**File: fi03c9c4 -- Midwife - Meya
Duration: 0:48:01
Date: 14/11/2019
Typist: 690**

START AUDIO

Interviewer: To begin with, can you tell me a bit about the work you do as a health professional?

Respondent: Yes. I've been a midwife for [number of years] years-ish. For the first few years I solely worked clinically between an ante- and postnatal ward and high-risk delivery suite. Then I was seconded to [job role] on a part-time basis, so I had a dual role then. Then took a permanent contract in [job role area]. And I do just overtime at the minute. So I just work on the bank, on delivery suite.

Interviewer: Quite a varied role that you do then, isn’t it?

Respondent: Yes.

Interviewer: Can you tell me, is abortion something that you come across often or have come across often?

Respondent: Yes. It’s difficult. I don’t know if abortion’s the right… Well, I suppose it is the right word, but yes. Not early abortions or social abortions. Usually around from 20 weeks onwards.

Interviewer: Yes, other people have questioned the terminology a little bit.

Respondent: When I was training to be a midwife I went to [sexual health service name] for a couple of placements, but I'm not really knowledgeable about early terminations. But yes, I've looked after a few women on delivery suite who were having terminations of pregnancy.

Interviewer: How have you found that?

Respondent: I think it’s always difficult, isn’t it? Because it’s a difficult time for the woman and her family. And it’s out of the ordinary from what you do day to day. But I think it’s an important part of our role really. I don’t know how I find it.

Interviewer: Have you always had that view, that it’s part of your role, or have your views changed as a result?

Respondent: No, I have done, because when I was training I looked after a lady who was having a therapeutic induction – you bandy round all different terms, don’t you? – for abnormality.

So quite early on I was not comfortable with it, but I was familiar with looking after those women and obviously sorting out their babies after the babies have been born and everything. So yes, I accept that it’s part of my role really.

In terms of to what extent it’s part of my role, am I just caring for the woman, like providing clinical care or administering drugs that will create an induction? I'm getting my words confused. That will induce the woman into labour. I don't know. I think it’s part of my job, yes.

Interviewer: What’s informed that belief that it’s part of your job?

Respondent: Just my training really. And obviously you study it in university, that you will come across that. I think they start with stillbirth and bereavement care. Then gradually as you learn more about high-risk women you obviously get trained to look after that group of women then. I don’t really know what’s informed it. It’s probably just my mentors really.

Then obviously I trained in [name of town] in [country name]. It was quite unusual for me to look after this lady as a student, just because they shielded the students a little bit there, but my mentor was just looking after her, so I ended up looking after her as well.

So that when I came to the [name of hospital] I think I’d only been on delivery suite a few weeks, and there was a lady coming over from the ward who was… She wasn’t having an induction or a termination. She’d just gone into premature labour, like around 23 weeks, I think.

And I ended up looking after her because there was no other midwife to look after her, and that was the first time I’d done it as a qualified midwife. So that was a good experience, because then when I looked after women having a therapeutic induction I was familiar with the process.

And I think in our Trust bereavement care is quite a hot topic really. The bereavement service is really, really good. And that includes all women, regardless of why they have their baby early, whether it’s because they’ve chosen to because of an abnormality. Those women are still looked after in the same way as women who have a miscarriage or a stillbirth.

Interviewer: Would that apply to women who have social abortions as well, or is it classed a little bit differently?

Respondent: No, I think it’s classed a little bit differently, but I don’t think I could comment on that, because I'm not familiar. Like at the [name of abortion clinic]. I've never worked there, so I don’t know.

Interviewer: That’s fair enough. Don’t worry, yes. Thank you.

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

Respondent: Do you mean the reason you would object or at what point you object?

Interviewer: What you think conscientious objection-

Respondent: The term means?

Interviewer: Yes, to you. Where would you draw a line on participation in abortion, for example. That’s one way that it could be looked at.

Respondent: I think having a conscientious objection means that morally you don’t agree with something, so you're not prepared to participate in it.

In terms of where the line’s drawn, it’s probably the same answer you’ve had from everyone. It’s really difficult, isn’t it? Because I suppose it depends from midwife to midwife what their, like you say, perceived… When is a foetus viable and when is it alive, if you like. I don't know.

Interviewer: Would there be a limit that you would impose yourself? Say for example you were looking after a woman who was undergoing an abortion, whether that was for a foetal abnormality or something else, would you place a limit on what you would perceive as acceptable maybe and not acceptable?

Respondent: I probably would in my own head, but I probably wouldn’t voice it, because I think ethically if the woman has come to receive care, whether or not morally I feel that it’s appropriate or not, she’s there already and she needs to be looked after.

Obviously, women have abortions for a variety of reasons, and it’s not really up to me to decide. I think the thing I would personally struggle with would be… Is it up to 24 weeks you can have a social abortion? Is that right?

Interviewer: I'm not entirely sure.

Respondent: I know it’s around that.

Interviewer: I think it’s around 20-odd weeks. I know there was a debate quite recently, wasn’t there? So I can’t remember whether they reduced it.

Respondent: Well, they're thinking of reducing the age of viability, aren’t they? Because you get some 22-weekers now. Although their long-term prognosis might not be what you would hope, they do survive.

I think on a personal level I would struggle with somebody having an abortion at that late gestation if the baby was likely to be viable. Even though the age of viability is still 24 weeks, I have actually…

This is probably not even relevant, but as a woman I had twins at 22 weeks and 5 days, and one of the babies was technically a miscarriage and the other baby… [child’s name] was technically a miscarriage, because he was 22 weeks and 5 days, but [child’s name] was alive for an hour and a half. He was born.

So just after that I don’t think that I could look after a lady having a termination for social reasons at that gestation, because I would struggle with that. But if she was having it for an abnormality that wasn’t compatible with life… I probably wouldn’t look after her now, but that’s a different situation, isn’t it? It’s a difficult one, isn’t it?

Interviewer: Oh, thank you for sharing that.

Respondent: No, that’s fine. Although that’s a personal thing, that’s changed my… Not necessarily my practice, but it’s changed my views on things, definitely, because experiences shape your practice all the time, don’t they?

Interviewer: Yes.

Respondent: I thought it would ruin my career, to be honest, and in some ways I still think it has, but in other ways I think it’s made me a better midwife as well.

Interviewer: Maybe compassion and you can resonate maybe?

Respondent: I think that’s what it is, yes. And when I reflect back I've looked after women in similar situations to what I had, and I look back now at the way I've looked after them and I think… I did a good job, because you always do your best, don’t you? But I look back and I think, “Aw…”

And you remember people, don’t you? And you think, “I wish I’d just said this to her, because I would have liked someone to say that to me.” Does that make sense?

Interviewer: It does. Hindsight’s 20-20 though, isn’t it? (Laughter)

Respondent: It is, isn’t it? It’s interesting, isn’t it?

Interviewer: Yes. But you can use that and apply it to the next person. And, like you say, you gave that woman your 110% at that time. She’s not going to go away thinking, “Well, she should have said that,” because you’ve given her everything that you could.

Respondent: Yes, I know. So I think that that has changed my opinion of it, because it became extremely real that a baby is viable. Not viable, because he’s gone now, but he was alive for a little bit. Do you know what I mean?

Interviewer: Yes. You still had time with him and that.

Respondent: Yes. So for women coming in to have a termination for abnormality there’s a decent chance that that baby is going to have signs of life when it’s been born, so then obviously we offer foeticide as well in the foetal centre.

I'm getting trailed off now. I've lost track of the question. It’s a good job you’ve got them written down. (Laughter)

Interviewer: No, that’s absolutely fine. What I was saying was where would you draw the line on participation?

Respondent: On a personal level…

Interviewer: It sounds like you’ve got a professional head and a personal head. Although you may have a personal opinion on whether you agree or disagree on whether that abortion should take place, it doesn’t sound like it would impinge on your care.

Respondent: I don’t think it would, no. I don’t think I really have a line, because I feel like ethically if it’s the law it’s been generally we offer that service to women. Regardless of how I feel about it, it’s my job to provide that service.

I've looked after women that I've thought to myself, “It’s sad that she feels like she can’t continue with that pregnancy, because I would.” Do you know what I mean?

Interviewer: Yes. If you were in that situation you could see a different way.

Respondent: Yes. But I would never say that ever, because that’s not up to me.

I think I would probably draw the line at a social abortion after 22 weeks, I reckon I wouldn’t be comfortable with.

Interviewer: Would you remove yourself from care of that woman?

Respondent: Yes, I would. But I'm quite well protected, because I had my babies here. I think they purposely wouldn’t give me that lady to look after. But previously I still don’t think I would be comfortable with it. I would look after her, because I would, and I would deliver the same care, but I just wouldn’t feel great about it, I don’t think.

Interviewer: That was going to be a question actually. Would you object if it’s a…? You have the right to invoke. You don’t have to give any reason. It’s your right.

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

Interviewer: It sounds like you put the patient very much first before your own feelings.

Respondent: Well, that’s it. These women, it’s their decision at the end of the day, isn’t it? It’s not up to me. I'm not here to judge them. I'm just here to make sure that they're safe and that they have the best experience that they can have really.

Interviewer: Yes, it sounds like you’re doing that.

Respondent: Because they carry the weight of that decision for the rest of their life, and that’s enough, isn’t it? You don’t need someone shaking their finger at you.

I think as well, even if a midwife does object inside, it is really important to make sure that you don’t purvey that to the woman, because we’re all in tune, aren’t we? You know what someone thinks of you before… (Laughter) Do you know what I mean? You can tell, can’t you?

Interviewer: You can pick up on things, can’t you?

Respondent: Yes. But yes, personally I don’t think I would have a line of what I was comfortable with, because if she was here and being looked after it’s not up to me. She’s already here. [Crosstalk 0:12:41].

