**File: fi472f0c -- Midwife - Megan  
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START AUDIO

Interviewer: If you just tell me a bit about your role at the moment.

Respondent: My name’s [name of midwife]. I am currently in a [job role], so I oversee all the students at the Trust, but I've only recently come into this role. I was a [job role] on the maternity assessment room prior to that. And I've been qualified for [number of years] years now.

Interviewer: What would you think the term ‘conscientious objection’ means or what does it mean to you?

Respondent: I would say it probably means different things to different people. To me, I see it as being able to object to something that you don’t believe in, whether that be religious or personal reasons, and being able to object whether it’s a procedure or care provision, if you feel that is not or should not be within your medical remit.

Interviewer: What would you say constitutes participation in abortion?

Respondent: In my opinion, I would say anything that involves or surrounds the actual act of ending the foetus’s life, so to speak.

I have personally looked after women who have had terminations and then come to our delivery suite, and we provide the care for labour and often delivery and postnatal care. So personally I feel like that is within a midwife’s remit and is not something that I would object to, because you are caring for a woman post-procedure.

I personally would object to anything that involved being involved in the foeticide side of things, so actually ending the life. But the actual care post, once that has happened, and the delivery and postnatal support, is something that I would happily provide to women.

Interviewer: When you say, “Object to the ending of the life,” what would you think about maybe giving that woman advice, maybe giving her information leaflets in relation to, say, a KCL procedure? Would you feel that was participation?

Respondent: I think with anything you're providing informed consent to, as long as that woman was in receipt of all the information surrounding her options, so both for termination and for continuing with the pregnancy, say, then I wouldn’t object to providing the information, because obviously education is part of our role as a midwife.

So I wouldn’t object in providing them with all the information. I would just then find it difficult to be involved if her decision was to terminate the pregnancy and to be involved with that actual procedure.

Interviewer: Because this is the difficulty, you see. I'm going to drill down a bit now.

Say somebody else undertook the actual procedure, say they gave a pessary or KCL, and you were in the room, would you be okay then to carry on looking after that woman? Or how would you feel then?

Respondent: I think I would class being in the room for the actual procedure as being involved in the procedure, so I personally-

Interviewer: That’s really interesting.

Respondent: After providing the woman with the information leaflets, again it would have to always be from both sides of the argument, I then feel like I couldn’t be actively involved in her decision-making process or be present if her decision was to terminate the pregnancy. I feel like I couldn’t be present in the room even as a support mechanism if that was her choice. That’s where I feel like I would be able to say, “I object to being in the room.”

Interviewer: Then afterwards, say the procedure had occurred, would you feel you could look after that woman during labour?

Respondent: Yes. It wouldn’t affect my care of the woman. Obviously internally I would disagree with the decision she’d made, but I would care for her as a labouring woman and as a postnatal woman. That wouldn’t affect my care that I provided. Obviously just internally it would be something that I didn’t agree with.

The same way I am pro-breastfeeding. I don’t agree with women bottle feeding. It’s something that we support as clinicians outwardly, but inwardly you might be thinking something else.

Interviewer: I know we talked earlier about the midwives, the case in Glasgow, the things that they objected to. It was caring for the woman’s family and partner. What did you think? Did you think that maybe they’d gone too far in relation to what constituted participation? Or do you think people can individually decide?

Respondent: I think it’s difficult, isn’t it? And obviously this is where it comes in. But I think people should have that right themselves to decide at what level of involvement they want.

Something that I deem acceptable to be involved with someone else might think, “I wouldn’t even want to be involved in that level, and I wouldn’t want to care for them post-procedure.”

So I think it is an individual’s right as a human being, even though you are a health professional, that you should still have your own choice and decision-making process whether you do or don’t want to be involved in something.

Interviewer: Following on from that, we’d like to work towards a guideline. What do you think would need to be in that guideline or what do you think about a guideline?

Respondent: I think there should be something in black and white, so that people do have a supporting policy or procedure to fall back on. Obviously it would have to be quite descriptive and not open to interpretation.

Personally I would think it should involve wording that would support practitioners to be able to be involved in the entire process, whether it was the delivery, the postnatal, the antenatal discussion, or none of the above if they didn’t want to be involved in any of it whatsoever. I think that should be their right as a health practitioner. They can’t be forced into doing something that they personally don’t agree with.

Interviewer: I think what you're saying there is if there was a guideline it couldn’t be, ‘The following things you can refrain from. The following things you can’t refrain from.”

Respondent: No. I think it would have to be down to the individual, so that it can’t be interpreted differently. Obviously it would be hard to list every individual aspect of it and say, ‘This you have to do. This you don’t have to do’. I think that is taking away an individual’s human rights with regard to it.

I think it would have to simply be as clear as, ‘You can be involved with as much as the decision-making process, the care, or as little or none, if you deem that matches your rights as an individual’.

Interviewer: Have you ever verbalised that you object? Have you ever had to let anybody know in the hospital?

Respondent: No. I've never been in the position where I have come across an incident where I needed to be involved, either in antenatal discussion or the procedure itself. I've only ever been involved with regards the labour care and the postnatal care of a woman who’d already undergone a termination already.

Interviewer: When you came for the job there was no discussion surrounding it, I presume. Whether you’d object.

Respondent: No. I would say even during the training it’s not something… You understand you will care for women who have lost babies and who have chosen termination, but it’s never something that comes up in your training as to, “This is what you have to be involved in or you can opt out of.”

I think if you didn’t really have an opinion on it it’s not something that you would be prepared for in that instant, if you got faced with the option, because there’s not really any prior discussion, whether it’s training or post-qualification. It’s not something that gets talked about really.

Interviewer: Are you aware of the policy here at [hospital name] in relation to conscientious objection?

Respondent: I'm not, actually, no. I know there probably has to be one and there is one, but no, I'm not aware of the specifics.

Interviewer: You’re not the only person to say that, yes, in some way.

So you’ve never actually been in a situation where you’ve had to refuse care?

Respondent: No.

Interviewer: If you were in a situation how would you feel about verbalising that here?

Respondent: I’d hope I’d be aware of the situation I was asked to be involved in prior to entering the room and being in front of the patient and their family.

I’d hope I’d be able to object to it prior to meeting them or entering the room, so that there was no awkwardness or making the woman or family feel bad about a decision they might make.

I’d hope, because it is quite a personal touchy subject, that that kind of thing would be discussed prior to being dropped into the situation.

If I did know about it prior to entering a room I would feel confident and feel strongly enough to be able to go to a manager or a shift leader and explain that I didn’t feel happy to go into the room, knowing that was the discussion that was going on or the procedure that was about to happen.

Interviewer: Have you ever been anywhere when you have seen that happen?

Respondent: No, not personally.

Interviewer: Or do you know of any cases where anybody’s refused?

Respondent: Only the Glasgow case. I don’t know the details of the case in and out, but I know that it was something that the midwives had been taken to court over. At the time I remember thinking, “How awful. Just because that’s something that they don’t agree with their hands are being forced almost.”

And the views of family and friends differed just by hearing the case on the news and things. So I think it is something that you're never going to get 100% in agreement or 100% in disagreement. It’s always something that is so personal. I think that’s why the choice should be left to an individual, as opposed to your hand pushed in one direction.

Interviewer: How do you feel about countries where they won’t employ somebody, a health professional, if they are a conscientious objector? Sweden is one of those countries.

Respondent: I think it’s quite shocking that for something that is quite a personal thing to decide on they can agree to not employ just based on that alone. I didn’t even know that that was in place in certain countries, so it is quite shocking.

I think as a health professional you get into a profession to be a carer, and you obviously have strong views about things because you are an advocate for women and you stand up for things. So I think to have that part of your beliefs taken away and dictated, “You have to do this,” is really bad.

Interviewer: And the opposite would be there’s whole hospitals in Italy where everybody is a conscientious objector. What do you feel about whole institutions…?

Respondent: You mean where women couldn’t go and have the option?

Interviewer: Yes. Or they would be refused.

Respondent: It’s difficult, isn’t it? Because I do feel relatively strongly about it, but at the same time I understand that it is the woman’s choice. I would never push my opinion onto somebody else. So likewise they shouldn’t be able to push an opinion onto women. They should still have a choice as to what they would like to do.

You’d like to think that there always would be people who are happy to provide that level of care, so the woman would never hopefully not have anywhere to go and no options.

Likewise, the same way Trusts shouldn’t be able to not employ you because you are a conscientious objector, I don’t think hospitals should be able to say, “As a Trust we are making the decision that women cannot come here.”

The same way it’s an employee’s right to conscientiously object I think it is a woman’s right. If that’s her decision she should be able to receive care.

Interviewer: When you were thinking about becoming a midwife was it something you thought about?

Respondent: No, I don’t think it is. You obviously come into it with rose-tinted glasses, I suppose, and think it’s all happy and nice happy endings and lovely family stories. You don’t realise the other side of the job, which is looking after families who have had bereavements or terminations.

As I say, I can’t remember any aspect of the training even discussing the topic of conscientious objection and what your rights are and where you stand as a health professional.

I think it’s not something you think of at all coming into midwifery, because you think of it as caring for women and their babies. You would never presume that would include having to be involved in the process of a termination.

Interviewer: Have you always had the same views? Because some people’s views change over time. Maybe they have their own baby or they work in a service.

Respondent: Yes, I think I have. Personally, my mum used to be a trained counsellor for women who were considering a termination. She worked for a charity. Kind of the opposite to the Brook services in [city name]. They offer women advice more leaning towards termination. My mum worked for SPUC, I think the charity was called, that did the opposite.

I've always been brought up… Not involved with the women, but obviously the women became close friends of my mum’s and she’s kept in touch with a lot of them, and I've been brought up amongst their children.

Thinking those women had had that discussion and thought process of, “Should I end this pregnancy?” and then they haven’t. Then they’ve gone on to have further children, and these children have grown up and are successful and they’ve got new partners.

To think of that family without that child, just because the woman didn’t have the information at hand that she didn’t have to go down a termination route, I think that’s always stuck with me and made me realise that the women should… It’s their choice at the end of the day, but they should always have the option of an alternate route.

Then I've also been involved in families who have gone ahead with the pregnancy and the child’s been put up for adoption, and they’ve then had a relationship with their child later in life once they’ve got past the age.

So I think I have been brought up seeing the positive side of things. Obviously I've not had much exposure to the negative, the other option, where women do go down the termination route.

I've also got family members who’ve got children who are severely disabled and were given the option of a termination and haven’t. And you see how happy and lovely the children are, and they grow up.

So I think I've always had that slant on it, that there are other options [and the route 0:14:52] of adoption, so I've never personally agreed with termination, whether it be for a medical reason or a social reason, I suppose. I think that’s always been my view, because that’s how I've been brought up.

Interviewer: Yes. Because usually, you’ll probably agree, people think it’s on religious grounds. Would you say your views have been formed because of just personal experience?

Respondent: I would say so. I think my mum’s views are extremely religious. I would say she’s not pro-choice. She doesn’t think it should be a woman’s choice to end a foetus’s life.

Whereas, having been brought up so blinkered I suppose my mum’s view is, I feel like I can [see that] woman should have a choice in some circumstances.

Personally my choice would always be to continue the pregnancy, but I understand that there are circumstances where women have that choice open to them and should have the option to go down that route, should they so wish, after having all the information presented to them.

So I wouldn’t say personally it’s a solely religious view, but I do understand the religious aspect to it. People say, don’t they, people are playing God by taking that decision into their own hands? And although I don’t totally agree with that I can see what they mean by saying, “Who are we to decide who can continue to pregnancy and delivery and a life? And who are we to decide that they can’t do that?”

Interviewer: Yes, that’s really interesting.

We’ve talked about a guideline. We’ve talked about different countries.

You don’t think you have to declare that you're an objector, do you? Or are you not sure about that?

Respondent: It’s difficult whether you would only have to say that at the time or whether it’s something that you state upon employment. I don’t know what would be the easiest way to go down that route.

I think maybe just if an incident or occurrence arose you could then say at that point, “I would object to this,” and then be able to remove yourself from it.

Or if from a planning point of view Trusts should know which of their staff are, so that they know whether to put them in that scenario in the first place. Whether that is easier to manage.

Because I understand women still need to be cared for, and if you do object to something there needs to be an alternative staff member present to provide whatever it is. So whether, from a planning point of view, it would be easier if Trusts knew who was an objector and who wasn’t I'm not sure.

Interviewer: I think we’re quite clear your limitations are that you wouldn’t want to be around during the actual decision making and the procedure but care before and after you would be willing to provide.

Respondent: Yes. Because it’s not pushing the woman to any particular decision. It’s not involved in the process. So consciously I wouldn’t feel like I’d had an active role in that termination.

Whereas I understand part of your role as a midwife is providing support for women. That is why I personally feel like the antenatal and even intrapartum and postnatal aspect of it is caring for the woman. The procedure’s already happened. I feel like that would mean I wasn’t conscientiously part of that woman’s decision or part of the procedure. I was just involved in the aftercare.

Interviewer: I think we said this before. You said it was more within the role of a midwife you have to give education, so women can make informed choices. So you would give advice, as such, but you would obviously counter that. You’d just give it as part of advice giving. You wouldn’t think that that was…

Respondent: No, because it is physically an option. I would never not mention to a woman that termination wasn’t an option, because it is an actual option that she would have open to her if there was a medical reason or a social reason. So I would still present it as an option.

I obviously wouldn’t encourage them, but when you're giving informed consent you don’t lean towards one or the other. You're just providing the facts. And that is a fact that she has that as an option.

Interviewer: You need to come and write our guideline. (Laughter)

I think that’s everything really. Is there anything you want to add at all?

Respondent: No.

Interviewer: No? I think we’ve covered most of the things. If I need to come back to you…

Oh, the only other thing was a lot of the pharmacists talk about, “It’s a duty of care to the patient.” They're talking about mainly giving emergency contraception, the morning after pill, and they’ve used that term ‘duty of care’ a lot.

I don't know if we use it the same in midwifery, but if someone said to you, “It’s your duty to be in that room to comfort that woman while she’s having that procedure,” do you think that should ever override your human right to object?

Respondent: I don’t think it should, because I think, as I said before, there would always… It’s such a hot topic. People will always differ. It’s not like if you weren’t there, there wouldn’t be anybody else to provide that care.

I do think women should always have a healthcare provider there to support them, and I think that just by you not being there the woman is not missing out on anything, because in my opinion there would always be somebody else to be able to provide that role who doesn’t object to the procedure.

So I don’t think duty of care should outrank the importance of your own human rights.

Interviewer: Just finally, would it make you feel uncomfortable maybe going on an area where they had more terminations?

Respondent: I think it would, personally, where they actually perform them. