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START AUDIO

Interviewer: Okay. So, to begin with, can you tell me a bit about the work you do as a health professional? So, you were a midwife in the [hospital name]…?

Respondent: Yes, I was a midwife in the [name of hospital] for, oh God, [number of years] years I was there for and before that I was in [hospital name] Hospital for three-and-a-half years. I’ve always been [job role]l, no matter what other role I’ve taken on as well. I’ve always been rotational as well.

Interviewer: Oh, so you get to see a bit of everything, I suppose, in that role?

Respondent: Yes. So, working on the delivery suite you do see a lot of still births and late TOPs for foetal abnormality, usually. There was a lot more in the [hospital name] than there was in [hospital name], but that’s because of the amount of referrals that you get from all over the country to the Foetal Medicine Unit.

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

Respondent: Yes.

Interviewer: I see. So, is abortion something you come across often or came across often in that role, I appreciate you’re teaching now, but…?

Respondent: Not obviously in the early stages. I mean, there would be more, I suppose, if you were working on community or in antenatal clinic because you’d get women coming to book in who were unsure what they actually wanted to do, whether they wanted to continue with the pregnancy or have a termination, what they actually wanted to do. In that instance then you would be counselling them on what their options were and just giving them some general advice, to go away and speak with someone who they trusted.

Interviewer: Is that something that you did in your practice as a midwife?

Respondent: Yes. I mean, as well around [name of Maternity service], so a lot of women would use that as a service for things like that because when they’re not actually seeing somebody face-to-face they often find it easier to be able to discuss things, especially anything to do with things like that. It’s a taboo subject, isn’t it?

Interviewer: Yes, there’s a little bit of stigma so maybe that anonymity almost helps.

Respondent: So, I’d get women getting in touch saying, “I really don’t know what to actually do.” A lot of it would be just their situation in life or it could be that financially they didn’t feel they could support a child or if their partner wasn’t actually involved, anything like that. I’d actually then pick up the phone to them and we’d end up having an hour long phone call and discussing things, and just discussing their options.

A lot of the time they don’t actually know just your general things, like support that they can get with financial things, like housing and support that they can get through social services, the health visitor and things like that. When you’ve never actually been in that position you don’t know, do you? You don’t know what you don’t know. (Laughter)

Interviewer: This is it, and they sometimes need somebody who is in the know to, sort of, signpost you.

You mentioned there about when you were working in the [hospital name], the Foetal Medicine Unit, were you involved in those late terminations as well? Is that something you did on your rotation?

Respondent: I didn’t do much work on rotation in the Foetal Medicine Unit, I did as a [job role] and that was for several different things. We did some studies on cardiac anomalies… There were a few different studies that we did. Women were really, really good in wanting to take part because, because obviously they don’t want another woman to be having to go through this in the future. So, even though they were going through something that was awful they were really happy to take part in the research.

So, yes, I’d have some kind of follow through, their journey through a termination for foetal abnormality. Again, they would use the [name of maternity service] service as well. Even if it’s not a foetal abnormality, it might be something like their waters have gone early and they’ve been advised that this could happen and this could happen, and they just wanted an extra opinion. Then they would get in touch and we would, kind of, talk about, basically, everything they’d already discussed but they just needed that extra…

Interviewer: Yes, it’s like a little crutch isn’t it?

Respondent: Yes, like a second opinion just reinforcing everything that’s been said and just giving them that added extra information. Obviously, you know, it goes out of your head when you’re in a really awful situation, it sometimes just goes in one ear and out the other.

Interviewer: And it’s just nice to know you can pick up the phone and get another reassurance, as such.

So, as you know, this project’s looking at conscientious objection to abortion. What do you think constitutes conscientious objection to abortion?

Respondent: Well, I mean, from what I’ve seen in the past it’s usually been on religious grounds. But, I suppose then there could also be people who just don’t agree with it. In one way I think, “That’s fair enough,” everyone’s got their own right to have an opinion on abortion or termination of pregnancy, but then I think, “Every woman has got a right to have a termination as well.” There are so many individual reasons to need a termination.

It’s actually something that is spoken about quite a bit at the [hospital name] Hospital.

Interviewer: Conscientious objection or abortion?

Respondent: Both really, because we get a lot of [nationality] women coming over and they’re usually, obviously, for foetal anomaly. It’s such an awful experience for those women, having to come for a late termination. Obviously they don’t want to terminate, necessarily, but they’ve got this dire situation where the baby has got something severely wrong with it and it’s not going to survive, yet they’re having to travel over to another country and somewhere that’s alien them to then terminate their pregnancy. Once it’s all over they have to go and stay in a hotel until they’re well enough to then go home on a boat or a plane. It’s just shocking.

Interviewer: It sounds like your own personal position on abortion is it’s up to the woman, would you say that’s a fair reflection?

Respondent: Yes, and this is going back some time, when I was training, in my first year… I mean, this is [number of years] years ago now, I saw something that was a really shocking case when I was on a gynae placement. It was a woman who was thought to be around 15 weeks and she’d come in for a termination. They tried all the usual ways, basically, she’d been for about a week trying to pass this foetus. Nothing was working. There was still a foetal heart. She was bleeding, and obviously they couldn’t do a D&C. So, she ended up having to go, basically, for what eventually had to be a caesarean section. When they did it it was more like the foetus was about 22 weeks.

Interviewer: Oh no.

Respondent: It was just awful.

Interviewer: It sounds really traumatic.

Respondent: Obviously, there was signs of life and stuff, and it was just awful. But then, from the woman’s perspective, she then lost three litres of blood... I think the reason for it was she already had three children, I think she’d had an affair and this baby was the result of an affair, and that’s why she was adamant. But, it was just so awful.

That kind of made me think. I mean, that was a real individual case.

Interviewer: Yes, it’s quite an exception to the rule that, isn’t it, really.

Respondent: Yes, and I was thinking, “The abortion rules need to be changed and I think it needs to come down from 24 weeks to 20 weeks.” To be honest, I think it needs to be about 18 weeks. But, I don’t know how you change that.

Again, it’s like, at what point do you need to do a foeticide before…

Interviewer: Yes, you deliver the baby.

So, would the foeticides be for later abortions, and it’s where it stops the heart, isn’t it, and then the baby is delivered or evacuated?

Respondent: Yes, so you do that for any therapeutic termination for any baby that’s found to have an abnormality. But then you think, if it’s for social reasons that you’re having a TOP then at what point do you then…? You know, you could have an 18-weeker that has signs of life.

Interviewer: Yes, and with medical advancements it is becoming more and more common for younger foetuses to survive out of the womb.

Respondent: Yes, and if you think if they’re suffering at what point…? I know it’s an absolute minefield, but then you think, “That’s horrendous for that baby, that foetus to have any suffering whatsoever.”

Interviewer: It’s almost like that experience jarred with your opinion of abortion. I don’t want to put words in your mouth and correct me if I’m wrong, but maybe before that had you considered changes in the limitations?

Respondent: I think I was probably a little bit more against abortion, to be honest, because I also know that there are women that will use it as a contraception. There are women who will go back and have four/five/six abortions, which is so unhealthy for them but they don’t seem to understand that. Because they can go in as a day case and it’s over and done with pretty quick, especially when they’re early on, they don’t see anything other than some blood so they just think of it as a late period or something.

Interviewer: Do you feel that some women are a little bit blasé about it, like, “I’m pregnant but I don’t want it, so I’ll have an abortion”?

Respondent: In that case it’s kind of like, “You really need educating on what you’re actually doing to your body. That’s actually a life that you’re destroying there.” To me, if I became pregnant it would be a very, very huge, massive decision to have an abortion for whatever reason. It would have to be that the baby had massive problems that would be incompatible with life for me to have a termination because I just wouldn’t.

Interviewer: So, what helped inform your views around abortion?

Respondent: Knowledge and experience.

Interviewer: It sounds like that.

Respondent: The more that you look after women who are going through these awful experiences of just being around the Foetal Medicine Unit where you’re seeing so much of foetal abnormality or the hardship of how women are going through those pregnancies and really wanting them to be healthy pregnancies, but they’re not. A lot of the time they’ll end up having a still birth anyway, unfortunately, but they’re given this decision and it’s the hardest decision for them to make.

I think, in that respect, they would have a baby that ends up having to suffer for their whole lives. They’re in and out of hospital having to have all sorts of surgical stuff for the rest of their life. Every day they could have to have… I don’t know.

Interviewer: Huge medical interventions, yes.

Respondent: All sorts that they’ve got to have, you just don’t know. It could be a horrendous life for them, that’s going to also impact on the parents, siblings, rest of the family, and you think, “Is that the right thing for them all?”

Interviewer: It sounds like you have quite a lot of empathy really, for people in that situation?

Respondent: Yes.

Interviewer: Also what I wanted to add, it sounds like you have a professional head and a personal head. Where your personal view is you might not agree with that woman who’s on her fifth abortion, but…?

Respondent: Well, at the end of the day I’m a midwife and I’m there to be caring for that woman. So, it’s not up to me what happens. If she wants to have her fifth abortion then that’s their decision. I’m there to care for her and make sure that she comes out of it safe.

Interviewer: Would you ever object to caring for a woman who was, I don’t know, on her 25 abortion or something?

Respondent: No. No, I wouldn’t because, again, it’s her decision. It’s her decision.

I don’t know, it’s really difficult. I mean, I’ve seen lots of abortions as well for social reasons rather than just terminations for abnormality. But when you see those women, they’re also in a right pickle, and sometimes there are ways out for them. We’re okay, we’re in our nice jobs with our nice little houses and our nice little lives, but other women haven’t got that.

Interviewer: You sound very understanding, very patient focused, and almost like if you were in their situation you might not make that decision. But, actually, you withhold your personal views and maintain your professional views, as such, and you split the two?

Respondent: All you can do is give them as much information as possible so they can make an informed decision themselves. A lot of the time they can change their minds. The amount of women that come through who’ve been raped, and at the beginning they’re like that, but a lot of the time they’ll end up keeping the pregnancy and then being really happy. That’s great. But if that baby’s just going to remind them of what’s happened to them then you’ve got to be able to have that choice and respect that that’s their decision.

The same goes for somebody who maybe hasn’t got the right mental capacity or… You just don’t know what everybody’s situation is until you can step in their shoes and really sit down and talk with them.

Interviewer: Where would you draw the line on participation in abortion, for example, some people take a very broad perspective of abortion and see that as signposting information giving, even booking in, as well as the more hands-on activities, such as giving medication? Would you draw a line at those broad activities or would you consider participation in abortion as just those hands-on activities?

Respondent: I’ve given the medication and all that kind of stuff. But, because I’ve not, kind of, had to do things like that, like consultants have to do foeticide and things like that, I’ve never really thought about that. So, I think it just depends on, I suppose, what it is. I mean, if I had to go and help with a D&C or something I think I probably would, again, because it’s her decision.

I’ve delivered babies that have been as a result of a TOP, but I don’t know how I’d feel about foeticide because that is so invasive. But, obviously, I’d never do that, that’s not part of my role.

Interviewer: No, you wouldn’t do that in your role as a midwife.

Respondent: I think that would be really difficult as a doctor. But then again, you know, you’re weighing up the wellbeing of the whole family, aren’t you?

Interviewer: I suppose it’s as you say, it’s what lens you look at it through. So, do you look at it through the wellbeing perspective of the woman or everyone involved, or do you look at it through the lens of your beliefs? I suppose, different people have different perspectives really.

I suppose, this project is trying to understand the extent and limitations of participation in abortion. I don’t know whether you’re familiar with the case of the two midwives in 2014…?

Respondent: I don’t know much about it, to be honest.

Interviewer: So, basically, there were two midwives up in Scotland and they worked in a centre very similar to the [hospital name]. My understanding is they originally weren’t doing abortions on the ward that they worked on, so I think they worked on the delivery ward. They were practicing Catholics, very senior midwives, and then abortions were introduced.

These two midwives invoked their right to conscientiously object. It’s their right and they’re allowed to do that. But, it ended up in court. I think, originally, they won. They developed a list of 13 things that they felt constituted conscientious objection to abortion. The trust then took them to the Supreme Court. There was quite a lot of legal battle involved. It ended up in the Supreme Court and they eventually lost, they ruled not in their favour.

She said that when the Abortion Act was envisaged it was created around hands-on activities, so the list of things that the midwife developed included things like taking phone calls to book women in, supporting other junior staff who may be supporting women who were undergoing abortions, supporting family members of the women undergoing abortion, providing breaks for other midwives who might be answering emergency buzzers… There was a whole list of different things, but the judge ruled that they were more peripheral to the actual hands-on activity.