Interviewer: That must be quite a challenge, because you’ve got your personal opinions, and like you say that’s informed from experience, and then you’ve got your professional head. But it still sounds like you put the patient first above yourself.

Respondent: Well, I would like to think so, but to be honest it hasn’t been tested an awful lot since, so I don’t really… I've only looked after one lady, and I didn’t deliver her baby. I just transferred her, because she was starting to labour. Do you know what I mean?

Interviewer: Yes.

Respondent: And I only went in the room because she pulled the bell and because I knew why she was there, and I knew that she needed to move, and I thought, “I'm going to have to go in, because there’s no-one else here.” Do you know what I mean? So I'm not really sure-

Interviewer: But you still did it.

Respondent: Yes, because you’ve got to, haven’t you? It’s our job.

Interviewer: Well, you haven’t really. You have got the right to object.

Respondent: Yes, I suppose so.

Interviewer: But you still did it.

Thank you for that. Thanks for sharing that.

Respondent: No, that’s fine.

Interviewer: I've asked you what’s helped to inform your views. I was wondering did you have a particular view on abortion before entering the profession at all?

Respondent: Not particularly, no. Just that women’s bodies are their bodies. I didn’t really know enough about the complex nature of it. I think going to [sexual health service name] was really interesting for that, because maybe that helped to make me think that women’s bodies are their own bodies and they're entitled to make those decisions. No, I don’t think I did have a view on it really.

Interviewer: It’s a funny one, isn’t it?

Respondent: Yes. And I think that unless you’ve got something really specific that leads you to have a very particular view on a topic, unless you’ve had an experience of it personally, it’s difficult to form a view on it maybe. It’s difficult to form a view that’s based on anything. You could just say something but you don’t really know enough about it.

Interviewer: No. It’s that old adage, isn’t it? You never really know what you’d do in a situation until you're in that situation.

Respondent: Yes. So no, not really.

Interviewer: Brilliant.

What do you think are the limitations to participation in abortion?

Respondent: If you’ve got a conscientious objection or just generally?

Interviewer: Either or. Generally, what’s your view?

Respondent: Directing women to a service that will provide an abortion. That’s contributing to the process, isn’t it? Basically any advice from the point of, “I want an abortion.” Any help that you give the woman.

Interviewer: Ah, so it sounds like you see abortion as a process rather than hands-on activities, for example.

Respondent: Yes.

Interviewer: I only ask that because I don’t know whether you're familiar with the case of two midwives back in 2014. Long story short. They were senior midwives. They were working in a hospital similar to the [name of hospital – midwife works at], actually, but up in Glasgow. I don’t think they’d actually participated in terminations at that point. They're practicing Catholics.

Then as systems and operations changed, procedures changed, abortions were introduced, and they created a list of 13 items that they felt constituted participation in abortion.

They took the case to court. They won originally, but then they were brought to Supreme Court and they lost. And at that point the judge ruled that abortion, when the Act was created, was envisaged as being hands-on activities only.

On their list of things, like I say there were 13 things, were things like answering a buzzer to women, providing support to families, providing support to other midwives who may be caring for those people, answering the telephone, booking people in, providing information, that type of thing. So would you see those elements as part of the abortion procedure?

Respondent: I would, but I don’t think that you should be entitled to object to them.

Interviewer: At what point would you think that somebody-?

Respondent: Probably administering drugs. That’s the actual act, isn’t it? It’s not a transaction, but that’s the moment when there’s going to be a change, and if you’ve administered a drug that’s caused that change then I can understand if someone did want to object, that they wouldn’t be comfortable with that. But I do think that they should be able to care for the person.

But, to be honest, if they object to it they probably shouldn’t be looking after her anyway, because however they look after the woman is going to be affected by their own… If it’s that much of a strong conviction you're not the best person to care for the woman, I don’t think, maybe.

Interviewer: Maybe it would come over in the quality of care.

Respondent: Yes. You would hope that it wouldn’t. And maybe someone who objects is a better… They wouldn’t think that. They would think that you wouldn’t even know.

Interviewer: But then I suppose it goes back to what you were saying earlier, that as a patient and as a woman you pick up on these subtle, unspoken, non-verbal things.

Respondent: Yes. And say you were a woman and you were getting looked after by a midwife or a nurse or whatever, and everything was fine and she was really nice and she was lovely, but then the other midwife came to give you a drug because the first one wasn’t happy to do it. It’s not continuity for the woman, and they would know then that… I don't know. It would just be a bit of a weird setup.

But I suppose the actual act of providing drugs would be the line, I think.

Interviewer: That’s the limit as such?

Respondent: If you have an objection, yes.

Interviewer: Do you think somebody who is an objector can work in this type of environment? That they can work in midwifery, nursing, gynaecology. Do you think they can work here?

Respondent: Yes, they do work here. I couldn’t comment on how it affects them because I am not an objector. I think they can work here, but I think…

It’s difficult, isn’t it? Whether you like it or not it is part of our service as a whole, in terms of answering the buzzer. As long as you're prepared to go and do those things then yes, it’s fine.

Interviewer: Do you know any colleagues who do object or have objected?

Respondent: I don’t think so. Not in the [name of hospital]. You hear people make comments about what they think, but that’s not really objecting.

Interviewer: I suppose that’s venting, really, isn’t it?

Respondent: Yes. It’s different, isn’t it? No, I don’t think I do. I did where I trained. There were midwives who just didn’t look after those women who came in.

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

Respondent: Not an awful lot, to be honest, no. Just that they got assigned to different jobs. And usually it was because they were Catholic, and that was it.

Interviewer: So it was accommodated? They just objected and then-?

Respondent: Well, yes. They just didn’t look after that woman. It wasn’t like a big thing. I think probably because there’s not many people who… I don’t think there are. I don't know. There are probably not that many midwives who object. And I think that now that we’re moving towards more…

I know people can object on a moral level, but usually it’s to do with a faith, isn’t it? So I think now that we’re moving away to a more secular society less and less people will probably object.

Interviewer: Have you been ever asked what your position is on whether you’d object or not object?

Respondent: Not directly, no. I've just been asked, “Are you okay to look after that woman?” But I don’t think they ask you those questions.

We’ve got two bereavement rooms on delivery suite. They generally allocate the same group of midwives to those rooms, and they tend to be really lovely and caring and nurturing and the perfect people to do that. Do you know what I mean?

Interviewer: Yes, for that job.

Respondent: But they will ask you, “Are you okay to go in Room 1?” or “Are you okay to go in Room 8?” But I think it’s usually because they see whether you can cope with it on that day. Because it is draining, isn’t it? It’s a different type of work. It’s mentally draining and often clinically it can obviously turn a little bit more complicated as things go on. But I've not been asked, no, if I object to any of them.

Interviewer: You mentioned earlier that you’ve had experience of working with someone previously who was an objector. Did their objection have any…? Or do you perceive any impact on colleagues that somebody who is an objector…?

Sorry. I'm not making sense, am I? In my head that makes sense. (Laughter)

Respondent: No, I understand what you mean.

Interviewer: Basically, if somebody was an objector would that have any impact on their colleagues?

Respondent: I didn’t notice it, but it probably would on their student, I think, wouldn’t it? If they were given a student midwife. That’s just hypothetical. But no, I didn’t notice.

Interviewer: No? Do you think if somebody did object that would have an impact on their colleagues and maybe their ability to do the work? Or their wellbeing or anything like that.

Respondent: Probably not here, no. It depends what group you're in, doesn’t it, and where your position in that group is? Whether you're an influential person or not. It just depends what type of person you are. Most of the midwives in the delivery suite are quite strong-willed women and aren’t really bothered about what other people think. Do you know what I mean?

Interviewer: Yes. (Laughter) They just let it wash over them.

Respondent: Yes. It just depends what sort of person you are, so I don’t know.

Interviewer: If somebody objected and you were working in that environment would it have any impact on you?

Respondent: Not really, no, because I'm not there for them.

Interviewer: You're very patient focused. That definitely comes across.

Respondent: Yes. That’s why we’re all here, isn’t it? I don’t think it would bother me what another midwife thought, because she’s not looking after her, so it doesn’t matter. As long as they were supportive if there was an emergency and they participated in an emergency then that would be fine. It wouldn’t really bother me.

Interviewer: Do you see referral to different services as part of participation in abortion? For example, I’ll give the case of a pharmacist who objects to giving or administering – or dispensing rather is the word, isn’t it? – the morning after pill. If they object they are meant to refer on. If a doctor objects to signing the forms they're meant to refer on. Would you see that as part of the abortion process?

Respondent: Yes, I think it is, because it’s facilitating the process, isn’t it? Helping to move it along.

Interviewer: Do you think objectors should be allowed to object to that?

Respondent: Personally I don’t, no. I don’t think that. But it’s hard, isn’t it? Because personally I think that… Not you lose your right to object. That sounds a bit like sweeping.

Let me start again. I don’t think that they should be able to object to that, no, but also that’s not really up to me either. They're entitled to feel how they feel. No, I just think you should just support her to do what she wants.

And if you're a GP or a pharmacist all you're doing by referring them is you're just sending them to someone who can help them. That’s all you're doing.

All that’s going to happen is that woman’s going to ask another person and they’ll go, “Yes, you need to go there.” You're not achieving anything by not telling her, like, “It’s a secret and I'm not going to tell.” It doesn’t do anyone any favours, does it? It just prolongs the experience for the woman.

Interviewer: Whose rights do you think come first, as such, with regards to this?

Respondent: That’s why it’s difficult, isn’t it? Because obviously all professionals are allowed to have their own opinions and I understand that. So I don’t know the answer to that, because that’s hard, isn’t it? I don't know.

Interviewer: It’s like the million dollar question. (Laughter)

Respondent: Yes. I suppose as long as you're very clear from the beginning that, “This is what I object to, and this is what I'm not prepared to do,” if it’s agreed at the beginning of your career or your post somewhere then that’s fine. Even if I don’t agree with it, that’s what you're happy with.

Interviewer: It sounds like you're saying that maybe if somebody identified as an objector they’d have to say to somebody in a position of authority, “I object to this.”

Respondent: Yes. It’s difficult though, isn’t it? Because what are people’s opinions on being an objector based on? Because if you go into your career as an objector and you’ve never looked after anyone, you’ve never directed anyone to services… I don't know. You don’t know everyone’s situation, do you?

Interviewer: No.

Respondent: It just seems a bit black and white for me really. That’s the bit I don’t get about being an objector. What are you objecting to? Which situation? Is it a girl who’s come in for the fifth time to have an abortion? Which happens a lot, doesn’t it? People have repeat abortions all the time. Or is it the person who’s baby is going to die when it’s born or a few days later and be in pain? Which bit aren’t you happy with? Because I feel like it being all of it just seems a bit…

Interviewer: Arbitrary almost, yes.

Respondent: Yes. It just doesn’t sit well with me, I think.

Interviewer: Do you think people should be asked what their position is?

Respondent: Probably, yes. Probably a sensible thing to do.

Interviewer: Do you speak about it amongst your colleagues at all or has it ever come up?

Respondent: No. We talked about it in the [job role] office, because we have a lot of time to talk about a lot of things. And I think doing our [job role] role we look after women in the foetal centre, the Fetal Medicine Unit, that are in different trials, so we come across women with more complex pregnancies a lot more.

Whereas on delivery suite it’s so busy and everyone is just so focused on what they're doing there isn’t that time to sit and have a chat about it.

But I think that is a good idea when you start your job. “How do you feel about this?” Because it makes you consider how you do feel about it then. So then when it comes up you're prepared with an answer, aren’t you?

Interviewer: Yes. Rather than being thrown into it at the deep end.

Respondent: Maybe there should be a bit more of a focus for students on that and how they feel about it.

Interviewer: Did you receive any training at all when you were a student?

Respondent: Not really, no. I don’t think we did. I don’t remember any. I feel like I would remember it as well, because it’s an interesting topic, isn’t it?

Interviewer: Yes. It’s like one of those ethical debates, isn’t it? People think they know where they stand and then when it comes to it you come across different situations.

Respondent: It’s a lot more grey, isn’t it?

Interviewer: Yes, it definitely is. Thank you.

Have you ever refused or considered refusing participating? You mentioned earlier there’s been some… You used the term ‘therapeutic inductions’. We use the term ‘abortion’, just to make it clear really. I appreciate that might not be the language that’s used. But has there ever been a point that you have considered refusing, wanted to refuse?

Respondent: No, I don’t think there is, because I've never been in a position that I'm uncomfortable with really.

I think the only thing that I've struggled with is… I didn’t look after the woman, but it really just… It didn’t upset me, but I couldn’t get my head around it. And this is well before I had my twins. A lady was pregnant with triplets. She’d had more embryos than is usual put in with IVF, found that she was pregnant with triplets, and then had selective reduction to twins.

And I struggled with that, because I thought, “You’ve made that happen by having more embryos put in.” Do you know what I mean?

Interviewer: Yes.

Respondent: “You’ve purposely thought, ‘I'm going to put three in and see how many babies I get’, and then…”

I understand that there are lots of complications having triplets. I'm not naïve to the fact that you're going to have complications along the way and they're going to be premature. But I just couldn’t get my head round that there was absolutely nothing wrong with that foetus. Nothing.

Interviewer: And I suppose IVF you're working against the odds of not having a baby, so you're…

Respondent: This is it. I couldn’t really square it with having the selective reduction, because I just thought, “Well, why wouldn’t you just wait and keep going as long as you possibly could until there was a problem and then deal with the problem?” But again that’s not up to me. That was up to that woman.

But it made me feel sad, because I was like, “It’s just a waste of a baby.” That sounds awful. I don’t mean that, a waste. I just couldn’t get my head round it really.

Interviewer: I know what you mean. It’s almost like there’s no hard justification to sort of go-

Respondent: No. A baby that’s healthy potentially. Although it’s a high-risk pregnancy, there’s no evidence that there’s anything wrong with that baby, that it’s going to have a difficult time when it’s born, that it’s going to die, that you're going to be unwell. I just couldn’t…

In the end it was very, very sad. The woman ended up losing… I think she might have lost all of them or another one of them.

Again, this is what I mean about carrying the weight of your decisions. It’s irrelevant what I think. That woman is carrying the weight of that decision for the rest of her life, and that’s enough, isn’t it? She doesn’t need someone being judgy.

But I don’t think I would have been comfortable looking after her. I would have looked after her, but I wouldn’t have been happy about it, because I would have just thought… Well, it would have made me sad. Do you know what I mean?

