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Duration: 0:46:10
Date: 16/12/2019
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Respondent: I do lots of [job role]. They’re around perhaps women who want to make decisions that are a little bit outside of our guidelines, so they don’t want to stick to what we recommend. So I see lots of them who had planned home birth, but who might be having twins or something like that, where we wouldn’t recommend that. We’d go through what the options are and things like that.

But I see lots of different women. I see women who have got fear of birth, who want to have a caesarean and there’s no reason. So quite wide ranging really. I see women who are having babies with abnormalities or who have been traumatised, because they’ve been through something difficult in the past, like a miscarriage or a termination.

I’ve worked in the delivery suite for about [number of years] years here, and so I was directly involved in looking after women then.

Interviewer: So have you been a midwife for [number of years] years then?

Respondent: I’ve been a midwife since [year], however long that is now, that’s a long time.

Interviewer: My brain’s not working to calculate that.

 (Laughter)

Respondent: [Number of years] years.

Interviewer: Oh, so what you don’t know about midwifery is not worth knowing then.

 (Laughter)

Respondent: No, it’s not like that midwifery, you learn something new every day that’s why it keeps you on your toes. You can’t learn all of it definitely, it’s an impossibility.

Interviewer: The joys of working with humans.

 (Laughter)

 Okay, so can you tell me, is abortion something that you come across often in your practice, or have done in the past maybe?

Respondent: In the past, definitely. So I’m on the [department name] here, we look after a lot of women who would perhaps terminate their pregnancies because of a serious foetal abnormality. We get a lot of women coming over from [country name], because they can’t access that service there. So a number tends to be the later in pregnancy, rather than the very early abortion. So there’s usually a reason why those women are having an abortion, other than it being their choice.

Interviewer: What’s your feeling about that? How do you feel?

Respondent: About women choosing an early pregnancy or?

Interviewer: Yes, both really.

Respondent: I think, personally it’s probably not something I would do myself, but I can bracket that I think, because I’m a really strong believer in women’s rights and it is a woman’s right to choose to do whatever she wants with her body, including whether she wants to have a pregnancy.

It’s difficult to understand and it’s not for us to judge or to try and understand women’s situations. If that’s what somebody feels is the right thing for them, at that time in their life, then I certainly believe that should be available for women.

Interviewer: Yes, so it sounds like you have two heads, almost like a personal head where for you it’s not something for you, but actually on a professional front, you accept it’s part of the job role maybe?

Respondent: Yes, absolutely. You wouldn’t know, because I’ve never been in that situation, so you don’t know until you’re in that situation, do you? We come across women who are in terrible situations, where it actually absolutely conflicts with strong religious beliefs. You know that they’ve got an abnormal baby that stands no chance of being born alive, so what do you do in that situation? Do you go through the whole pregnancy? And yes, I’ve looked after women who’ve had such strong beliefs that they wouldn’t do anything, and they’ve given birth at full term to an abnormal baby and then the baby’s either died at the end of pregnancy or been born and died soon afterwards.

 They have to make that really, really difficult decision, and you can see the conflict that causes. But I think we’ve got a pretty good team here, and we’ve even got – I don’t know if you’ve heard of anybody else talk of Father [name of Priest]?

Interviewer: No.

Respondent: So Father [name of Priest]’s one of our – so he’s obviously a priest, he’s a Catholic priest, so it’s quite unusual for women who’ve chosen to have a termination, to be supported by a Catholic priest.

Interviewer: Yes, it is, isn’t it?

Respondent: Father [name of Priest] will come and do a blessing on the baby and he’s absolutely fantastic. So clearly being a Catholic priest, he doesn’t believe in abortion. But he can see the needs of the women and put a bracket around his personal beliefs and actually give the women the support that they need. And for the women who come over from [country name] that’s just like, invaluable.

Interviewer: Yes, it’s compassionate isn’t it? You know compassion, as a very lapsed Catholic I understand compassion does run within the religion, as for most religions.

Respondent: But it conflicts, doesn’t it? For some people it’s a real struggle when they get something that really conflicts with their religious belief. But then you’ll get some people who can seem to say, “Well this is my belief, but this is the situation, and I need to reach out to this person, and it doesn’t really matter so much what my personal beliefs are.” That desire to look after and care for somebody who’s had to go through that difficult decision, I think for some people overrides their personal beliefs.

Interviewer: Yes, it’s like a rational approach really, or a humanistic approach really to a very difficult situation, you can only imagine.

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

Respondent: I mean I have been thinking about, just like this morning really to be honest. I mean the way that we interpret it on the labour ward, is really, if anybody does strongly object, then they don’t take part in the actual initiation of the procedure. So they might not be involved in taking the actual consent.

 So we’ll have some doctors who won’t be involved in consenting women to have the procedure or prescribing the medications, because they’ve got an objection to that.

 Then, we have had some midwives who have objected to giving the first dose of the medication and I think that still falls within being a conscientious objector. So they haven’t actually prescribed it, but in our hospital, I think it’s a bit unusual, we used to have the midwives giving the doses of vaginal Prostaglandin, and that would be the very first step in the process.

 Whereas in lots of hospitals it would be the doctor who prescribed it who would give the first step, and then the midwife would just look after the women afterwards. So that was when I worked up in [name of area in UK], that’s what happened there.

 But when I came here, the midwife would actually give the first. So we had a few midwives who felt that because it was the first step in actually starting that process, then they wouldn’t want to be involved in that. So they didn’t have to be involved in that.

 I don’t know if that’s a legal thing, I really don’t know that much about the law, but that made sense to me, that you wouldn’t false somebody who, from looking after your staff point of view, you wouldn’t want to put somebody in that situation, because that’s a heavy burden for them to carry personally, isn’t it? If they believe they actually initiated the abortion.

Interviewer: What reasons did they give, or did they give any?

Respondent: I can only think of a couple of people, but it was their religious beliefs that they didn’t feel like that married up with – I don’t know if they thought they would be burnt or whatever. I’m not a Catholic, but it was more a couple of colleagues who definitely had strong Catholic beliefs didn’t feel that that was something that they could take part in. But I don’t really know what the thinking is behind that. Whether it’s you don’t go to heaven or you go to hell or whatever it is.

Interviewer: You’re probably asking the wrong Catholic, to be fair.

 (Laughter)

Respondent: But it must be something really strong, underpinning that, because these weren’t people who didn’t care about women. They were very caring people; it was just that was the point that they couldn’t go to. But then they would look after the women afterwards and be very caring with the babies and things like that. It wasn’t like they wouldn’t take part in anything.

 I don’t think I’ve met anybody at this hospital, and previously, who said, “I’m not having anything to do with it at all.” I think it’s just that initial, whether you want to be involved in making that final decision. It sort of makes sense as well, because you might influence, because it is hard to talk to somebody and come across in a compassionate way that really conflicts with you.

Interviewer: Oh God, I can only imagine, yes.

Respondent: In my role now, you know I meet so many women who are doing things now, that doctors would believe is the wrong thing. It’s like against what they believe is the correct thing. So an example would be, in fact I’ve got a lady today. So she’s very, very overdue and our hospital guideline is that we offer induction when somebody is a week overdue. We encourage it when she’s ten days overdue, and we say, “It must happen before you’re forty-two weeks.” This lady is over that and she understands that it’s because there’s a risk of stillbirth. So I’m supporting that lady because every doctor she’s met is like, “But you really have to do this.” But she doesn’t have to do it, because it’s her choice.

 I get lots of different scenarios. It’s a bit similar really isn’t it? That they’ve got such a strong belief that they don’t want any babies to die, that they’d probably induce everybody before they got to full term, because they never want to be in that situation.

 I’ve been caring for this woman, and she ended up having a stillbirth, but that’s not actually their decision to take. It’s about giving the woman the information and her making her own decision and trying to not let her know what you feel.

Interviewer: Yes, so it’s like again that professional front almost comes forward.

 You mentioned there about conscientious objection with your colleagues. Were they vocal in their conscientious objection? Is it something you’d discuss regularly?

Respondent: Yes, because on the labour ward it’s very busy and I do think you need to know if there’s somebody who wouldn’t want to be involved, because there’s not loads of staff just hanging around, so you need to know.

 I know, I mean her name is [name of colleague], obviously don’t use that, but I know that [name of colleague] would never want to look after a lady or do that first step. But she would come into the room if I asked her to come in and support me, as the baby is being delivered, and she would look after the lady afterwards and she’d support other midwives to do it, because she’s a senior midwife. But she would never want to do that first step herself.

 So I think it’s important that you know which members of your staff do have these objections, because you don’t want to put anybody in that situation.

Interviewer: No, no, that’s true. And I suppose it’s about management as well? You know, management of staff, management of skills as well. You’ve got a lot to deal with.

Respondent: We haven’t got a lot of midwives who I’m aware of, have those objections, it’s useful.

Interviewer: As midwives, is it something that you’ve discussed previously, or you talk about openly?

Respondent: I’d say I’ve had a couple of discussions, but more on a one to one basis. It’s not something that we talk about a lot. I think it’s just something that we know, so and so doesn’t want to be – but I don’t think we talk about it probably as much as we should do. How we feel about it and I would say that goes for lots of midwifery issues. We’re just there and doing the job and yes it would definitely be useful to take some time out and explore how we all feel about these things.

Interviewer: The reality is time, isn’t it? The time consumption of it, I suppose.

Respondent: Yes, so if we had an incident, then yes we’ll do something. So if there was an issue, then we would all get together and talk about it, and we might get some actions to do and things to change. But if there’s not really an incident and everything is just bobbing along, then there’s probably not much time, just every day, I wouldn’t say that we really talk about it a lot.

Interviewer: Yes, I understand.

Respondent: Probably in some areas they might do. So say the midwives in the foetal medicine unit might have more in-depth – I don’t know, because I don’t really work there.

Interviewer: Obviously you know, conscientious objection exists, it is sort of in law as such. Were you ever asked when you were employed, what your position was on conscientious objection?

Respondent: No.

Interviewer: Or we refer to people who may not wish to participate in abortion as objectors, just as a shorthand label for us. Were you asked if you were ever an objector or a non-objector?

Respondent: No. I’ve never been asked that question anywhere that I’ve worked. I’ve worked in [number of hospitals] different maternity hospitals.

Interviewer: So going back to conscientious objection and abortion, what’s helped inform your views? Your own views around the area?

Respondent: I think I’m just like a feminist. I think that’s the bottom line and I think my mum was a strong feminist and that belief that women have a right to control what happens to their own bodies and that these decisions are never easy for any woman to take. But there might be times in your life where it’s something that… And we should have that right.

 It really, really worries me, like in America where women can’t choose. The foetus has rights and all this, it’s a very worrying situation and you hear awful stories about what’s happened to women and being forced to have caesarean sections and being forced to continue with pregnancies and all kinds of things.

 When, that’s just not acceptable to me. I think that’s just part of who I am. I don’t really know where it came from, probably just from when I was small and being with my mum and my nan and all of those things.

Interviewer: Lots of strong women.

Respondent: Yes.

Interviewer: We need strong women in the world, we definitely do need strong women in the world.

 (Laughter)

 Did you have a particular view on abortion, coming into the profession?

Respondent: No, it was the same. I thought that women should have the right to choose if they want to have an abortion. But they also need the support to make that decision, because I know that making a decision like that can have a massive impact on women’s mental health going forward. So it’s not a decision anybody should take lightly and offering that support, to actually think the decision through, I think that’s a really important part of it.

 Not just to say that should be a snap decision, but to have somebody to go through. And if you want to tell them the reasons, tell them the reasons. If you don’t want to tell them the reasons, then you don’t have to tell them the reasons. But for some people it’s an emotional turmoil, isn’t it? And if they make the decision quickly and then they regret it afterwards.

 In my [job role] I meet lots of women who have got a lot of guilt, because, did they really make that decision for their own reasons? Or did they make it, you know, because of their partner, or whatever was going on at the time.

Interviewer: Being pressured maybe?

Respondent: Yes.

Interviewer: That must be very difficult for them, it must be very difficult.

 Have you views changed around abortion since becoming a midwife, or working as a midwife?

Respondent: I don’t think, because of my work in midwifery. I think sometimes I struggle a little bit with the work in the foetal medicine unit. More so if there’s a problem in the baby and I do worry a little bit that we’re getting to the point of, everybody wanting an absolutely perfect baby. And I struggle a little bit with that. At which point are we going to actually stop and say, “But this is still normal, it’s just a normal variation.”

 So some of the genetic conditions, where people can have a very fulfilling life, people will still receive counselling and I think sometimes the women don’t have an understanding that, actually this might be a perfectly normal human being, it’s just got a genetic condition. I think that’s possibly changed, because I personally have a genetic condition, which I’ve passed to both of my children.

 They’re fine, absolutely fine, they’re young adults now. But at that point, when I found out and the baby was still inside, everybody was sort of skirting around the issue, but nobody actually said to me, “Have you thought about a termination?” And I think probably because they knew that I knew that was an option, but nobody actually said that.

 But I probably would have been very upset if they had said that, and I’ve got two fit, healthy children, that potentially, if I hadn’t had the knowledge I had, I would have been offered a termination. Because they thought it was quite a serious [type of condition] at the time, but it just didn’t occur to me that I would not carry on with the pregnancy, because there was always a chance that it would be fine.

Interviewer: And again, it comes down to personal choice, doesn’t it, I suppose?

Respondent: Yes.

Interviewer: Can you give an example of, you mentioned there in the foetal medicine unit, sometimes you worry about some genetic conditions and you mentioned the [type of condition]. Are there other conditions?

Respondent; I think downs syndrome is one of them. Because I’ve got a family member who is downs syndrome, he’s now 50. He’s absolutely fine. He has a brilliant life; he loves his life he’s got that valuable contribution. But I think sometimes the way we present downs syndrome, it’s the worst-case scenario. You know baby could have a serious heart condition. It’s going to have serious developmental delay.

 It’s about the way you present the information. I’ve no objection at all if somebody doesn’t want to have a downs syndrome baby, but actually some people make that decision based on the information they’ve been given about downs syndrome. And it’s hard, because you don’t know, you don’t know if you’re going to get the worst case, or you’re going to get a very valuable person to society, and somebody who is going to bring you a lot of joy in your life. You don’t really know what you’re going to get.

Interviewer: I suppose that’s true about any baby though, isn’t it?

Respondent: Absolutely, but that’s what I would say. You don’t know what you’re going to get.

 (Laughter)

 I don’t think we present it so much like that. I think we present it like, “This is a serious genetic condition and we’ve had all of these tests because there’s an option that you can terminate.” I don’t know if we do it in a – I think it depends on who they see.

Interviewer: Yes, it’s quite an ethical debate around that, isn’t there?

Respondent: Yes.

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

 So you mentioned a little bit earlier about your colleague who refused in the first step, but then she would go on to care for the woman. It sounds like she takes quite a narrow view of what abortion is, in terms of its hands on administering the medication?

Respondent: Yes.

Interviewer: But the other people might take a more broader view and say a pharmacist who refuses to give abortion… Oh sorry, morning after pill, will signpost or refuses to signpost rather, they take a broad perspective in anything to do with the procedure as such?

Respondent: I think if you could facilitate that, because you don’t want anybody to feel really uncomfortable, but I don’t think it’s a legal thing, that you can object to being involved in it. Because then at what point would you stop? What point would you stop who’s not involved? Do we have to tell everybody that that lady in that room is having an abortion? You can’t possibly do that, can you?

So it shouldn’t be fair that the pharmacist is aware of what that medication does, so she doesn’t get involved in the care. But the healthcare assistant, who doesn’t really know why that lady’s in that room, but she’s been asked to go and help her have a wash, that she actually would have to be involved.

 So I think that’s impossible to implement. But if somebody specifically says, “I really don’t want to do this.” And they’re aware of what they’re doing, then if you could facilitate it, then facilitate it, because staff are important as well, aren’t they? But it would be interesting to explore their reasons for it.

Interviewer: Yes, it kind of brings me to mind of, I don’t know whether you’re familiar with the case of the two midwives from Scotland. So it was back in 2014, two midwives working in a hospital similar to the [hospital name] and originally the ward wasn’t doing abortions that they worked on. They were senior midwives and then abortions were brought in, as such.

 They invoked their right to conscientiously object, and they came up with 13 points, or 13 things that they perceived would be participation in abortion, such as booking women in, answering telephone calls, answering emergency buzzers, providing support to family members and the woman. Providing support to other midwives who may be caring for those women.

 They took the case to court. They originally won, but then it was overturned in Supreme Court and they lost. The judge there ruled that when the Abortion Act was envisaged, it was envisaged that abortion participation referred to, or the conscientious clause, was only referred to hands on activities of abortion, such as administering the medication.

 I am just wondering are what your views and opinions are on that?

Respondent: I would agree with that, because it’s too difficult. And isn’t it a breach of somebody’s human rights to tell every single person working in a hospital, “This woman’s having an abortion, so do you want to be involved in her care or not?” It’s just an impossible situation, isn’t it?

 How would those midwives know if a midwife was upset the day after, and she’d inadvertently supported her, and then it turned out it was about the care she’d provided to a lady having an abortion, the day before. It just doesn’t work in practice, that, does it?

Interviewer: It’s seen that you sort of almost take the view of the judge, that it should be limited as such, conscientious objection?

Respondent: Yes.

Interviewer: To hands on activities?

Respondent: I do, but if it was a member of staff and they were very – you know I wouldn’t purposely put them in that situation, if you could possibly help it. Because that’s not going to be good for the woman either is it? If that comes across, which very subtle things, it can come across. I don’t think anybody would walk in and say, “I’ve been made to come in and look after you and I really don’t agree with what you’re doing.”

But just very little things, you know, the woman can pick up, “This person doesn’t really want to look after me, there’s something about what I’m doing that this person doesn’t like.” You wouldn’t want the staff to be in that position. You wouldn’t want the woman to feel like that.

 So if you could facilitate it, but I think that every single activity that’s involved in the care of a woman who’s has chosen to have an abortion, that’s just crazy and it’s not feasible is it?

Interviewer: Do you think conscientious objection can be accommodated if somebody did take that broad perspective?

Respondent: Not really, not without compromising the woman’s right to privacy and dignity, no I don’t think you could really.

Interviewer: Do you think it could be accommodated if some people were a little bit more narrow in what they perceive participation in abortion is, such as hands on activities?

Respondent: I think it would be useful to have some kind of guidance on what… What the law says you can do. I think that would be useful, but in practice I think that people would still change its guidance on practice might be a little bit different to what the law says. So I think guidance on practice might be more useful from a pragmatic point of view of people working in the NHS.

Interviewer: Do you see referral as participation or signposting women to abortion care or services as participation in abortion?

Respondent: No, because a lot of women don’t actually want to have the abortion. They want to talk about, “What my options are.” That’s what they want. But actually, when you talk to people that might be the last thing they want, they might be feeling it’s the only option at that point in time.

But after the conversation they might think, “Well no, I’m going to go and get some psychological support or help with my relationship.” Or whatever else it is that’s leading them to think about that as an option.

 So no, I don’t think it is, but I can see that some people would, but personally I don’t.

Interviewer: That’s brilliant. And like you say, just because somebody accesses that care, doesn’t necessarily mean they’re going to end up having an abortion, does it? It seems like that’s what you’re saying?

Respondent: Yes.

Interviewer: What would your limits to participation in abortion be? Sorry, it’s quite a sensitive question that.

Respondent: I don’t really have any limits, but I’ve never been involved in women who’ve chosen to have multiple abortions, because they’ve just got pregnant lots and lots of times. But I can say that I’ve met lots of women like that, who have had multiple terminations in early pregnancy, just because they haven’t really done anything about contraception.

And I still feel that you should have a right to end a pregnancy if that’s not the right thing for you. And some of the women have got dreadful social circumstances, and goodness knows what’s going on, and why they have multiple pregnancies, and feel that they need to do that.

 But I think that’s still fine. But no I’ve personally given the first dose of prostaglandin to women who’ve chosen to have an abortion, but only really in the context of foetal abnormality. But not always serious foetal abnormality or definite foetal abnormality.

 So sometimes it has been possible, structural, and then when the baby comes out, there’s actually not that much – not as serious as we thought.

Interviewer: Yes, that must be difficult.

Respondent: We used to get them all years ago, the scans are much better now. When I was first a midwife, sometimes you would get that, the doctor might have said, “Your baby has got a serious structural abnormality.” And then the baby would come out and it wouldn’t have as much as the woman had been led to believe.

Interviewer: Ah, that must be very difficult, very difficult for you and the patients.

Respondent: But luckily now, we don’t get so much of that. The genetic testing and everything’s much better as well.

Interviewer: Ah, that’s good. Have you ever refused or considered refusing participation in abortion?

Respondent: No.

Interviewer: Are there any circumstances that you can sort of consider that you might?

Respondent: I don’t think so.

Interviewer: I suppose it’s hard to say unless you’re faced with a particular situation?

Respondent: Yes.

Interviewer: Say, for example, a woman decided for social reasons she wanted an abortion at 32 weeks, how would that sit? I’m sorry it’s a sensitive question.

Respondent: No, no, it’s fine. That is a difference. So if it was a baby that was well, then I’d be very worried about that woman, that she’s made such a really massive decision. But if she had serious psychological problems, if she needed treatment herself or a condition, there would be situations where that is still absolutely an acceptable thing to do.

 We have had women who have had serious cancer, and things like that. But don’t usually, they would just have an early delivery, they’re not talking about termination. That’s usually what happens, they’ll have an early delivery. I don’t think you’d find a doctor who would do a feticide. We normally do feticide before we do the delivery, and we’re not going to be doing feticide after.

Interviewer: That’s brilliant, thank you. Have you ever experienced a woman seeking an abortion who has been refused an abortion elsewhere?

Respondent: Just the women from [country name] really. We did get the woman would have a scan and there would be serious abnormality and then they would get sent really to – or given information about our foetal medicine unit. That was just, well it still is, we still get women in very, very difficulty situations, because then, they’re often taking their little tiny baby back over to [name of country] with them.

It’s just not compassionate, is it, to tell the women that sort of news and then say, “We can’t help you here, but if you get on a ferry and make your way in, it’s very expensive, and all of this.” Some of the women – there must be women who’ve had to go through absolutely dreadful things, because they haven’t been able to get over to [city name].

Interviewer: What impact does that have on the woman, being refused that abortion care?

Respondent: I think obviously there’s the practicalities, but I think it’s a point of turmoil, isn’t it? It’s absolutely a dreadful situation to be in, and then to have people around you say, “But we can’t do anything, because we don’t believe it’s the right thing to do.”

Well a lot of these women don’t really believe it’s the right thing to do either, that it’s against their religious beliefs. But what else? Are you going to go to full term and give birth to a very abnormal baby? We’re not talking just little things; we’re talking very serious things. That’s an intolerable situation as well.

 It must have a massive emotional…We don’t really see the women very much afterwards, but there must be multiple women who actually then can’t go and get any support, because there won’t be any counselling available to these women, or they won’t want to go and tell their GP.

Interviewer: The fear of being judged I suppose comes in, quite a lot there.

 On a slightly different perspective, does objection from a colleague’s perspective, does that put any strain on any other colleagues?

Respondent: As far as I’m aware we don’t have a huge amount of people who are conscientious objectors in the Trust. I think we have one or two different doctors, but we have a pretty good system of being able to refer to people who we know will help. So we don’t have an issue getting women seen or anything like that.

 I mean we’ve got some fantastic doctors in foetal medicine who are – they will really support women with whatever they want to do with their bodies. So I think we’re quite fortunate. I’m sure at other hospitals where we haven’t got quite as many experienced consultants or people who’ve actually supported women who’ve got such difficult decisions to make, previously, then that would be a real struggle. But here I think we’re really fortunate.

Interviewer: Yes, it’s a big hospital I suppose. Where one person might refuse, another person might step in. It sounds like you’re saying that?

Respondent: Yes.

Interviewer: The scenario happens?

Respondent: Yes, definitely.

Interviewer: What elements of the process of abortion do you think midwives should be able to refrain from?

Respondent: I don’t think it should be like a set rule. I think it should be perhaps individualised really. You know that first giving of the medication, I think is a big thing for the midwives who do object. I think that’s the main thing.

 But once that woman’s in labour she’s in labour and no, I don’t think we have anybody who wouldn’t look after a woman in labour, whether her baby has died or whether her baby is alive.

But if somebody really doesn’t feel comfortable doing that, because the woman’s chosen to have an abortion, then I don’t think we should put those midwives in with that woman. It’s not the right thing for anybody.

Interviewer: So there are places in the world, such as, where professionals can’t conscientiously object, so like Sweden is one. I think Iceland might be another and then there’s other countries like Italy, where who institutions will invoke their right to conscientiously object. Obviously, I assume there’s a big religious element in this really, so no abortion services will be provided. I’m just wondering what your views are on that?

Respondent: It’s awful, because what do the women do, if you happen to live in that town where there’s a big hospital. I mean it’s similar to here really, isn’t it? It’s similar to the women in [country name] having to come over, and I’m sure the women will find ways to access, but it’s just making things difficult for everybody, isn’t it?

 So I think the organisation thing definitely is crazy, because you don’t know how big your catchment area is for that. Women could be travelling hundreds of miles to get what they want. What happens to the midwives in Sweden, sorry did you say?

Interviewer: It’s unlawful to conscientiously object.

Respondent: Obviously you can’t, okay.

Interviewer: You can’t no. So doctors, nurses, pharmacists, healthcare assistants, no one can object to abortion.

Respondent: And I think, as a starting point, if you had some clinical guidelines, I don’t personally think that’s a bad idea. Because it’s more about supporting your staff. So for it to be – you know it’s not about saying, “We’re going to force anybody to do it.” But, you know, the women need to be looked after, don’t they? But potentially it’s got that, somebody in some clinical area, might force somebody to go in and look after a woman who… You know and that would just be awful for both people.

Interviewer: Yes, of implications there.

Respondent: Yes.

Interviewer: Whose rights do you think sort of come first, the healthcare professionals or the patients?

Respondent: I think they’re both really, really important. I think it’s not really about rights, it’s about respecting each other’s opinions and accept that people will make decisions that we personally wouldn’t make. And that’s, from the work I’m doing, with all of the women wanting to do things outside of guidelines, it’s very, very similar to that.

And I think that’s what we need to get really good at, that we’re all individuals and we all have our own needs, and it’s about respecting what those needs are, and not judging each other. But it’s a bit harder to control that in patients, I suppose.

Interviewer: Yes.

Respondent: We could train our staff to do that well, which would be a really good starting point.

Interviewer: Do you think that anybody working as a midwife, that they should have maybe a bit more – you know if they were an objector, if it did go against their beliefs, given the way that abortion services have evolved over time, do you think they should really have a little bit of forethought of what the job role might entail and might sort of conflict and jar against their own beliefs?

Respondent: Yes, no I think that’s really important, because I do think a lot of people coming into midwifery have a really specific view, and they just think it’s all really positive and it’s for babies, and it’s you know. When you go and interview people who are coming to go onto a course, you know if they’re talking about just wanting to look after babies, then straight away midwifery is not about that, it’s about looking after the woman.

Yes, you might deliver some babies but it’s about looking after the woman, and I don’t think people really consider that we might quite regularly have to look after a woman whose baby’s died or has got an abnormality and people can find that quite shocking when they first come in. So I do feel that’s really important that you think through, “How would I feel if I’m in that situation?” Because you will be in that situation.

Interviewer: Yes.

Respondent: It’s an unavoidable situation.

Interviewer: I suppose the service, like midwifery services have changed so much in quite a short period of time really, you know, that you do everything, don’t you really?

Respondent: There’s a lot of – well we know in midwifery there’s lots of emotional work and people don’t really consider how emotional it is to be a midwife and it’s not always positive emotions, it’s lots of difficult situations as well. I think you have to have a certain level of emotional resilience to be able to manage that. So yes, thinking about that before you come into the profession would definitely be a very, very good idea.

 (Laughter)

 Or perhaps some kind of an assessment, say not just a reflection, “How would you feel about this situation, this situation?” Because you can see the people who think they want to be midwives are initially very focused on babies. But yes, they really want to support the women, but would you support a woman in this situation or this situation? Or if she didn’t agree with what you were saying? Or, if it didn’t resonate with what you would do, you know, all of those kind of things would be really difficult.

Interviewer: I suppose as human beings you’re going to come up against a multitude of different beliefs, attitudes, behaviours. You can’t really quash into one little label, as such?

Respondent: No, but I think it’s about, are you able to actually bracket your own personal beliefs, so that you can support other people. I think some people are pretty good at it, and some people aren’t so good at it, but it’s a definite quality that people who are working with women who are making these decisions, they need to have, or at least to start thinking, “I need to develop this skill.” Rather than just having their own opinions, it’s not really about that when you’re caring for people, is it? It’s not about you.

Interviewer: It sounds like you’re very patient centred, the patient does come first?

Respondent: I am, but I do think it’s really important to recognise your staff, because, as you said, thinking about, even before you come into the profession, have you got that capacity to do that emotionally? I don’t know if there’s any kind of test you can do to figure out whether that’s something people can do.

Interviewer: I should imagine there probably is.

Respondent; There probably is, but I don’t think we do anything really around that at the minute.

Interviewer: Yes, okay. If the conscientious objection clause was abolished as such, what do you think should maybe replace it, if anything?

Respondent: I think some kind of guidance for people in clinical practice really. So for doctors and midwives and nurses to say, how we should deal with people who don’t want to be involved in the care, how we manage that situation. And for services as well, if they had a large number of people and how are they going to manage? Do we have to refer people to other services, where women will get supported?

Because if you’ve got a very tiny little unit and one doctor who doesn’t believe, then women still need to access care, don’t they? But you wouldn’t want to force them to do that, because the women aren’t going to get a good standard of care. But it’s setting up that process, isn’t it?

Interviewer: Is there any referral guidelines that you maybe go to at the moment?

Respondent: There is a guideline, but I don’t if it’s around consent. I think it’s a guideline for consent for abortion, termination. But because I don’t actually do that paperwork, but yes there is part of our consent guideline that if – I’m pretty sure it’s in there.

Interviewer: Yes. That’s what I was going to ask, did you receive any training on conscientious objection, when you were doing your training?

Respondent: Not that I can remember, no, but it’s a long time.

 (Laughter)

 They might get it now, but I don’t think we got it.

Interviewer: Fair enough, like you say what was a surgical procedure is now a medical procedure.

Respondent: You do get a training in consent, but I’m pretty sure there wasn’t anything about conscientious objection in there.

Interviewer: No. Okay, I think I’ve asked everything. I know you’ve spoken about those women who do object to administering the medication. I suppose, it would be interesting to know how other colleagues perceive them. Are they aware of their objection? Or is it an implicit understanding?

Respondent: I think, because there’s only a few people who do object, then I think definitely all of the senior midwives are aware of who they are. Possibly the junior midwives aren’t aware. I don’t think we ostracise those people for their personal beliefs. I don’t think every single person knows. I think just the people who need to know, are aware of people, if they’ve got some strong views. Which I think is probably the right thing, isn’t it?

Interviewer: Well if you are an objector, you don’t want to have to go around with a red letter on, or something like?

Respondent: A big red lanyard “I object.”

 (Laughter)

Interviewer: I mean it’s like that balance, isn’t it?

Respondent: Yes.

Interviewer: Does their objection put any strain on any other colleagues?

Respondent: I don’t think so, because there’s not a lot of them. But I could imagine in some places it would, but it doesn’t do that here.

Interviewer: No, it’s a big hospital, isn’t it really? I think I’ve asked everything to be honest, is there anything that you would like to add at all, around conscientious objection, thinking about the extent and limitations of it?

Respondent: No, I don’t think so, I think we’ve covered everything.

Interviewer: Yes, it’s quite an intensive subject really to cover.

Respondent: It was fine, honestly.

Interviewer: Thank you very much.

END AUDIO

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