So, having heard that, would you agree with the judge or would you be inclined to see the abortion process as all those different things that lead up to the abortion, or as the judge said, just those individual hands-on activities?

Respondent: Obviously, I’d have to see exactly what the list was and that…

Interviewer: Yes, I did used to have it actually, but I don’t think I’ve got it with me.

Respondent: I think if you’re a midwife then you’ve got to still be a professional and still be able to undertake all of those peripheral tasks that need to be done.

Interviewer: Sorry to interrupt you, I did find them. So, the management of resources within the labour ward; providing a handover to the ward coordinator; appropriate allocation of staff; providing guidance, advice and support to other midwives; accompanying obstetricians on the ward and award round…

Respondent: So, the judge is saying that they’ve got to go in and look after that women?

Interviewer: The judge ruled that, basically, they’re not part of the abortion process.

Respondent: Well, they’re not, no.

Interviewer: Would you agree with the judge?

Respondent: Yes, I’d agree with that, yes. I agree that, you know, on religious grounds or as a conscientious objector that you shouldn’t necessarily have to go and care for that woman. You’ve got a right to be able to believe in what you want to believe in, so that’s okay, as long as you’re not trying to enforce those beliefs on anybody else.

I mean, I have seen and there have been one or two midwives that I have seen kind of trying to do that.

Interviewer: Okay, can you tell me a little bit about that?

Respondent: Yes, it’s just somebody who is religious. I don’t actually think she refused to look after somebody with a TOP. I think she was trying to put across her religious views, not just to the midwives but to the women as well. She’s been reprimanded for that. But she’s still not quiet about it.

Interviewer: I assume that she’s an objector if it’s a religious perspective, what impact do you think that would have on the women that she was caring for?

Respondent: I think that it would make them feel like she was judging them. I think a lot of the time they already feel like that.

So, I think that any religious views should be totally kept to yourself. I don’t think that it’s up to you. Unless that woman asks specifically to speak about them, then that’s fine. But otherwise I don’t think you should ever speak up about your religious views. You’re there to be a support for that woman in a professional manner, as a midwife.

Interviewer: So, not unsolicited and not unrequited.

Have you had any other experience of objectors within midwifery?

Respondent: I’ve had a student, I think she was young and she was very naïve. She’d never come across it before.

Interviewer: Oh right, okay. I can imagine it is a bit of an eye-opener, working on the midwifery ward. (Laughter) In more ways than one.

Respondent: Yes, but it was quite shocking then to meet and think, “You’re a student midwife, you’re going to come across this all the time, you need to know a lot more about it before you make a decision on what your practice is going to be.”

It was years ago, but I think we spoke to the PEF and said, “She needs to spend a lot more time on the delivery suite and get a lot more used to this,” because she was just, “Oh my God.”

Interviewer: Like Bambi. (Laughter) Oh bless.

Respondent: Yes. (Laughter) But, I can’t think of anything specific.

Interviewer: No, that’s fair enough.

If an objector did work in the delivery or in foetal medicine, what impact do you think that would have on the patients?

Respondent: I don’t think they’d be able to have anyone on foetal medicine that was an objector because it just wouldn’t work. On delivery suite, you possibly could but only because it’s a big delivery suite. You know, in a smaller unit you wouldn’t be able to.

Interviewer: Would that be in relation to trying to get someone to replace them or would that because of the nature of the job?

Respondent: Well, probably both because you don’t know who’s going to be free at what point and who’s going to walk in the door. So, in the [hospital name], because it’s a big delivery suite and you’ve got 12 midwives there, it’s a bit more flexible with who you can have to look after those women. Whereas in a smaller unit, if you’ve only got five or six midwives, you haven’t got that flexibility.

Interviewer: So, it sounds like it would impact on other staff in that other staff would have to step in?

Respondent: Yes, because then you might have to interrupt the flow of care, you know, you’re not going to get continuity if you’ve got to go and swap a midwife out. That’s going to affect somebody else’s care, for a start. But, I mean, I think you’d try not to let it affect a woman because you wouldn’t be telling them. You know, you wouldn’t be letting them know, would you? “Oh, she’s a conscientious objector so she can’t come in here,” you wouldn’t say that to a woman.

Interviewer: It might make them feel a little bit uncomfortable and self-conscious.

Respondent: But, I don’t actually think women think that actually happens.

Interviewer: No. When I was having my children, it was obviously different because I was having children, but I don’t think it ever entered my head that that doctor or nurse or midwife could go, “I’m going to withdraw care because I don’t agree with whatever.” I don’t think it would’ve entered my mind.

Do you think healthcare professionals, including midwives, because you mentioned there about the student, should maybe consider, before they enter that role and decide to pursue that career, what the involves?

Respondent: Definitely.

Interviewer: That, actually, it could involve terminations, still births, maybe administering medication that will induce a termination or an abortion?

Respondent: Definitely. That’s part of that job. That’s part of that role. You know, you wouldn’t be a hairdresser and then say, “I’m allergic to hair dye so I can’t dye your hair.” You know, that’s ridiculous. It’s the same kind of thing to me. Even if it’s your personal beliefs then you have to put it aside and put your professional head on. Sometimes you just can’t let your personal beliefs get in the way of your professionality [sic]. They’ve got to be two separate things.

Interviewer: It sounds to me that your duty of care to the patient almost overrides your personal beliefs?

Respondent: It does, yes. It does. To me, once I put my uniform on I become [name of respondent] the midwife.

Interviewer: Yes, that makes sense.

Respondent: Then once I’ve taken it off I’m just me again. I can say what I want just have whatever kind of beliefs, obviously to a degree… (Laughter)

Interviewer: (Laughter) I know what you mean.

Respondent: I’m not going to be an extremist. You know what I mean.

Interviewer: [Name of respondent] the extreme organisation member. (Laughter)

Respondent: Yes. (Laughter)

Interviewer: I know what you mean.

Respondent: Yes, you know what I mean, but it’s kind of like your cloak, isn’t it? You put your uniform on and you’re like, “Right, that’s my midwife hat on for the day.” That’s me, I’m a professional today. Although I’m very much myself and I’m jolly, you know, that’s how I build my rapport with patients. I’m really just myself with them. I’m also very professional with them.

Interviewer: Yes, you talk differently to patients to how you would your closest friends.

Respondent: Of course.

Interviewer: I understand that entirely.

Respondent: I’ll do whatever is in their best interests.

Interviewer: Yes, definitely, from the midwifery perspective, from your healthcare professional perspective, it’s that that comes forward.

Respondent: Yes.

Interviewer: You mentioned earlier that you’re views have been very much shaped, if you like, by experience. Have your views changed since entering the profession? Did you have different views around abortion?

Respondent: Probably, yes, but I think that was just from being young and a bit more naïve to it, because I didn’t have that much experience of it beforehand. You know, I mean, I’d had friends who’d had abortions, from school years and things like that, and even the morning after pill and all that kind of stuff. I’d always been, “Oh, for God’s sake, why didn’t you just use a condom?” or, you know, that kind of thing. I’d still be a bit like that now, to be honest, but things happen.

Interviewer: I think when you’re young the world’s very black and white, there are no shades of grey. I say that from when I was younger, I was very opinionated and I knew everything. There was a right way and a wrong way…

Respondent: I think when you’re young things shock you a lot more. When you’re older, and especially when you do a job like ours, nothing shocks you, does it? You see so much that it’s just life. There could be a lot worse that goes on, so…

Interviewer: (Laughter)

Respondent: As I say, at the end of the day, none of it is our decision. It’s not our decision. We’re just there to be able to give them the information. That’s what we are, we are full of information for them, and that’s what they can take from us.

Interviewer: Would you ever consider refusing anyone abortion under any circumstances, or refusing to take part in an abortion?

Respondent: Maybe something exceptional. Like, I heard of somebody having a TOP at 24 weeks for a cleft palette, which to me is absolutely bloody ridiculous.

Interviewer: It’s a treatable condition, isn’t it?

Respondent: That was in the news, wasn’t it?

Interviewer: Oh was it, I didn’t catch that.

Respondent: Whatever doctor agreed to that is just crazy and should be struck off. (Laughter) So, something like that then, yes. I think, one, that woman hasn’t been given enough information, because that’s just ridiculous…

Interviewer: Sounds like there have been a few omissions in the chain, even from the doctor’s side, and given the legal reasons as to how and why, and what meets the criteria for an abortion. It seems like they’ve bent that very much. Like you say, that woman maybe hasn’t had all the information to hand that she [Crosstalk 0:39:19].

Respondent: Or kind of like a late TOP for no reason.

Interviewer: For a social reason. It’s interesting you say that, actually, I did hear of some case of a lady who was known to the hospital for being quite chaotic, so social services were involved, and had a chaotic lifestyle and chaotic life. She just decided she wanted an abortion, and she was around 30-odd weeks.

Respondent: What?

Interviewer: I know. The doctor’s refused, but then the lady changed her mind back, that she would proceed with the pregnancy and so it never really quite came to that crux of a decision.

It sounds like you would say-

Respondent: Yes, but then I think there are so many other options, put the baby up for adoption, for God’s sake. There are so many people out there that can’t have children and that want children…

Interviewer: Yes, definitely.

So, have you known anyone to refuse to give an abortion to anyone or for a patient to come in and them go, “We’re not getting involved in that”?

Respondent: Let me think…

No, not on conscientious objection grounds, no. I’ve known them to be refused an abortion for being too late, but no. As I say, I’ve known a midwife to say, “I’m not going to look after her,” but then there’s always somebody else that would.

Interviewer: What were the reasons around why they wouldn’t look after her?

Respondent: Religious.

Interviewer: Oh, so they’d had an abortion and they refused to look after them on those grounds?

Respondent: Yes.

Interviewer: Oh right, so they’d invoked their right to conscientiously object.

What impact did that have on the other staff?

Respondent: It was kind of like a given, that they knew.

Interviewer: Oh, so had their declared that they were an objector?

Respondent: Yes. So, it was kind of like, “She doesn’t look after those women anyway,” kind of thing. It wasn’t like anything on that list, she wouldn’t say, “I’m not going to do any of the peripherals” or anything. It was literally was looking after when she’s in as an in-patient. But, it was just kind of fine. There were other people there who could look after her, so it wasn’t an issue really.

Interviewer: I appreciate the [hospital name] is a big hospital, could you see that being an issue elsewhere?

Respondent: Yes, probably. But then, if it is then they could place her elsewhere, you know, on the post-natal ward or something.

Interviewer: Do you feel that a conscientious objector has a role in midwifery?

Sorry, I know, it’s so difficult, isn’t it?

Respondent: It’s difficult because, again, to me, it’s part and parcel of midwifery. So, I think you know that that’s part of that role so why…? It’s just like shift work, you can’t go into midwifery and say, “I’m not going to do shifts.”

Interviewer: Babies are born every minute of every day. (Laughter)

Respondent: You just can’t do that. So, it’s a real difficult one. But, personally, I think no.

Interviewer: No, that’s fair enough.

Respondent: But legally, I suppose, yes.

Interviewer: It’s almost like there’s a practical argument, an ethical argument and a legal argument to it. (Laughter)

Respondent: I’d never sit there and argue with them, and say, “You should’ve thought about that before you became a midwife.” You know, I’d never do that. But, personally, in my head, I’m thinking, “Why did you?”

Interviewer: “Maybe you should’ve thought about it.” (Laughter) Yes.

Respondent: Again, in a smaller unit it would impact on everybody else. It’s just always going to be part of maternity care because it’s always going to happen.

Interviewer: Have you ever been asked if you’re an objector or what your opinion is, like entering the job role? Say, in your interview for the [hospital name], for example, were you ever asked if you were an objector or told you couldn’t object?

Respondent: No.

Interviewer: Oh, that’s interesting to know.

I suppose I’ve asked you that, but I don’t suppose I’ve really asked it in that way. So, what elements of the process do you think midwives should be allowed to refrain from? In the abortion process, do you think they should be allowed to invoke conscientious objection for every step of the process or just those hands-on activities, such as being in the room when a foeticide is administered or giving the lady, if it’s a social abortion, the medicine for the abortion?

Respondent: I just think they shouldn’t provide any care for them. You’ve got to think about it from the woman’s perspective as well because, inadvertently, that midwife could be a bit short with her, could have an attitude problem with her, rather than being nice, understanding and supportive.

Interviewer: Yes, so the compassion element of the care could be almost taken away?

Respondent: Yes. And even though she shouldn’t be, that could come across, which obviously is not what you want for your women. So, I just think they shouldn’t provide any care for that woman if she’s opting for a termination. But, everything outside of that, you know, covering breaks or whatever, then that’s fine.

Interviewer: So, just the one-on-one patient interaction?

Respondent: Yes.

Interviewer: That makes sense really.

There are some places in the world where healthcare professionals can’t invoke the right to conscientiously object, so that’s Sweden and I think Iceland as well. Then there are other places, like in Italy, where whole institutions will invoke their right to conscientiously object. I was just interested to know what your perspective is of that. Do you think that it’s right that whole intuitions take a stand, or do you think we should go all the other way and just not have conscientious objection?

Respondent: I think it’s backwards really, that you’ve got institutions that the whole place will conscientiously object, but they’re very religious, aren’t they?

Interviewer: So, there’s obviously a religious element, you think, in Italy?

Respondent: Yes. But, you know, it’s like [country name], you just think, “How can somewhere so near be so bloody ridiculous.”

Interviewer: Yes, just the complete opposite perspective.

Respondent: Yes, it baffles me to be quite honest. I think if it was a man that was having to make these decisions and go through this kind of stuff then it wouldn’t be happening.

Interviewer: It’s like what’s happening in America, you see the white, very privileged men, making those decisions. (Laughter)

Respondent: So, yes… In a way, I think Sweden and Iceland have got it right, because you can’t take the decision away from the woman. It’s not up to us to me making them feel bad about it. You know, that’s the kind of thing that happened 50 years ago. It drives me insane.

Interviewer: It sounds like you’re saying, if the patient was to know that you’d made that conscientious objection, they’d be aware of that judgement and feel judged, and feel stigmatised because of it? Actually, by removing the conscientious objection you remove the danger of that happening?

Respondent: Yes.

I understand that as midwives we’ve got rights as well, I understand that, but it’s how far you go with that because then you could have 90% of midwives coming out and saying, “Oh well, I object.” So, where does that leave anybody? You’re not going to have any woman-centred care then are you, it’s going to be midwife-centred care.

Interviewer: (Laughter) Role reversal.

Respondent: Which is ridiculous.

Interviewer: So, whose rights do you think override whose? Do the patient’s rights override those rights of the healthcare professional, or the other way around?

Respondent: Well, if it’s about an invasive procedure then, yes, it’s the patient’s rights. If it’s to do with care for them then it’s their rights. Obviously, if it’s to do with something like, “Has the patient got a right to punch the midwife in the face?” then no.

Interviewer: (Laughter) Absolutely not.

Respondent: But, it just depends on what it is. Sometimes it can go overboard and that’s when you get women’s expectations being far too much, and you get the problems, like we’ve got now in this country, where they just expect everything like this. They come in and expect one-to-one care on the post-natal ward…

Interviewer: The poor midwife’s got 12 women.

Respondent: They’re pressing the bell so you can pour them a glass of water and plug the phone charger in for them, and things like that.

But, overall, when it comes to their care and hospital care/maternity care, then no, of course their rights outweigh anything.

Interviewer: So, if the conscientious objection clause within the Abortion Act was scrapped today what do you think should replace it, if anything at all?

Respondent: I suppose something more local that is under the discretion of the trust. I don’t know because it’s a legal minefield, isn’t it?

Interviewer: It is, yes. I suppose that’s quite similar to the whole institution approach?

Respondent: It also has to do with the needs of the service as well. You know, if it’s absolutely ram packed, it’s at the point of closing and you’re the only person that can do something, then how can you say no?

Interviewer: Again, it’s that patient care, that duty of care, that obviously shines through for you. I can see why you’re a midwife. (Laughter)

Respondent: If you’ve sent home a woman who’s been in had Mife and come back in because she’s bleeding and having pain, you’re the only person who can take her, and she’s about to deliver… I mean, are you going to say no? Really?

Interviewer: I suppose it takes… You’d have to have very strong beliefs, very, very strong beliefs.

Respondent: She could sue the leg off you, you know?

Interviewer: That’s true.

I was just scanning over the questions that I felt that I needed to ask, and I think we’ve come to an end now. But, you mentioned at the beginning about the limitations around abortion itself, that you feel maybe, actually, the outcome from that experience, which sounds quite traumatic to be honest with you, should maybe be limited? Do you still feel that way, now, today or…?

Respondent: Yes. Obviously it’s different for terminations for foetal abnormality, that’s something else and that’ll obviously depend on when it’s found, if something progresses and becomes worse. So, you can’t put a limit on that.

But, for social abortions then, yes, because, number one, we’ve seen 22 weekers who survive now. There are medical advances in neonatology, so that needs to be taken into perspective. And number two, when a foetus is born with signs of life then, to me, that’s like… Surely that’s a cut-off? There’s got to be a cut-off point there.

Interviewer: It’s that viability question. I think that’s certainly what makes this so difficult. It’s not conscientious objection to an exam or something, it’s about life, isn’t it? I suppose that’s what makes it so-

Respondent: And suffering of that. Obviously, you know, nobody knows really when a foetus starts to feel pain, it could be really early on and nobody actually knows. No research is ever going to answer that.

Interviewer: No, not really.

Respondent: But, it’s just a real difficult one. I just think, to me from what we’ve got now, the earlier on that it can be is going to for the better, because it will mean that that woman will be more proactive about making that decision.

Interviewer: Obviously, as a midwife you care not just for the woman but you also care for that baby, so when you’re presented with a woman who does want a termination it must jar with that initial, I suppose, what’s the predominance of your role, you know, caring for babies and caring for women. But, you’ve got to care, in that situation, even when it is a termination or an abortion, for the woman and the baby. So, I can see that the earlier that it’s done you do the best by the baby and still the best by the woman, because the earlier it’s done the better.

Respondent: I mean, the amount of women who’ve had miscarriages at 13 weeks and they don’t actually realise what they actually deliver looks like a baby. So, if that shocks them how do women who are having a TOP at 18 weeks going to feel when what they deliver is even more like a baby?

Interviewer: Yes, growing and bigger.

Respondent: Yes, and might move and might have signs of life. You know, I think that’s going to be really detrimental, not just to that baby but to that woman. She might have massive long lasting effects for the rest of her life.

Interviewer: It’s traumatic, isn’t it? It is traumatic for everyone involved.

Respondent: Unless you’ve got that knowledge and that perspective, they don’t know. They don’t understand.

Interviewer: Well, to be fair, I’m not a midwife, my background’s [discipline name] and it’s only through this that I’ve heard these stories. And experience is obviously worth its weight in gold, isn’t it? I’ve heard your story there about that woman who, effectively, had a c-section, and I’ve heard from a different midwife in a different interview, and I think it was a 16 week abortion but the baby was very big. Although there was no sign of life it was a fully formed baby.

As a woman, when you’re pregnant, you don’t really see anything until much later on. You might feel a slight flutter at that point but only if you’ve been through a pregnancy will you know what that fluttering means. So, you don’t associate it with a baby, I don’t think anyway. That’s my personal opinion.

Respondent: No, and that’s it. They make these decisions not actually realising what they’re going to pass or that it’s actually going to be a baby.

Interviewer: Yes, the gravity of the decision almost.

Respondent: Yes. You do get a lot of women who are traumatised by the decisions that they’ve made. They’ve had an abortion when they were 16/17 and been absolutely traumatised for the rest of their lives, because they didn’t know.

Interviewer: Well, how could you know until you…

So, that’s the end of the interview, is there anything that you wanted to add?

I suppose, thinking about the goals or the aims of the research is to understand the extent or limitations to conscientious objection from your perspective. But, we’re also hoping to use this information to maybe develop some guidance around conscientious objection. Do you think there’s anything you’d like to add?

Respondent: It’s a really… I don’t know how and even where to start, to be quite honest. But, I think, overall, it’s got to be led on the needs of the service at the time. If you are a conscientious objector then I think you need to be placed somewhere where you are at less risk of having to care for somebody who is in that position. That might feel like you’re being, kind of, singled out a bit, but, at the end of the day, it’s about the woman, not about you as a practitioner.

Interviewer: That’s brilliant. Thank you very much. I’ll just stop this, if that’s okay.

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