Interviewer: Yes. I suppose the other end of that spectrum is you could argue the same for a social abortion really.

Respondent: Absolutely, yes. But this is the line, isn’t it? I'm only looking at it as a midwife and I only meet women later on when the baby is viable. But that’s a really good point. Every abortion is a potentially viable baby, isn’t it?

Interviewer: I suppose it’s a little bit harder the later on, because… Not that I've ever seen the procedure. I'm speaking to different midwives and they describe it. I wouldn’t go so far as to say graphically. That’s unfair. They describe that they see. You do kind of go, “Ooh.” It’s a hard thing to swallow.

Respondent: Yes, it is.

Interviewer: So I wonder whether that makes a bit of a difference.

Respondent: I think that’s probably what it is. When I was training I looked after women who were having social abortions, like from 13 weeks or less, as part of my training, and you’d give the women the misoprostol. So I have experience looking after women. You’d give them the misoprostol and they would put it in their vagina themselves, obviously inducing abortion.

When obviously all the products of conception are delivered it looks different to a baby. Even though it’s the same. It’s just a little bit further down the line. It is different, isn’t it? Emotionally it’s a different level. But it is the same thing, really, isn’t it?

Interviewer: Yes. It sounds like it’s almost like that tipping point of the viability issue.

Respondent: Yes. When is it okay to object and when is it not okay to object? And I don’t know the answer to that.

Interviewer: No. I don’t think anyone really does at the moment. Hopefully we’ll find out. (Laughter)

Have you ever cared for a woman who’s been refused an abortion before?

Respondent: No. I've looked after women who have wanted an abortion but it’s been too late and then they’ve had a baby. I've looked after them women in labour, a couple of them.

And I've looked after women who have gone to [name of abortion clinic], changed their mind, and then…

Because a couple of women have gone to [name of abortion clinic], found out there’s two of them, there’s twins, and then they think, “I’ll carry on.” That happens more than you would think.

Interviewer: Oh, really?

Respondent: Yes.

Interviewer: That’s interesting.

Respondent: Yes, it is interesting, isn’t it? Because obviously you can see all the woman’s notes previously and that does happen. And it’s probably because it’s so rare. They think, “I might not get this opportunity again.” Do you know what I mean?

Interviewer: Double the guilt.

Respondent: Well, yes. You don’t know, do you? So I've looked after them women. I've looked after women who have waited too long to go and get an abortion and they’ve ended up continuing with the pregnancy.

Interviewer: They’ve waited too long and then they’ve passed the 20-odd week?

Respondent: Yes.

Interviewer: I'm sorry. I should really know that off the top of my head, but the 24-week-

Respondent: Yes, 24 weeks. They’ve passed the point and not been able to have an abortion. I've looked after them women.

Interviewer: That’s interesting.

I've asked whether you’ve heard of any colleagues who’ve objected.

Sorry. I seem to have asked quite a lot of what I wanted to ask.

Respondent: That’s alright. That’s fine.

Interviewer: Oh, yes. I don’t know whether you know. There’s some places in the world that as a healthcare practitioner you can’t object, like Sweden and I think Iceland. Then also there’s countries like Italy, where whole institutions will invoke their right to conscientiously object. I'm making a jump and an assumption here but I assume that’s religious based.

I'm just wondering what your thoughts are on that. Do you think the conscientious objection should be entirely unlawful, or do you think it’s okay that institutions invoke that right?

Respondent: I think it’s okay, even though personally I don’t agree with it, because people are entitled to their own moral views. I don’t think you should be unable to object, because again it’s sweeping, isn’t it? Again, it’s exactly the same as being able to object. You can’t stop people from objecting, because where is the line where…?

In Iceland they’ve got the lowest rates of people with Down syndrome in the world.

Interviewer: Somebody told me that previously. It’s interesting.

Respondent: I don't know the exact number, but the majority of women who have screening for congenital abnormalities and their baby’s found to have Down syndrome decide to have a termination. It’s interesting that in Iceland you're not allowed to object, isn’t it?

Interviewer: Yes.

Respondent: Because it’s not just objection, is it? It’s objection, again, to what? Obviously, terminations, but for what reason? It’s not as easy as just that. There’s so many different things that go into it. I think you should be able to object, yes. I don’t know at what point though. Probably administering medication.

Interviewer: It sounds as though you see abortion as a process of different elements to getting to the end, and although you accept that that abortion might not have happened if the woman hadn’t had all these other previous bits that the abortion only really happens when medication’s administered.

Respondent: Yes.

Interviewer: Yes, I can see that. I can see why that is.

Do you think there’s a conflict of interest or a problem to be an objector if you're caring for somebody who may choose to take an abortion or have an abortion?

Respondent: Yes.

Interviewer: How do you think it would work? Or could it work?

Respondent: Again, it’s just what we were saying before, isn’t it? It depends. If you’re a nurse and you're a conscientious objector you probably shouldn’t be working in an early pregnancy assessment unit or a unit that offers abortion, because that is going to be a big part of early pregnancy.

So it depends where you work. You should go and work in another department, like respiratory or like cardiac or something. Just don’t be there. (Laughter)

Interviewer: Have a bit of forethought on what you're going to do.

Respondent: Yes. You just wouldn’t put yourself… But that shouldn’t exclude you just from gynaecology nursing, because you might really love gynaecology.

I don't know how it would work really. I think it depends what sort of person you are.

I had a friend years ago. She went to the GP to ask for a termination, and he objected and said no and sent her-

Interviewer: Oh, what impact did that have on her?

Respondent: She was devastated. She was really upset. And she said she felt like he wouldn’t help her. He wouldn’t help her any further and said she needed to make another appointment and see another GP. So she did. Saw another GP and then got referred, I think, to wherever she was going for the termination.

But it is a conflict of interest, and it just won’t work, will it? Because if you declare it to the patient you can’t…

Interviewer: Undeclare it.

Respondent: No. You’ve said it, haven’t you?

Interviewer: Yes. What impact did it have on her? You say she was devastated.

Respondent: She was really upset. I remember she was sad that she was making that decision anyway. She had a lot of guilt around it. But at the time she felt like it was the right thing to do.

We used to live in a house share, and she came home and she was crying. She was like, “What am I going to do?” So she made another appointment, went back.

Then we ended up losing touch, because she got pregnant again pretty soon afterwards and has got a daughter, and then when I trained she had another abortion. We had a weird relationship then, because she thought that I wouldn’t approve of it because I was a midwife. Do you know I mean?

Interviewer: Yes.

Respondent: So we drifted apart a bit after that. Then when I saw her again months later and was like, “What’s going on?” she was like, “Well,” and told me why it was that we hadn’t seen each other. And I was like, “What?” (Laughter)

Yes, it was really sad. I felt really horrible for her. That might have something to do with why I think that you should just help the woman in what she wants.

Interviewer: You’ve definitely had various different experiences that may have informed. Because, like you say, we are all shaped by our experience.

Respondent: Yes. You’re products of what’s come before, aren’t you? But yes, that was really upsetting for her, and it made her feel more guilty about the decision that she was making and she struggled with it.

Interviewer: Yes. Which doesn’t sound very nice for her at all, does it?

Respondent: No.

Interviewer: In the Abortion Act there is the clause that you can conscientiously object. If that…?

Sorry. I’ll go back a little bit. The Abortion Act was introduced over 50 years ago. Obviously, abortion at that point was a medical procedure, or surgical procedure I should say, and obviously now there’s different ways. Pharmacists are involved. Nurses are involved. Midwives are involved. Doctors as well. But obviously it’s changed in the way that it’s carried out.

If the Abortion Act was overhauled, for example, and the conscience clause was scrapped, what do you think should maybe replace it, if anything?

Respondent: Probably just another clause but with more clarification. And a lot of research would have to go into what people think, what professionals feel is acceptable, and what women feel is acceptable as well. It just needs to be clearer, doesn’t it, where that line is? Because I think in the information leaflet there’s not a lot of guidance round it.

Interviewer: From what I can remember the wording of the Act is just very, ‘A healthcare professional has got the right to conscientiously object’.

Respondent: It’s strange, isn’t it? It was over 50 years ago. If you think of how many things have changed in healthcare in 50 years but not that. Technology has changed. Abortions have changed.

Interviewer: And everything, I suppose especially in the NHS, is evidence based, everything in the NHS.

Respondent: Yes, absolutely. Yes, so I think that what you're doing is really good. I think it would be good to speak to women as well.

Interviewer: Yes, definitely, because I think we need that 360 sort of thing.

I think I've asked everything. You’ve been absolutely brilliant. Do you mind if I just scoot through and make sure I haven’t missed anything off?

Respondent: Yes, that’s fine.

Interviewer: Sorry. Just going off a little bit, would you perceive the morning after pill as being…?

Respondent: Do you know what? I never even thought about that until you said about pharmacists before, but it is, really, isn’t it? It’s stopping a potential pregnancy. I don't know. Would I perceive it as abortion or assisting an abortion? Is that the question?

Interviewer: I was going to say, “See it as part of an abortion?”

Respondent: Yes, probably.

Interviewer: So an abortion or part of an abortion.

Respondent: It is, yes, technically, isn’t it? But it probably doesn’t feel like that, because you're potentially not even pregnant. It’s just potentially an abortion, isn’t it?

Pharmacists can object to giving people the morning after…?

Interviewer: There was a little bit of a change. Pharmacists can object to giving the morning after pill, though they do have to refer on.

But there was a recent case. It was only a few weeks back, possibly a couple of months ago, in the summer, where a woman had done all the questionnaire and ordered a morning after pill online. Went to the chemist. I think the chemist was based in a supermarket.

She phoned up to see if it was there or being processed. She was told it was ready for collection. So she went in the store, and the pharmacist who was dispensing it refused to give it to her but said, “You can go elsewhere.” They did refer her on. But it was a Sunday, so obviously everywhere shut early.

What are your thoughts on that? Do you think it’s-?

Respondent: That sounds like a bit of a joke, to be honest. She shouldn’t have got to the point where she could order it from a pharmacist who’s not going to give it to her. That’s a service issue, isn’t it?

This is what I'm saying. If you get asked at the beginning they need to make it clear that, “You’re not going to get the morning after pill when this pharmacist is working.”

It’s fine that he didn’t want to give it to her, but he should have made… That’s not really referring her on, because he hasn’t helped her, has he? He hasn’t referred her to anyone that can help her right now when she needs to be helped. He’s referring her to someone the next day when it might not even work. She shouldn’t have been able to order it, so I feel sorry for her.

Interviewer: Very time sensitive, isn’t it?

Respondent: Yes, absolutely. This is the thing. Even if he or she objected to it. That’s fine. They're entitled to do so. But you need to provide other arrangements, don’t you?

Interviewer: Yes.

Respondent: That’s hard on that woman.

Interviewer: I know. Hopefully there was some resolve to that.

Respondent: Yes, there probably was. Also whoever she ordered it off needs to sort it out. (Laughter)

Interviewer: Yes.

I think we’ve covered everything, to be honest. Is there anything that you want to add or any questions that you’d like to ask?

Respondent: No, I just think it’s really interesting work that you're doing and I'm interested to read all of the findings.

Interviewer: Oh, yes. Once it’s all done.

Respondent: Yes, that would be great. And I'm sure the midwives would be interested to hear about it as well.

Not really, no. I just feel like maybe I shouldn’t have mentioned the twins now. That maybe that’s not really relevant. But I'm not just telling you for the sake of it. To me it’s relevant, because it’s affected my… Do you know what I mean?

Interviewer: Yes.

Respondent: But I know that that’s not what this interview is about.

Interviewer: It’s absolutely relevant, because what we’re interested in is your opinion. And, like you say, your experience and everyone’s experience informs opinion, whether that experience is religion, whether that experience is seeing something or personally experiencing something. So it’s all really, really relevant.

And other people have mentioned things that they’ve encountered in their lives. Very personal things. I'm just grateful that you shared that, because it’s important. As you say, that provides the background to where you’ve come, which is what we need to understand if we’re going to have any sort of guidelines, so please don’t feel-

Respondent: Like I said to you, I wouldn’t be comfortable looking after someone having an abortion at that gestation. It’s not even a conscientious thing. Mentally I just don’t think that I could cope with that. Do you know what I mean?

Interviewer: Yes.

Respondent: So I think that’s a separate issue really. I personally wouldn’t agree with it, but if I hadn’t had the twins I wouldn’t agree with it but I probably still would have looked after her. But now I just wouldn’t be able to look after her, because that was extremely traumatic for me and I wouldn’t put myself… I wouldn’t give her good care, because I just couldn’t concentrate on the situation. Does that make sense?

Interviewer: Yes, it’s absolutely understandable.

Respondent: I don’t think that’s a moral thing. I think it’s just more of a personal thing.

Interviewer: You’ve got to protect yourself almost, yes.

Respondent: Yes. That’s what it’s about, isn’t it?

Interviewer: Yes. Almost having that professional boundary to protect your own wellbeing.

Respondent: Well, that’s it, yes. My career’s different now because of that. When I go to delivery suite, and I had the twins on delivery suite, I'm happy to work there because that’s my job and I'm good at it, but I wouldn’t want to go into the room where I had them. I would never do that again. It’s just about protecting myself, isn’t it?

Interviewer: Well, it’s like revisiting.

Respondent: Yes. It was bad enough having to come back to work. I don't know. But that’s not an objection thing. Does that make sense?

Interviewer: It sounds to me that you're saying if you’d never experienced what you’ve experienced you would not agree with what the woman was choosing to do but you’d still look after her.

Respondent: But I’d still look after her. I’d make sure she was safe and that she was okay.

Interviewer: And it wouldn’t affect your care.

Respondent: I don’t think it would, no.

Interviewer: Whilst right now you know that it wouldn’t affect the way that you’d treat that woman, in the sense that you’d still believe that it was her choice, but actually you’ve got to take that-

Respondent: Yes, I wouldn’t be able to look after her now.

Interviewer: You’ve got to protect yourself.

Respondent: For myself, yes, rather than…

Interviewer: It’s like an ambulance man or woman who experiences some sort of traumatic experience. They're not going to necessarily want to put themselves in that situation again. We’re all human at the end of the day. That’s clear. That’s come across.

Respondent: That’s good.

Interviewer: Thank you very much.

Respondent: That’s fine. Thank you.

Interviewer: Thanks. No, that’s great.

Respondent: You’re very welcome.

Interviewer: Brilliant.

END AUDIO

[www.uktranscription.com](http://www.uktranscription.com)