social, I think there should be some restrictions on what goes on, how many you get for nothing on the NHS or whatever. But, as far as conscientious objections are concerned, doctors conscientiously object…

Interviewer: Have you had experience of that here or anywhere else?

Respondent: Oh yes. Oh yes, definitely.

Interviewer: Can you tell me a bit about what happened?

Respondent: When they come into the emergency room they get given a tablet called Mifegyne, which, effectively, stops the pregnancy. Two days later they’ll be admitted to the ward for, what everyone says is, the rest of the treatment. We have a tablet called Misoprostol, which softens the cervix and starts contractions. Effectively, when they come to us… Really, it’s the emergency room girls who are doing the worst bit because when they come to us that pregnancy has been stopped by the first tablets.

 But, the way our computer system works is the doctors prescribe in the emergency room for when they come in, but it never comes through onto the computer on that day. It can be seen in the process and orders section, but it doesn’t come through to the bit where we actually dispense. So, then you have to find a doctor who will re-prescribe. I have had, on occasions, on one very good occasion I had all but one doctor in this hospital wouldn’t prescribe.

Interviewer: What happened there?

Respondent: Some Muslims who are just like, “No,” they won’t do it. But not all Muslims. “We don’t do it. I don’t do it. I don’t do it.”

Interviewer: So, do you think that’s religious for those individuals?

Respondent: They’re just like, “I don’t do it.”

 So, I had three doctors on the ward and a consultant, “I don’t do it,” off all four of them. I said to the consultant, “What about am I going to do? What about this woman?” This was actually a foetal abnormality girl, totally distressed as it was and then I can’t give her her tablets. They lie to their families and everything to come to do this, because it’s totally against their religion. They’ve done all this and they’re really distressed.

 The consultant said to me, “Try obstetrics.” I rang the obstetrics reg, “No, I don’t do it.” The SHO, “No, I don’t do it.” The last doctor in the hospital, Saturday morning, was the obstetrics consultant and she said, “Yes, I’ll do it for her.” What she said was, “There are a lot of ethics going on up there.”

Interviewer: Oh really, and what were the ethics?

Respondent: You know, “I can’t do it because I…” They must hear this all the time, the doctors, because we are always having to do it.

Interviewer: Can you tell me about the impact that has on your ability to care for the patient?

Respondent: Well, it has a great restriction on how we can look after them because, in theory, they should come in about 9:00, be given their first set of pills after they’ve had some obs taken and you’ve had a quick chat to them, 9:30. And then they get given tablets every four hours after that.

 The theory of it is that after the second lot of tablets, so if you do 9:30 and 1:30 you give them the second lot of tablets… Hopefully before night-time they will have passed the product. If they don’t get started until 11:00 or 12:00, because I can’t find someone to prescribe, then all of that is put back. So, they can often end up for an overnight stay which, again, for the Southern Irish girls is a big deal because they come and they pay for what they get, so they pay for their overnight stay.

Interviewer: Of course, I never thought.

Respondent: They pay for being here, they pay for the medication and they pay for the overnight stay, which is only an overnight stay because the doctors have conscientiously objected to it.

Interviewer: So, it sounds like it has a huge impact on the patient?

Respondent: It has a big impact. It has a huge impact. Now, as nurses we’re told that we can’t conscientiously object anyway, even if we have objections.

Interviewer: Really? Who tells you that, if you don’t mind me asking?

Respondent: We’re all told the same thing.

Interviewer: Is that at interview, for example, or were you aware of that before you came to the job?

Respondent: Because it’s part of care, my duty is to do no harm and do good.

Interviewer: So, how does it make you feel that if you were an objector you can’t object, and your fellow colleagues can’t, but doctors can? How do you feel about that?

Respondent: On this instance, when I had this particular one. That was the worst one I’ve ever had. I did actually put in an ACE form about it.

Interviewer: Is ACE a complaint, is it?

Respondent: Yes, like an internal thing where if something’s gone wrong… And said that it wasn’t fair on either me or, more particularly, the poor woman who came for this procedure. I felt that they were putting her care in jeopardy and I wasn’t happy at all about the way everything proceeded and how late it was that the poor girl got the tablets.

 One of the doctors who then received a copy of this put an ACE form in about me, to say that I made her feel that she wasn’t doing the right thing for the patient. Well, that was exactly what I intended, she wasn’t doing the right thing for the patient. Even if you don’t agree with abortions, if two doctors have signed the piece of paper to say they can have it then they can have it. It’s not illegal.

 Whether I agree with it or not I don’t think actually comes into it. It’s something that’s done here. Why get a job in a [name of the hospital] when you know that there’s a whole ward where they do nothing but terminations? Also, that there will be terminations in the gynae ward. I don’t understand the idea of getting a job doing gynae stuff if you don’t like part of what’s done.

Interviewer: Do you see abortion as part of the care that…? I suppose, I’m thinking more about a midwife and obviously you’re a nurse so you deal with different gynae issues. But, do you see that people who may object should be aware of that before they come to the role, and maybe be a bit more cautious about what career paths they choose?

Respondent: Yes, especially if they’re doctors. Most nurses will put to one side their, whatever, dislike of doing that because it’s a legal procedure and because when the person comes into us it’s our duty to do what we’re told is no harm and to do good.

 So, if we let that woman know that we have total distaste for what she’s doing, well we are doing harm, aren’t we? Rather than trying to explain how she can end up not coming back here, giving good contraceptive advice, trying to encourage them to think about what they’re doing and how they’re doing it. Also, a little bit of a discussion around sexually contracted diseases.

Interviewer: I don’t really know how to describe it, not a them and us, that’s not fair, but it does seem that there’s one rule for nurses and midwives, and another for doctors.

Respondent: It is them and us.

Interviewer: I’m wondering what impact, when you do come across objectors, that has on staff?

Respondent: The nurses don’t like it because we do it. I mean, they’re not even giving the pills, all they’re doing is typing it in on a computer, they don’t give the pills. So, they don’t do the nasty bit. They don’t look after the patient when she’s passing the products. But, they are allowed to say, “I don’t.”

Interviewer: Do they get asked if they’re an objector before they are employed, so that you, as a member of staff, know, “Don’t ask Billy-John because Billy-John won’t do it, but Joseph will?” So, you are kind of able to work around it.

Respondent: I think we know by looking at them, really. That’s probably not a good thing to say, is it? Because the women are primarily Muslims, which is fine, I have no objection to them being Muslims if that’s what they want to be. But, I don’t think that should have a knock-on into what we do in the hospital. It’s part of what the hospital does, whether we like it or not when we work here shouldn’t come into it.

