**File: fi4d9510 -- Midwife - Melanie.mp3  
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START AUDIO

Interviewer: Can you tell me a bit about your role at the moment, [name of respondent]?

Respondent: I work in- can I say the trust I work in?

Interviewer: Yes.

Respondent: I work at [name of Hospital] as [job title], which is a corporate role. It looks after all fields of nursing, ODP and maternity.

Interviewer: Obviously we're going to discuss conscientious objection to abortion. Really, what we want to know is, first of all, what you think that term means, conscientious objection. What does it mean to you?

Respondent: That you consciously have an opinion or a thought or a judgement towards something that's happening or you're presented with. To be honest, before this I'd never really thought we'd have a choice. I didn't realise that we could say, "Actually no, I don't agree," and I've got an option or a choice to say, "I'm not going to provide care or be involved with."

Interviewer: Was anything mentioned in your training about it at all?

Respondent: No. If anything, I mean I can't remember anything ever being discussed around conscientious objection. But if anything, you're forced to think, or you're led to think or taught to think that you always have to be non-judgemental and therefore your role is to care for people that are within your care, whether that be for say maternity delivery or if it's pre-conception advice, if it's around fertility miscarriage, TOP. I went to [name of abortion service] during my training and went to theatre list where it is evacuations, whether it's for miscarriage or TOP.

I guess I just felt that you didn't- I knew I didn't have to go there on placement or you didn't have to work there because, as a midwife, our remit is a nursing domain. But I felt like you should be non-judgemental, that they're there to be cared for and I'm here working as a midwife.

Interviewer: Would you say that people who object, you think that they are possibly being judgemental about that woman, her decision?

Respondent: Well they are, aren't they, because you're saying, "I believe something different," so I'm consciously choosing to say, "I'm not going to be involved in care because I don't agree with what you're doing so you are judging. It's an unconscious judgement really. I don't know. My opinion is it's a choice, isn't it? Sometimes you'll come in contact with women that don't have to tell you their choice why they would be presenting for a TOP. I feel like I'm there to provide the care. As long as they are informed then should I take that choice away from them by not providing the care?

Interviewer: Would you agree with countries like Sweden and Iceland where, for somebody to be in say a midwifery role, they can't conscientiously- basically, if you conscientiously object you can't have that role.

Respondent: You're talking small numbers though, aren't you? But I guess why should it always fall to the same people then who decide that they think that they're happy to provide that care? The same people though would be ultimately forced to always care for those types of women or patients because other members of staff and your colleagues won't care for them. I think that could be hard. Yes, I do, I don't think we should have a choice as such. I mean I would never want to work on a unit where they did that solely but I feel like everyone has a choice.

Sometimes, if that's part of your role, then that has to be part of your role on the understanding when you entered into a professional programme.

Interviewer: Have you ever known of any cases of anyone where they've objected?

Respondent: No.

Interviewer: You never come across it here?

Respondent: Actually, sorry, I look after the students and we did actually have one student who was placed on [name of abortion service], didn't understand what [name of abortion service] was, which is our termination ward/theatre. Hers was from a very personal reason, that she had undergone a failed infertility and felt she just couldn't, at that point- she said, "I'm not against it as in it's their choice but I don't want to be involved with my history."

Interviewer: That's quite interesting because there was some research done and when it looked at why people object, I mean what would you think the main reason is? Would you hazard a guess?

Respondent: Yes. I would say people who maybe struggle with fertility or people who are presented with patients who are having miscarriages or early losses. We've got quite a big fertility centre so when you've got thousands of people on a waiting list to come for fertility treatment and then you have a clinic where you've got a conveyor belt of people who come for terminations that can be really hard. But then again, I think as a healthcare professional it's all encompassed in part of your role.

If you're going to support people who are choosing to have, I mean it could be a designer baby or they want to have a chosen gender or you're supporting someone who's coming for sperm donation and wants a specific ethnicity or wants this particular background, it's all the same thing. That's your choice and you're supported to do that. But someone who chooses, they don't want to go through pregnancy for whatever reason then suddenly they're isolated.

Interviewer: Would you see those all on the same spectrum really, it's about choice rather than...?

Respondent: I think the patient needs to be informed and needs to understand the choices that they have and ensure they have the right amount of support around them. If it's been a product of maybe an assault or something like that, that they understand they actually have counselling. For someone like that, maybe you wouldn't encourage such an early decision because obviously everyone is encouraged to do it as early as possible. Making sure the patient knows what pathways and what's available.