 I don’t like it on the basis of seeing other people struggling to have babies, you know… And I know that there are times when people get pregnant when they didn’t mean to, and, of course, for girls who are raped if they end up pregnant there’s no question about that. But still, that would be a conscientious objection to somebody else, they would say, “Even so…”

Interviewer: There are no exceptions to the rule.

Respondent: No exceptions, except for the life of the mother. I think the make exceptions for that.

Interviewer: That’s firmly in law, isn’t it?

Respondent: If the mother’s life is in jeopardy by keeping the pregnancy then I think their conscientious objections go out the window then. But otherwise, regardless of how the girl got pregnant, they will say that they won’t prescribe.

 I just feel, if that’s the way you feel you shouldn’t work here. It’s not like at a different hospital in area not providing maternity or at yet another hospital in area that provides maternity services where they do maternity, so they do pregnancy, they do pregnancy loss and they do abortions over there. But, you can be in the rest of the hospital, if you get a job in another part of the hospital, but you can’t do that here.

Interviewer: No.

Respondent: As they learn their trade they do obs and gynae here, that’s what they do. So, they stay here and ask to come back again. I mean, gynae is all very interest and all that stuff, but part of what’s done in the hospital is terminations.

Interviewer: It sounds like you see it as part of the spectrum of the job role, you can’t pick and choose what aspects you do.

Respondent: It’s part of the hospital. It’s part of what’s done. If you don’t like it you shouldn’t do it, you should go and do some other kind of doctoring.

Interviewer: Sorry, just to go back, do they get asked whether they’re an objector or not?

Respondent: I don’t know.

Interviewer: Have you ever discussed it with someone who is an objector, what their reasons may be or anything like that?

Respondent: On this particular occasion I said, “I don’t understand you.” I said, “I don’t understand this at all. You work here but you object to part of what happens here.” “We’re entitled to, we can object if we want to,” was the answers.

Interviewer: So, there was no discussion about it?

Respondent: No, “Hey-ho.” They are allowed to object, but I don’t think they should put themselves exactly in the firing line if that is a big objection to them.

Interviewer: Do you think nurses and midwives should be able to object if doctors are able to?

Respondent: Well, if we did then we’d only be putting more jobs onto one of our other nurses, wouldn’t we? So, if I said, “I object to doing that, you’ll have to give her the pills. She’s in my team, but you’ll have to look after her,” then I’m giving somebody else work to do. I think that’s ethically incorrect, actually.

Interviewer: It sounds like you’re worried or you’re concerned it would be affecting the wellbeing of your colleagues really?

Respondent: Yes. Because why should somebody else have to do something that I say I won’t do? I mean, there are occasions when people shy away from certain things, if one of the girls has had problems with having babies themselves or maybe miscarried then we would expect to move across and away from that for a little while whilst…

Interviewer: It’s just compassionate really. (Laughter)

Respondent: You know, while she healed herself, and for her not to have to do those things. That would be fine and we’d agree that between us, that that wouldn’t happen.

 If somebody’s had a family loss then we try to not have them looking after someone who’s in the hospital and probably going to die.

 So, you know, we kind of look after ourselves like that. But when it comes to the terminations like this, you know, doctors can just say, “No, I don’t want to do it.” If I said the same thing then I’d only be putting it on you. How is that ethical? In any case, it’s not ethical for me to say, “I don’t like shooting people but you can go to war and shoot him for me.” Why is that ethical? It’s not ethical.

Interviewer: No, I see where you’ve coming from there.

Respondent: So, if they have real ethical grounds for not doing something which is normal practice in their working area they shouldn’t work here whoever they are, nurses, doctors, whatever they are. They shouldn’t work here.

 Pharmacists have to dispense the stuff. You know, midwives have problems with later terminations than what we do. Midwives will see women in tears because they’ve lost their little babies and they’re birthing a baby that’s big enough to be a baby. There is all kinds that goes on here. And it is part and the parcel of this being a referral hospital, that women are secure and safe with the procedures that we do and we get paid for.

Interviewer: It sounds like you’re saying that, actually, it’s your duty of care, really, to not only the patient but also to your colleagues?

Respondent: Yes.

Interviewer: You mentioned earlier on that you don’t like it, and I understand why. It’s easy for me, I’ve never seen a termination or an abortion. I’ve never seen what happens. You know, I likely probably won’t. It’s easy for me to be able to gloss over it a little bit. But, how would you identify yourself? Would you identify yourself as someone who does object or someone who doesn’t?

Respondent: Probably nearer objecting, but on the grounds that it’s not a contraceptive rather than… I do think that some babies are better off not born.

Interviewer: What would the circumstances around that be?

Respondent: To do with the way that the parents are. I can’t do anything about that.

Interviewer: No, it’s quite a sad testimony of the world we live in, really, isn’t it?

Respondent: Yes, it is part of the way we live. You know, girls think a lot less of themselves now, I think. We talk about emancipation and all that kind of stuff; I think they think a lot less of themselves now than girls did when I was young. They’re talking to people on the internet that they don’t know, about things that even close couples may not even talk about.

Interviewer: Yes. (Laughter)

Respondent: Getting involved with people that they don’t know and having sex with these people when they don’t know anything about them. Men still don’t like to wear contraceptives if they can get away with it, so you’re looking at sexually transmitted diseases, you’re looking at possible cervical cancer and vulvar cancer in their later age, pregnancies when you don’t want them, all because there isn’t a proper relationship between people and they don’t say to these men, “No, I’m not doing that. I don’t want to do that. If we’re going to do it then we have to do it as a measured thing and we have to think about how we’re not going to have babies. How many women have you slept with before? Where have you been?” basically. They don’t know where these people have been.

Interviewer: (Laughter) Oh I know, I remember my mum saying to me, but it’s true, “You’ve got to remember whoever you’ve slept with; you’re sleeping with whoever they’ve slept with.” And it horrified me. (Laughter)

Respondent: Yes, and it’s true. That’s how HPV virus passes from one to another, without anyone knowing they’ve got it, until they either get cervical or vulvar cancer, and it’s in nodes, or genital warts even, it’s horrible.

Interviewer: (Laughter) So, it sounds like a limitation for abortion for you would be the women that come back and back and back, and who do use it as a form of contraception?

Respondent: Yes, I don’t like that at all. I don’t like it.

Interviewer: Have you ever objected yourself in your career?

Respondent: No.

Interviewer: Is that because you can’t or…?

Respondent: It’s because I feel that part of my job here is to do what the hospital does. If I fully objected to it I wouldn’t work here. I love all the rest of it, I especially love the oncology, but it is part of what we do and it’s always been part of what we’ve done. The abortion clinic has been here as long as the hospital. So, it’s always been a part of what’s happened here.

 I do think there needs to be better education, not around what sex is but what sex does. I think girls now know all about having orgasms and stuff, but they know nothing about their own bodies. They know nothing about what can happen to them. They don’t understand the seriousness of having a termination, if it went wrong it could mean that they could have to have surgery. If the surgery went wrong then they could, very easily, lose their womb and lose their capacity for childbearing in later years. None of this seems to get anywhere near the psyche.

Interviewer: Do you think it’s the young people… I’m saying young people and that’s not fair. Women don’t want to listen or do you think that’s just the way of the world today?

Respondent: A bit of both, I think. I think people don’t want to hear that there might be consequences to lots of things, not just sex, lots and lots of things. These are having sex… And this probably sounds like a terrible thing to say, but when I was young there was no way that you brought a man back to your house and had sex in your house where your mum and dad lived. Not in this world. People didn’t have cars then so there were no cars to be having sex in. So, the ease with which people can actually find places to have sex now… I don’t think they think of the consequences at all.

Interviewer: It’s funny you say that, my mum takes great joy in telling me the only reason why she got married at 18 was because she wanted to have sex. She’s been with my dad, actually, 50 years on the 9th, but… (Laughter)

Respondent: She’s probably, along with me, the only virgins in the place. I was a virgin when I was married. It doesn’t happen very often.

Interviewer: So, you’ve mentioned religion around conscientious objection, but you’ve also mentioned your experience. What would you say has informed your beliefs around conscientious objection?

Respondent: I do have a religious belief which informs all of my life. However, I’m not a pro-lifer.

Interviewer: Is that like your religious beliefs just so happen to form-?

Respondent: My religious belief doesn’t give carte blanche to people about things like that. The church I attend would tend to say that all life is life. But, they would still give a proviso for certain people in certain circumstances. It’s not something that we would discuss as being a pivotal thing in what we believe. It would be a discussion with some people, just like, “I don’t think you should do it at all,” and others would say in the case of rape or if the mum’s ill, and other would say, probably like I do, that some children are better off never born.

 So, for me, conscientiously objecting wouldn’t be what I did anyway, I’d just object because I don’t think that it should be something that you just get on the NHS for as many times as you like. People can’t get IVF like that. The opposite end of the thing..

Interviewer: Spectrum, yes.

Respondent: They can’t get that on the NHS in this way. They spend absolutely fortunes to try and get themselves a baby. Some of these girls that we have just.. I don’t know what they think. I try to get them to talk about it, most of them won’t engage. “What contraceptive do you use? Will you be going back on that contraceptive? Have you thought about sexually transmitted diseases?” Most of them just are like, “Oh well… I wasn’t using anything because I was just at a party.” “Did you not think that…”

Interviewer: Quite laissez-faire.

Respondent: Yes.

Interviewer: So, what would you say has helped formed your views around the issue? Would you say it’s your experience more or your religion more, or a combination of the two or neither one really?

Respondent: A combination, I think. A combination because I do believe in the sanctity of life. I don’t believe in bumping people off because I think that’s open to a lot more holes than terminations are. (Laughter) So, my religious beliefs do have a knock-on into work, but there isn’t a strict yes or no about it, as in if I was Muslim.

 I do believe that when someone comes in for a termination, if two doctors have signed it then perhaps we need to go back to the ‘if’ about the doctors signing. If two doctors have signed the sheet to say that someone has social needs… Social needs used to mean that the poor woman was 45 and had 10 kids already. That’s where it started from.

Interviewer: Oh really, I didn’t realise.

Respondent: Social needs didn’t mean, “I don’t want it.” Social needs were to do with needs with your social situation, which isn’t the way it is now. Abortions were meant to be for people who either were ill or absolutely their mental health was going to suffer if they had anymore children.

 I think it’s probably very difficult for anyone now to understand what it was like in the ‘50s, ‘60s, ‘70s even. When they first started giving the pill it was only for married women, and you had to give a good account of yourself before you got it, even as a married woman. So, there was nothing there for girls who, for one reason or another, had gone and got themselves into trouble, and the man wasn’t going to stand by them. That’s not the case now. It’s not the case.

Interviewer: It’s really changed, hasn’t it?

Respondent: The whole of life has changed in the years since terminations started on the NHS like that. Social isn’t what it is.

Interviewer: So, what was your view on abortion before you came into the nursing profession?

Respondent: Similar I think. I think very similar. I could see the point of some terminations. I just don’t think that it should be allowed to just carry on escalating the way it is.

Interviewer: It sounds like your view is quite pragmatic, and I suppose realistic, really. But, like you say, coming back to those young- Well, women. I keep on saying ‘young women’, that’s terribly unfair. Women who bounce back and forth and use it as a form of contraception, that’s your limitation?

Respondent: Yes. And I can’t get my head around those ones.

Interviewer: Have your views changed at all as a nurse?

Respondent: I don’t think so. I don’t think they’ve changed much, to be honest. Think I already thought mostly what I think now. That termination is done by professionals was a good idea for women who either couldn’t cope or were raped, or whatever, really bad situations that they were in. I mean, girls used to get thrown out of their houses in the ‘50s and ‘60s, “If you keep that baby you’re out.” And parents would put them out.

 There was a girl who lived nearby me who was sent to a Catholic home in Wales and told not to come back with the baby. If she came back she couldn’t come home.

Interviewer: It was very strict, wasn’t it? Very different.

Respondent: So, the whole thing is different, isn’t it? The whole social thing is different from when they started it. I think it’s mainly just stayed the same. The rule has stayed the same whilst the lives have changed completely from where the standpoint was. There were women who did abortions for people…

Interviewer: Backstreet, yes.

Respondent: And there were doctors who’d give you pills and stuff to try and… But that was all under the radar stuff.

Interviewer: Yes, I remember my mum telling me.

Respondent: You know, women ended up with infections in their wombs, tears in their wombs, bleeding so that they nearly died…

Interviewer: It’s horrific, isn’t it? Absolutely awful.

Respondent: To keep those kinds of things from happening, yes, I think that’s essential. But the way people look at sex and having babies outside of marriage, and all that kind of stuff, now has changed so much that those things are not even the same. It’s nothing to do with it, it’s like a rule that’s okay for something that didn’t even happen before.

Interviewer: It sounds like you feel that people need to take responsibility for their own social actions?

Respondent: They do, yes. They do.

Interviewer: What do you think are the limitations to participation in abortion, because this project is around conscientious objection and trying to identify, I suppose, at the point where it would be acceptable to object? At the moment the guidelines or the law is quite woolly, there is a clause in there that gives health professionals the right to conscientiously object. It’s slightly different in different areas, so, I believe in Scotland, and don’t quote me on this, but if a case did go to court they have to always prove why they objected.

 So, we’re trying to identify the limitations of abortion. What limits would you put on yours or other people’s participation in abortion, if any?

Respondent: I think if you work in an institution like this then there should be none. You chose to work here. I chose to work here. I knew there were terminations done here. I chose to work here. Doctors choose to work here. It might be that they say to themselves, “Oh, but I like doing this and I like doing that,” “Well, yes, that’s fine, and I like looking after ladies who’ve got cancer, but that’s not the limit of my job.”

 You know, I can’t pick which patient comes in that day and say, “Oh know, she’s not a cancer patient, I’m not looking after her.” So, why should doctors be able to work here and say, “That’s a patient coming in for a termination, I’m not looking after her,” because that’s essentially what they do. They say, “It’s nothing to do with me. I’m having nothing to do with that.”

 I think, if you take a job in an institution like this… Well, you wouldn’t go and work in BPAS if you didn’t like terminations, would you?

Interviewer: Well, you’d hope not. (Laughter)

Respondent: You’d hope not, wouldn’t you, because you’d never sign anything for anybody, would you?

Interviewer: No, this is true.

Respondent: But, since we are aligned with people like that, you know… They do get on my nerves a bit here because the abortion clinic is on the same floor as me, on the second floor. I can get to that ward if I wish, through the doors. Patients can’t. A patient has to go in a different set of lifts up to a different door, as if they’ve come for a criminal thing almost. Do you know what I mean?

 There are those two lots of lifts up there, which are for going to either obstetrics or to gynae, fine. you can go to the IVF going up that one. But, if you’re coming for a termination or even to talk about a termination, never mind having one, you have to go through a lift that’s just here.

Interviewer: Oh gosh, like a lift of shame. (Laughter)

Respondent: Yes. Now, patients might not realise that, but I realise it and I think, “If we’re ashamed of them what are we doing even doing it?”

Interviewer: This has actually come up a couple of times in different interviews. Do you think there is a bit of shame around talking about abortion?

Respondent: Oh yes.

Interviewer: Here, in your experience?

Respondent: Yes. If it’s somebody who’s got something wrong with themselves or with the baby or they’ve been raped, then there would be no shame about it. But, what they call social, yes.

Interviewer: Are you able to identify the root cause of that?

Respondent: I think because people look at- There’s so much other stuff that goes on here about having babies, about trying to have babies, about losing babies, that I think the idea that then someone just comes and has a pill to get rid of a baby…

Interviewer: That’s quite difficult, isn’t it?

Respondent: When other women are struggling to keep hold.

 We’ve got a woman that’s just going for a removal of a miscarriage this morning. She opted to wait for another couple of days to see if, maybe, there was a heartbeat.

Interviewer: That’s so emotionally harrowing.

Respondent: So, you’ve got that lady there and you could have, next door to her, one that’s been in three times for a termination.

Interviewer: What would be your limit on…? You know, you say you’ve had experience of women with big files and that, what would be your limitation on the number of abortions someone was to have?

Respondent: If we could limit them to one. After you’ve been pregnant once you know how you got pregnant, and you should be able to then find out about not getting pregnant again, either by keeping your knickers on or going and getting something off a doctor. You can get contraceptive stuff free. It’s not like it’s going to cost you a fortune, you can get it free from the clinics.

 I think once you’ve been pregnant there’s no excuse.

Interviewer: It’s sort of lesson learnt.

Respondent: I mean, you can go to the chemist for the morning after pill now, you don’t even have to see a GP.

Interviewer: Do you see the morning after pill as abortion?

Respondent: I do actually, yes. It’s a possible abortion, isn’t it?

Interviewer: Yes, I’ve heard different scenarios.

Respondent: Because they don’t know whether they are pregnant or not. So, essentially, what they’re looking at is making sure they don’t get pregnant, I suppose, but in doing that cells are cells, if they get there and they’re doing what they’re supposed to be doing. So, essentially, you could be killing that pregnancy. But, they could do that on day one, rather than wait until week ten.

Interviewer: Yes, I see where you’re coming from there.

Respondent: Day one you’ve got a multiplicity of tiny little cells. They’re not actually anything yet. If you were a Roman Catholic or a Muslim you would say that at the moment of conception they were, you know… But, whilst they’re just a couple of cells most people would say that that’s more acceptable. It’s definitely more acceptable than killing off a 10-week or 12-week pregnancy, or sometimes 18-week pregnancy.

Interviewer: Have you ever refused or considered refusing taking part in abortion?

Respondent: I’ve never refused.

Interviewer: Have you ever considered it or wanted to, maybe, because you know you can’t? (Laughter)

Respondent: I’ve thought on occasions. I have thought on occasions, “Why do we have to do this?” But, I think the girls in the emergency room have the bigger thing. I don’t know how they look at that. Maybe because they don’t actually see the termination come to its end, but they give the tablet that, essentially, stops the pregnancy.

 Have you got anybody from the emergency room?

Interviewer: No, is the emergency room in the abortion clinic Suite? No? Not yet, no. I won’t lie, I’ve had difficulty cascading the information about the study down. So, an email was meant to be sent. I believe people haven’t received it from the people that I’ve interviewed so far. But, we would be very interested, obviously, in interviewing-

Respondent: I think the emergency room is… Well, the abortion clinic nurses because that’s all they do.

Interviewer: Yes, day-in-day-out.

Respondent: Would be good people for you to speak to, but the emergency room as well because of the tablets that they give before they come up to us. So, my colleague is the emergency room manager, I don’t know who’s the manager in the abortion clinic now.

Interviewer: That’s brilliant.

 Sorry, I’m just having a little look.

Respondent: Making sure you’ve asked me everything. (Laughter)

Interviewer: I think I’ve asked you this, what elements of the process do you think nurses should be able to refrain from, so I’m thinking about your role and conscientious objection? If you were a conscientious objector…

Respondent: Well, I think if you objected then the only thing you could really object to is giving the tablets. Anything else is patient care.

Interviewer: We’re trying to identify limits and the point that people would-?

 Actually, it might be a good point, have you heard about the case of the midwives from Glasgow at all?