But at the end of the day, I feel like if someone's made that decision then yes, personally I would feel that within my remit as a healthcare professional to care for them.

Interviewer: Then if we look at what actually is participating in abortion, if I refer to that case a few years ago where there were two midwives and they really, anything that was involved. It was the care of the woman pre and post. It was taking telephone calls in relation to maybe advice for termination, looking after partners, caring for the woman full stop. That was quite a wide remit. If you're thinking about it, what limitations should be on what you can refrain from doing or do you think there should be no limitations? Obviously you think...

Respondent: I think there should be no limitation. I mean to take a phone call or look after a patient after the event or anything like that, if my colleague didn't want to do that I'd find that really difficult to accept because I feel like that's not being involve within the act. Now you have a patient who could present to you at any point with these symptoms. Now you're caring for someone in that nurse domain if you like.

But when we were talking before, it's like some people who I feel, if we have a patient who has come for a foeticide and then they come up to the delivery unit and then as a midwife you're the ones that's administering drugs to induce the labour for the women to deliver the foetus, of which we know it's a non-live, non-viable foetus by that point, then I feel like that is very much involved because I understand that somebody else administered the drug that's obviously for the foeticide and essentially the baby has died from that drug.

But then there has got to be another element to that process. You're involved heavily in that process.

Interviewer: Would you say people who won't participate or pass the drugs for the KCL but then would actively look after the woman who's been induced, actively induced, are you trying to say that that's a bit of a parody really?

Respondent: Yes. I feel like just because- I know it's dead now or the foetus is non-viable now but if you weren't there to deliver that aspect of the care then they wouldn't be able to do the first aspect of the care. It's one pathway. It's one journey.

Interviewer: Would you say, and I know that you don't think anyone should be able to conscientiously object but if they did, would you say that it would encompass everything?

Respondent: If they were to object to caring for a patient who had a foeticide or had a TOP then at what point would I say it is okay for them to say they're not going to be involved?

Interviewer: We're doing a guideline, how do you think-?

Respondent: What happens when your unit is so busy and you have no one else to care for a patient that's then heavily bleeding after having some of these drugs? Is the midwife just going to say, "Oh no sorry, I can't do it," and the patient's life is at risk? I'm sure they would be happy to do it then. I think it's really hard to say what you think is okay and what's not because when you start asking everyone's choices, everyone's choices will be so different to create a guideline or a national benchmark.

I feel that there is an element of being a healthcare professional where okay, I accept maybe you didn't want to be the one that directly was to be involved in the foeticide or doesn't want to administer an oral drug that's then going to be the start of a TOP, whether that didn't happen and she ended up going for surgical, then ends up in your care. But how can you then refuse to care for that patient who has gone through that because you're presented really with a patient who just requires care. You've not been involved in committing that - I don't even know what you want to call it - act but then you have an aftermath of the act.

Then if you decline to care for that patient then for me, it's like declining care for a patient which goes against your duty of care within your registration, for me.

Interviewer: Do you think those two things could be separated out, the act of say maybe putting a KCL in or giving an oral medication, dispensing it, giving it to a woman, that should be separated - this is what you're saying - from the actual overall care for that woman?

Respondent: Yes. But then would someone say, "Okay, if I put a PV, Mife, in or if I put Miso in, is that administering a drug?" But I think, as a midwife, that would be separate than the act as well but you're still administering something within that journey.

Interviewer: Within that episode which is all part of a termination I suppose, isn't it? That's really what the midwives in Glasgow were saying that all those things that you do are all part and parcel of that episode of care. But I suppose what you're saying is care is care and then there is the physical undertaking of the termination.

Respondent: Why would anyone feel they can't give informed choice or information about contraception and within that comes the morning after pill, termination of pregnancies? Whether then you go down the route of miscarriages and all that kind of thing. That, for me, is just information. Why wouldn't a healthcare professional who is in a position to educate, to promote health, I really struggle to see how they would be not able to fulfil that role within their profession.

Interviewer: That's really interesting because that's what [name of respondent’s colleague] talked about as well, that it's part of the educational role of a midwife rather than it being delivering something that's against your beliefs or faith. I mean would you say, when you hear about conscientious objection, that you immediately think it's probably religiously based?

Respondent: I'd never really thought about the term conscientious objection because it never gets talked about. You never hear it. It's not a phrase that you hear. I think religion comes into it but ultimately, I feel like it is just an opinion. Whether that's an opinion generated from your belief or an opinion generated from the way you may have been brought up or the way you've been influenced.

Interviewer: Do you think, on a practical basis, that if a midwife is an objector, she should declare that because there isn't any onus to do that?

Respondent: Well you'd have to, wouldn't you, especially if you're a coordinator or a leader of a shift and you are presented with a case and then you're organising staff and then you end up saying, "Oh, [name of interviewer], come and look after the patient," you're going to go, "Absolutely not. I'm not having anything to do with them," that becomes really difficult. What happens if you had two patients on the same shift that had something like- it's not unusual for us to have two cases here at any one time that may be here for that reason. I do feel like it creates a barrier.

I mean it could end up- I mean I am not aware of that many people, I mean I've worked here [number of years] years, I don't know anyone that's ever refused to care for someone in one of our bereavement suites who come over for a foeticide. I feel like if you were to have individuals on your shift, would that actually create a bit of animosity in your work environment?

Interviewer: I think going back to what you said before as well that it could end up the same people caring for the women and possible burnout I suppose, wouldn't it? Certain countries, so an example is Italy, they will have whole institutions like a whole hospital like this where everybody objects.

Respondent: Yes. Has that happened?

Interviewer: Yes, in Portugal, Italy.

Respondent: Well it's a law, it's legal. We're a country that's pro-choice. How has that ever happened that you'd end up with an institution that every single person wouldn't agree? I feel like that that's just a bit like sheep following the same opinion. It's easy to conform to the fact that everyone else is being like that, would you be the odd one out if you didn't? How would you ever end up with that environment?

Interviewer: Those women have to go to another- there are other places but they do have to- that brings me on to referrals. I mean this is just a scenario really for the pharmacists but say somebody didn't want to give out the morning after pill because of objecting, do you still think that they- if they referred the woman to somebody else, do you think that they would be actively participating?

Respondent: Well the morning after pill is a bit neither here nor there because there is no confirmed pregnancy. It's a catch 22 really, isn't it, because you're administering a pill that actually could just be for nothing, in essence, because you actually don't know if there is a viable pregnancy. I feel like that's a bit ridiculous not to give it out. But then to refer on, I guess you're removed from that situation but you're referring to someone that you obviously know is happy to agree and you're not an objector. I guess therefore they must feel really strongly to object but still you're happy for the patient to go through it because you've referred.

Interviewer: It's like a catch 22, isn't it, because you think they are setting them off on the journey.

Respondent: You're basically saying, "If you were to have a pregnancy, I accept you don't want to have it," and you support that because you're going to refer on to someone else, "but I just, from my own moral, won't give it to you," for my own conscious.

Interviewer: You don't agree with people not giving it?

Respondent: I think they should just give it. I feel that I would deem that as so unprofessional for someone not to. If you attend with a prescription, I mean you don't have to have a prescription do you but if you were to attend someone saying, "I don't agree with that," I don't care if you agree or not. Your role is this. Your role wasn't to counsel me and to say this is okay or not okay.

Interviewer: In line with that, do you think that health professionals right to object - and they do have a right to object - should override a woman's care or choice or their duty of care to the woman? That's what's come up a few times.

Respondent: My judgement or objectivity would almost be seen as a refusal of care, that's how I would see it. I'd feel like why should a patient not have that choice or ability to have a termination if they don't wish to continue the pregnancy?

Interviewer: You're coming really from the duty of care aspect that that person is refusing to give care, rather than if you're looking from a health professional it would be exercising their human right to refrain from care?

Respondent: It's not you, is it? It's not happening to you. I feel like you have a human right for yourself. You don't have a human right over other people. I don't have a human right over anyone else. I have my own human rights. I can fight for what I believe. But then if we start to say other people are in control of other people's human rights, that's really difficult. That's a whole different ballgame. That's essentially what they're doing. Their opinion is it's my human right not to be involved but then you're controlling someone else's human right, especially if you end up in an institution that won't conform to it.

Interviewer: What do you think about, there was the midwife's case and then there was an incidence of a secretary refused to type out the letters for the consultants in relation to terminations. I mean it wasn't upheld.

Respondent: I mean where do you stop? You might as well say it is illegal then if a person won't type a letter. It is a choice, isn't it? I've looked after patients who have come over from [country name] where, at the time when I was practicing clinically, they didn't have a choice and still in some areas they still don't have a choice now. They would get referrals, so in essence, the person who is referring them knows what they're referring them for. Then they would come here, have their foeticide and deliver here.

I just think sometimes, from my own experience, what happens if that family had no choice and just had to suffer and go through a whole 10 months for something at the end that totally wasn't what they wanted, whether you think the child will live. How long will the child live for? What's their quality of life? Essentially, on a scan it's only ever an estimation, isn't it, as to how severe your disability would be. Sometimes I've even had patients where I've thought, "That's really not as bad as what was initially estimated. Are the family going to look at this 25 week foetus and think it looks normal?"

But then sometimes those kind of concerns, I'd never voice those. I've forgotten what I'm trying to say now. I feel like you'd always support a patient to have a choice. After my own experiences of seeing patients who have chosen that and gone through it and the relief that they have from their choice, I almost feel like you're enforcing somebody if you're an objector to go through something that obviously they don't want to do but then at the end could lead to something really horrendous. I'm so against the fact that you'd make someone carry a foetus but then they have a choice to give the child up for adoption.

Why would you ever perpetuate that cycle, especially if you were to think- I have no idea the amount of terminations that happen in the UK but I would imagine it's probably hundreds of thousands. Could you imagine if we were to start saying healthcare professionals are objectors? We've now got hundreds of thousands in our population that are necessarily unwanted. A lot of them may be disabled. It just creates further pressures on our society.

Interviewer: I think it's really interesting when you said about the person who is referring from [country name]. They're obviously an objector within a society that objects but they're knowingly referring them to undergo a termination.

Respondent: It's consciously that person may be an objector but still want a woman to have a choice. In essence, you're still promoting the fact that the woman can have a choice.

Interviewer: From that, would you say there are varying degrees of what people object to?

Respondent: Are willing to be involved with.

Interviewer: Yes.

Respondent: I feel like you're an objector and you'll be willing to be involved up to a point. I mean to be an objector and say, "I'm not going to take a phone call," or get a cup of tea for a family or type a letter," that's obviously extreme objector. I feel if you dig down into that, there are probably factors that have influenced that rather than just, "I can be pro-choice and I want to say that I'm an objector."

Interviewer: That's really interesting. Your views have always been the same would you say? They haven't changed at all?

Respondent: I guess before I did midwifery, I mean I was only young when I did midwifery anyway but I would have always felt, probably from my family beliefs and how my mum is that I would think, "Oh God, I'd never have a termination." Even if you had a disabled child, I have a really supportive family and you'd be fine. But then since actually being in healthcare and looking after families and seeing what it actually takes and the toll it takes on a family to ever support that- I am very conscious as well about society and our NHS and our country, we can't support all families that choose to keep disabled children.

I mean this is going to sound horrendous but it is a bit of a drain on a system. I'm absolutely fine if someone wants to keep a disabled child. That's not what I'm saying. I'm not saying everybody should terminate or anything like that. But I feel like now, for myself, I would be open to termination myself from seeing what other families have had to go through.

Interviewer: Your role, your experience as a health professional has changed?

Respondent: Yes, my experience, seeing families, seeing children themselves, speaking to other colleagues on NICU or at [name of children’s UK hospital] and understanding. Even actually I trained with a girl who had a disabled child and she died at age 11. The effect not only it had on the mother of that family but she had two other children in that family. It's honestly been- the mum would never say, "I regret keeping her," but she said, "If that was to happen to me again I wouldn't." I'd looked after a woman who had a pre-term, 24 weeker and actually she came in again at something like 24 and 4 as a labouring PROM.

She came but just said, "I do not want anything to be done. I don't want anything to be done." That was a really hard case because she was literally a day off actual medical necessity to intervene. She just said, "Living with my child that's living but is partially blind, on oxygen, got lots of issues, I cannot have another child like that. I love my child but knowing what I've gone through, I would not have this child."

Interviewer: That's such a difficult situation.

Respondent: I think if you've got a mother who can actually relay that and say that then it actually must be a horrendous situation to live with that child. But eventually when you're living with it, you don't have a choice, do you, so why would I inflict that non-choice on somebody if they can recognise and rationale why they're making the decision that they're making?

Interviewer: That's a terrible case, isn't it?

Respondent: She was distraught, like, "Please, please don't." She was like, "I'm going to self-discharge because I now want to be at home." She was a very well educated woman. She was saying, "But then what happens if I have complications or I bleed or I need help? I want to be here but you cannot do anything for my child." If you left it she knew it wouldn't survive. She said, "I know I might have to hold it and it might be an hour, it might be this long but I can't."

Interviewer: I suppose when we look at scenarios like that it's a very unusual, not unusual but it's a very individual scenario. I suppose from a guideline perspective there will be lots and lots of different scenarios that we possibly can't cover in relation to this. Okay, is there anything else you want to add do you think?

Respondent: No, I don't think so.

Interviewer: That's brilliant, thank you.

END AUDIO

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