 There were two midwives, it was in 2014, and they were objectors. They worked in a big hospital, I think it was the [name of hospital] in Glasgow, quite similar in terms of their maternity services, and where they worked didn’t perform abortions and then abortions were introduced. And so, they objected.

 They are practising Catholics and so they objected. They took the case to court. They won, up in Glasgow, but then they took that to the Supreme Court because, obviously, the trust wanted to overturn it. And they lost at Supreme Court because the judge rules that conscientious objection should be restricted to hands-on activities.

 So, they developed a list of 13 points, and it involved things like taking phone calls, and they considered that to be participation in abortions, so booking women in, supporting staff who may be involved in abortion… I’ve written them down, it’s a big long list. (Laughter) It really was a big long list. Providing guidance and advice and support; accompanying obstetricians; responding to requests for assistance or the emergency buzzers; acting as the midwives’ first point of contact; seeing how a patient was progressing; handovers and that type of thing.

 Would you identify any of those points as participation?

Respondent: I think once the patient has had the pills then after that everything else is patient care, isn’t it? You can’t just answer a buzzer and say, “Oh no, I’m not coming in here,” whilst a woman is sat on the toilet losing the baby, because she might start to haemorrhage. I don’t think you can step away from patient care.

 I don’t know where the doctors fit into that though when they object. I don’t know whether the doctors will still come.

Interviewer: Will doctors refer on when they object or…?

Respondent: Well, when they object to prescribing they don’t refer on. They just say, “I don’t do it.”

Interviewer: Really? What do you think about that?

Respondent: I think it’s terrible. I don’t think they have a right to say that. How do they have a right to say they won’t prescribe for something that’s a legal thing? It’s not illegal to do what the girls are doing.

Interviewer: I suppose their argument might be that conscientious objection is part of the law and under the law they’ve got a right to do that.

Respondent: Well, don’t work here then.

Interviewer: So, from their perspective they’re a conscientious objector, they don’t refer on… Sorry, if they do refer on would you see that referral as participation in the abortion process?

Respondent: I still don’t understand why they work here. I really don’t. And I’m not the only one who says that.

Interviewer: Oh no, I can imagine.

Respondent: I don’t understand why they work here when its part of what happens. I don’t know how much they get per termination, but there’s a ward open five days a week and so they’re getting a few bob in the hospital from the government for those terminations. So, you know, it’s not something the hospital is going to say, “Oh, we’ve got a few conscientious objectors, we won’t do it anymore.” Because it’s regular income, and all hospitals are run as businesses now and they have to look at their income, don’t they?

Interviewer: Yes, unfortunately. That’s the way the NHS is going, unfortunately.

 So, there are some places where a health professional can’t object, so I think Sweden and Iceland ring to mind, so it is unlawful. If you work in an environment like this you can’t conscientiously object no matter how challenging it might be. Then, of course, there are other places like Italy, where whole institutions will invoke their rights to conscientiously object.

 I wonder what your thoughts are on that?

Respondent: Well, if someone else conscientiously objects it’s still going to get done, they’re leaving you to do it, aren’t they? I don’t see how that is ethical. I don’t see how it’s ethical for me to say, “I don’t do that, you do it.”

Interviewer: So, would you say, in saying, “I don’t do that, you do that,” do you think that’s part of the process or do you think that’s…? I don’t know what [the other 0:52:13]-

Respondent: Maybe they don’t think that far.

Interviewer: Yes, maybe.

Respondent: Maybe they don’t, I don’t know.

Interviewer: Do you think that also cleanses them of that?

Respondent: I don’t see how by saying, “I don’t agree with doing something and leaving you to do it,” is ethical. It’s not ethical. If I think it shouldn’t be done then I should either not be here or I should do something about it not being done at all.

Interviewer: Do you think conscientious objection should be unlawful here, in this country?

Respondent: I don’t mind it being lawful, that’s fine, but then you should really be told that you can’t have a job in that place if you object to what they do. They’re passing it over to their other colleagues to do.

Interviewer: It sounds like you’re saying that conscientious objection can’t be realistically accommodated.

Respondent: I think it’s too hard to accommodate here. We don’t always have a lot of doctors in the night and of a weekend. We have a limited supply of doctors and if doctors won’t prescribe for someone who’s come in for a legal procedure then they can’t have that procedure. So, I don’t understand why, when they come for a job, they’re not told, “Actually, this is part of your work when they come here.”

Interviewer: Yes, I see where you’re coming from.

Respondent: If you go and work in a different hospital with the heart places and liver places and all that, you can get a job all over there and stay away from gynae. Some of them will say, “This is what I like doing,” “Well, so do I, I like parts of it but I don’t object to doing the other parts.” So, it is part of your job.

Interviewer: It sounds like you’re saying there shouldn’t be a situation where you can object, really?

Respondent: I don’t think they should be allowed to object, not here. Not here, where it’s in your face.

Interviewer: Is there anywhere rather where you do see the conscientious objection in…? I was going to say baby care, but that’s the wrong terminology, but in this kind of environment and in this sector of healthcare is there any area that you can see where it could be accommodated?

Respondent: Because it has a knock-on effect on other staff members and also to the care of that person, regardless of what you think about why they’ve come, then, no, I don’t think they should be able to object here. Because they’ve gone and got a job here… I don’t understand why you get a job doing something that involves doing something that you’re going to say, “I object to that.”

Interviewer: So, in any other areas in healthcare that do deliver abortions, gynae, deliver babies and care for women who are pregnant, do you think that they could be accommodated somewhere else?

Respondent: Not if they wanted to do gynae, no. I don’t think so because it’s all part of it. I’ve had one occasion since I’ve been here, a woman who came in to have a hysterectomy for cancer was found to be pregnant. So, in order to do that the surgeon had to get himself and somebody else to sign a thing for a termination because, effectively, they terminated the pregnancy as they took away the woman’s womb.

 But, if we conscientiously objected how would that have then impinged on that woman while we tried to find two doctors who would sign the piece of paper to say that she could have the termination, because he couldn’t take the womb. He couldn’t go and do the operation and take the womb without aborting the child.

 She didn’t know she was pregnant.

Interviewer: Oh, didn’t she?

Respondent: She was under 50, she didn’t know she was pregnant, and she had a cancer and it needed to come out. So, where would that have left us if there wasn’t enough doctors in to sign?

Interviewer: I can imagine, yes.

Respondent: If they were all conscientiously objecting, and there wasn’t anybody to sign the paper, he wouldn’t have been able to do the surgery for a woman who’d got a gynae cancer.

Interviewer: It sounds like you’re saying it significantly impacts on patient care.

Respondent: That could significantly impact on her care. Because what they’d have had to do then is they’d have had to say to the woman, “I’m very sorry, we can’t do the surgery today. We’ve got to try and get somebody to sign this paper and then we’ll bring you back another time.”

Interviewer: It’s very challenging, isn’t it? (Laughter)

Respondent: It’s very challenging. So, why would you get a job in somewhere that would put you in that position? They wouldn’t get a job at BPAS because they know that’s what it is. If you disagreed with ending people’s lives you wouldn’t go to Holland and get a job in one of those places where they do that. You just wouldn’t do it. So, why do it here where you don’t agree with terminations but you still want to work here, because you take on the nice bits with the non-nice bits here?

Interviewer: Do you think the way nurses here and midwives are told, “You can’t conscientiously object,” which to me is quite alarming because in law, strictly speaking, you could…? Do you think doctors should be told the same scenario as well?

Respondent: Yes, if you work here, if you want a job here… We are asked, or at least I was, about that on my interview. And everybody knows perfectly well that if they say, “I wouldn’t do terminations,” then the chances of you getting a job here would be very little. So, why they employ doctors who say that they won’t do it I do not understand.

Interviewer: Do you think they do get asked if they’re an objector?

Respondent: I don’t know.

Interviewer: Do you feel the rights of the patient override those of the health professionals? So, if a health professional was a conscientious objector whose rights do you think come first?

Respondent: I think they do, yes, because they do have the right, in law, to have what they’re doing. If there were still all kinds of rules and regulations about it, you know… There are still certain rules about how many weeks you are, but there are lots of other rules… When they first started talking about terminations like this it was more to do with women who had lots of babies and rape than anything else, mum’s health, that kind of thing, and mental health. I think the wording of the thing still involves something about mental health in it.

Interviewer: I vaguely remember something.

Respondent: I think it does. Which I don’t think is the case anymore. I think the whole thing about the rules about it, why you can have one, should be more pulled in. The rules are there but nobody uses them, I think.

Interviewer: The Abortion Act was introduced over 50 years ago, wasn’t it, and it is woolly, the Abortion Act, because, I suppose, the procedure originally was a surgical procedure. So, even the personnel who were involved has significantly changed. Obviously, it was dominated by doctors, so pharmacists and now it’s nurses and its midwives. Even patients themselves, they’re involved if they’re given the tablets and go home. So, it is quite surprising that something that was established over 50 years ago and has radically changed hasn’t been reviewed.

Respondent: Life has radically changed. The reasons for terminations have radically changed. And, I think it probably does need a proper overhaul. But, I do still think, over all of that, and while it’s a lawful thing to have, anybody who works here should not object to someone having it. You can object personally; I don’t like it. I don’t like it. I don’t like the fact that I have to put a poor little tiny creature in a poly bag. The doctors don’t have to do this. The doctors don’t do it.

Interviewer: I think people like me, I don’t associate… Obviously, the baby’s got to go somewhere, so it’s challenging.

Respondent: I don’t like doing it. I don’t know anybody who does like doing it. I don’t know anybody who likes being involved in it. But, we do it because it’s part of our job and because it’s lawful and because we take care of people, regardless of what they come in for.

Interviewer: It sounds like you have a professional head that you present there and then, and then you have a personal head.

Respondent: We all have our personal head, and we all chat afterwards about whatever. The 16-year-old I had with her mum sitting there on the phone, this is her mum when I’m talking about contraception and about sexually transmitted diseases. “We did that in school” she said. I said, “Well, doing it in school isn’t quite the same as having it. You’re 16, what are you doing?”

 Then I had another one, she was Romanian, 16-year-old. I said, “You’re very young for this.” And her mum’s sitting there, and the dad’s there. Their younger brother was there. First of all, I said, “I don’t know whether this is a conversation for the boy to hear, do you want to take him out?” “No, he’ll be alright, he doesn’t speak English.” Sure, he doesn’t speak English but I had to do a thingy with them so they knew what I was saying, and so they were reading that out and he was hearing it all. You know, I kept looking at this woman thinking, “Why do you want this boy to hear all this?” Everything’s changed from what it used to be.

Interviewer: It sounds like, even though you disagree with it and as challenging and as difficult as must be, especially at particular times, that you’re still able to be professional and patient-centred actually?

Respondent: Oh yes.

Interviewer: Do you think the patient comes first?

Respondent: I think the patient has to come first and hopefully when you talk to them, if you don’t come over all black and thunder, or as if you don’t care… I think you’ve got to be caring and you’ve got to tell them what could happen to them to warn them. There is such an upsurge at the moment of sexually transmitted diseases, and some of them are coming from the continent where people have misused antibiotics, so the antibiotics aren’t working on them.

 So, you’re getting an upsurge in gonorrhoea and stuff like that that hasn’t been seen in this country for a very long time. But besides that, we have chlamydia and HPV. If people don’t take care of themselves they don’t seem to realise what can happen. Chlamydia can make a girl infertile without her even knowing. She’s had sex with somebody who’s given her chlamydia and she doesn’t know that until she’s 28, or something, got a nice job, nice house, nice husband, and can’t get pregnant.

Interviewer: It must be very difficult.

Respondent: Those kinds of things are just not talked about. They’re not discussed. They shy away.

Interviewer: Do you think the shame element comes in then?

Respondent: I would think it’s a no-no, sexually transmitted disease is a no-no.

Interviewer: So like a lack of apathy or acknowledgement that it actually happens or it will happen to you?

Respondent: I think people just don’t acknowledge that there are such things. And if you do get them you’re probably a slag, which in actual fact then is not true. I mean, you might be but it could be your first time with a fella who’s been with one other person. And I’ve known that. I’ve known someone here with cervical cancer. She’d only been with this boy and married him, he’s had one other sexual partner, and she got HPV which developed into cervical cancer. So, you don’t have to be a slag to get any of these things.

Interviewer: No, not at all.

 So, thinking about conscientious objection, if the clause allows health professionals the right to conscientiously object was scrapped… We’ve been talking about the law and how it’s almost a bit outdated, if it was overhauled and conscientious objection was scrapped, what do you think should be put there in its place, if anything?

Respondent: Well, I think if the law was tightened so that it was people who, for one reason or another, had got pregnant and they can’t cope with the pregnancy, whether that’s because they’re 15 and they really didn’t understand what was going on, or they’re 48 and they’ve already got five kids and they’ve got grandchildren even.

 One of the girls in work, she has a friend who’s just had twins, and she was on the menopause. She thought she was on the menopause. She was in her mid-50s and got pregnant with twins. Not that she wanted a termination, she didn’t, but…

Interviewer: Having twins at 50 would be challenging.

Respondent: But, people who’ve got foetal abnormalities, if they choose to terminate that pregnancy there should be no conscientious objection about that. There isn’t about the mother’s health, if it’s believed that the mother’s health would be in jeopardy. And this thing about mental health, if it’s considered against the mental health of the woman then that should be tried properly to see that it is actually that and not just that she’s gone and got pregnant at some party and wants a termination.

Interviewer: So, using it as a bit of a get out of jail card?

Respondent: Yes. I don’t think the girls who come even realise that that is part of that. I mean, saying that, your mental health is in jeopardy because of a pregnancy surely you must have to justify that? How do you justify it? In what way is your mental health in jeopardy?

Interviewer: I suppose it depends on a consultation, doesn’t it?

Respondent: And there should be a proper consultation, not just, “Sign this,” “Okay, yes.” “You’re so many weeks pregnant… Yes, you are. Sign there.” Find another doctor, “Sign there.”

Interviewer: It sounds like it needs a bit more of an in-depth look because it sounds like you’re saying things have transformed quite significantly and changed from when the Abortion Act was envisaged.

Respondent: The way people live, the way that the world is, and not just here, but everywhere, it’s changed so dramatically from when that bill was first put into place. For it not to have been redone is a bit weird, isn’t it?

Interviewer: Well, the driving laws have been overruled… (Laughter) I was quite surprised coming into this-

Respondent: Lots of other laws get bits added and bits taken away, and that happens all the time. I suppose they’ll only change laws if somebody objects properly and takes them to the court or something.

Interviewer: It was raised only last year; I think it was last year… It was either last year or 2017, by Lord McKay in the medical activities bill. So, there clearly are questions around conscientious objection, it’s just, I suppose, people being willing to answer them. It is a difficult conversation really, in some ways, to have, especially for people like yourselves, you’re on the forefront of it. that’s what the project’s for, to try and find out that information so that proper guidelines can be developed.

 Can I just ask, if you were an objector… Obviously you’re not, but those way those doctors are, if you were would you consider referring on as part of participating in abortion? Would you see that as a significant part or an element of that process?

Respondent: I think if they’re going to say they object they shouldn’t just be able to say, “I object, I’m not doing it.” There should be some way of saying, “I object but I’ll find somebody else who doesn’t.”

Interviewer: So, you think that conscientious objection, if it is to be accommodated, then referral should be in that clause, if you like, within that objection.

Respondent: Yes.

Interviewer: Is there anything else that you think that should be added or taken away, if conscientious objection was to be accommodated?

Respondent: I just don’t understand why they work here. (Laughter)

Interviewer: It must be quite a sticking point really.

Respondent: As a person I object but as a professional I knew what was done here when I came. A lot of the doctors have been here as ST1s and all that stuff, they come and they’ve been here a few times. They come and go, and then they get a job here. They know what happens here. They know what the job’s about before they actually take a fulltime job here.

Interviewer: So, if you had to put a percentage on the number of doctors, that you are aware of, who do object, what percentage would you say that lies on?

Respondent: I don’t know, because it comes and goes and depends on who’s here. It’s a fair number because we do often struggle to get them to prescribe, so it’s a fair number.

Interviewer: Do you find yourself relying on the ones that you quietly know will be okay about it?

Respondent: Yes, we just hope-

Interviewer: That they’re around. (Laughter)

Respondent: Yes, we hope, especially of a weekend, because we get more of the terminations of a weekend when it’s a bit quieter, because we generally give them a side room. So, we have more of a weekend than the rest of a week, and generally we have less doctors in the hospital of a weekend. So, you just hope.

Interviewer: So, how does that affect your ability to do your job?

Respondent: It does because first of all you’re around and around and around trying to find yourself a doctor that will do it. when you find someone who just says, “Yes,” you almost think they’ve said, “No,” because that’s what you expect. You’re like, “Oh, do you? Oh really.” (Laughter)

Interviewer: (Laughter) “Did you say that?”

Respondent: You have to get them to do it quick before anything else happens.

Interviewer: What impact does that have on the patient?

Respondent: Well, they’re waiting, aren’t they? They come in; they’re told they’ll get the pills…

Interviewer: Do they know that’s what they’re waiting for?

Respondent: Yes.

Interviewer: Have patients ever said anything about that?

Respondent: They say, “What’s happening?” and stuff like that, and we just say, “We’re just waiting for the doctors to prescribe.” We don’t ever say, “We can’t get a doctor to prescribe” or, “The doctor that is here is conscientiously objecting.” We always just say, “We’re just waiting for a doctor to prescribe.”

Interviewer: So, a little bit economical with the…?

Respondent: Yes, we’re not even horrible about them when they won’t do a job for us. (Laughter) Because it’s not the patient’s fault, so they shouldn’t be made to feel, as well, that they’re doing something that’s looked at as being a bad thing. It’s not their fault because they’ve been through the channels and they’ve got the signatures, so they’re not doing something illegal.

Interviewer: That does sound like it’s a problem and that particularly needs some sort of resolution.

Respondent: It is a problem. It is a problem. And the fact that they can conscientiously object and we can’t, I think… I mean, I know somewhere in the cloud it says that we can, but in practice we don’t and we can’t.

Interviewer: You’ve worked here for a number of years, I think you said 15, was it?

Respondent: Yes.

Interviewer: Have you ever come across a colleague who has said, “Actually, no, sod this. I know I can?”

Respondent: I know one who didn’t like doing it and would make sure that those people weren’t in her team.

Interviewer: Really? So, how did that work? (Laughter)

Respondent: She just made sure. She just said, “She’ll have to go in that team,” so she didn’t have to do it.

Interviewer: Oh really? Right, okay. So, what did your colleagues think of that?

Respondent: Well, nobody liked it.

Interviewer: So, the objector went in a different team that didn’t have hands-on?

Respondent: Yes.

Interviewer: That could cause some conflict really?

Respondent: Yes, nobody liked it. We all knew she did it.

Interviewer: Did anyone challenge her at all?

Respondent: On occasions I think. But, for the sake of the patient we just… I think we put up with it.

Interviewer: Was it a manager who was the objector?

Respondent: She was a senior nurse, then later on a sister.

Interviewer: Oh right, so she could almost cherry pick what she did and didn’t want to do.

 I think that’s absolutely everything. I suppose the only other thing, and I suppose you’ve touched on it, I was going to ask is: how do objectors handle non-objectors? But, as they’re predominantly doctors I suppose you’re run ragged then trying to find someone who does-?

Respondent: We’re just trying to find another doctor, find a doctor somewhere.

Interviewer: That’s really difficult.

 I’m just going to scoot through these questions just to make sure I’ve asked everything, if that’s okay?

 I suppose, just again drawing on the conscientious objection aspect, where would you draw the line on participation? So, signposting or referral, giving advice, taking a phone call from the woman, would you consider them all parts of the element? If we think about abortion, do you think of it as a process or do you think of it as the [Crosstalk 1:16:43]?

Respondent: As a whole process, because they start off either in the emergency room or they go to get an appointment at the clinic, which is a nurse-led clinic in the [name of abortion clinic]. Those nurses then have to find… I think they give them a chat and they give them a week to think about it, then they come back and they go through it all, and they have to get two signatures off doctors. But, I think it’s still a nurse-led clinic.

 The process then is, if they’re over a certain number of weeks they come into the ward.

Interviewer: So, if you were an objector do you think you should be objecting at the very beginning, or do you think that an objector would like to object at any point in that process?

Respondent: It’s difficult to say that because there are so many different people who are involved in the process. You know, there is someone from the clinic when you ring up and ask for an appointment. I’m not even sure how you do that, to be honest. So, they get an appointment, they come in and see one nurse, they may see a different nurse the next time, and then that nurse has to get doctors to sign. Then they come on another time with another appointment to us, and then the doctors have to prescribe the tablets. So, there’s a whole bunch of people who are all involved.

Interviewer: So, if one of those people did object in that chain, do you think that should be allowed?

Respondent: I think the whole thing would fall to pieces if there were objections. When the doctors object it just slows it all down. It doesn’t stop it.

Interviewer: It’s like a sticking point, isn’t it? (Laughter)

Respondent: Yes. It just slows it all down, so then people have to wait longer than what they should do and are potentially made to feel that they shouldn’t be there.

Interviewer: So, the impact on patient care, and, of course, the impact on you [Crosstalk 1:18:56].

Respondent: And us, because we’re trying to find doctors. We could do without doing that, we could just get on and get the job done. It’s just… You know…?

Interviewer: That’s everything, to be honest with you. We’ve covered everything at least. We’ve talked about objectors and we’ve talked about how it works practically if someone refuses…

 I’m just wondering, because I suppose it boils down to that you can’t object and the doctors can. You said the doctors, generally, just say, “No” and that’s it. Is there any sort of referral process in place? I’m in psychology but I always hear about pathways in medical care, and I’m just wondering if there’s a pathway that you need to follow if Doctor A doesn’t do it? Is there any sort of guidance for you?

Respondent: Not really, no. We just have to ring round and try and find somebody. If we are upstairs and any doctors that are up there won’t do it, if we know there’s a doctor in the emergency room we’ll try them. If they won’t do it then we’d have to go to obstetrics. So, we haven’t got that any places to go.

Interviewer: Yes, you don’t have the luxury really. You don’t have a pot of people that you can go to. (Laughter)

Respondent: No, we haven’t got a hospital full of them, we’ve only got the two areas, the obstetrics and the gynae. So, basically, we’ve got two areas where they’ll be doctors.

Interviewer: Have you ever come to a point where there’s absolutely no one?

Respondent: No, fortunately. But, when I had six doctors who objected out of the seven that were in the hospital, I think that’s the nearest I’ve come to it.

Interviewer: What would have happened if that seventh had objected?

Respondent: I have not the foggiest of an idea, to be honest. I really don’t know what would happen if I hadn’t had got that doctor.

Interviewer: Would the patient have had to started again, the whole chain of events and their medication? Who knows?

Respondent: I don’t know. I don’t know what we’d have done, apart from putting in an incident form to say there were no doctors, but that doesn’t help the patient to do what they’ve come to do. I don’t know what we’d do if they all said, “No.” I suppose we’d have to try and get the consultant on-call or somebody. We’d have to ring our managers at home anyway, the on-call manager would have to be called. And I don’t know what they’d do, unless they’ve got more influence with the doctors than what we have.

Interviewer: Frogmarch them. (Laughter)

Respondent: I don’t know. It’s fortunately never happened to me. As far as I know, it’s never happened to anybody else, but we do come pretty close sometimes.

Interviewer: It must be nerve-wracking though; it must be quite stressful.

Respondent: It’s so time-consuming as well, you know, you’ve got other things to do and you’re ringing round and round trying to find some doctor somewhere, who’ll just prescribe a couple of tables, please. All you’re saying is, “Do you do…?” It becomes very clinical, “Do you do termination medication?”

Interviewer: Maybe there’s a better way.

Respondent: Yes, maybe. I don’t know. Perhaps if the government get their act together, stop talking about Brexit and do something useful.

Interviewer: They can’t make a decision about that. (Laughter) I’m not very hopeful.

Respondent: They can’t make a decision about anything, can they?

Interviewer: Well, they’re all on holiday, aren’t they, at the moment.

Respondent: It’s a pity they don’t stay there, isn’t it?

Interviewer: I was going to say, “They need a woman to run the country,” but that didn’t work so well. (Laughter)

Respondent: We had one, we’ve been there as well, haven’t we?

Interviewer: I think I’ve asked everything. Is there anything that you want to add or ask me at all, you know, thinking about what the project’s hoping to achieve, which again is around conscientious objection and trying to get some guidelines there about what abortion does involve and what constitutes- I suppose the two key questions are, what constitutes abortion and what’s the limits of or extent of…? So, what processes are involved and if people do conscientiously object at what point along that chain?

Respondent: I think maybe the objector’s need to think not just that they’re objecting but what’s going to happen to that person. They offer no assistance. They just say, “No, we don’t do it. I don’t do it. I don’t do it.” Maybe they should be then made to think, “Well, who’s going to help?”

 Not that I think it’s ethical to pass on something that you don’t do to somebody else to do, (Laughter) because I don’t, I think it’s very unethical. But, that being said, I think if they’re going to object then they should have a process whereby we have somewhere to go, a proper path to go from them to somebody who will help sort that situation out with the patient. Other than that, they shouldn’t work here or in any women’s’ area where terminations happen.

Interviewer: So, if you’re an objector, that’s okay but you must refer on.

Respondent: Go and object somewhere else. Go and take a job in a heart place or leg place or something.

Interviewer: That’s fair enough. Thank you. Is that the end?

Respondent: Yes.

Interviewer: Thank you very much.

Respondent: It’s alright, thank you.

Interviewer: I’m sorry to take up so much of your time, but it’s all-

Respondent: That’s alright.

END AUDIO

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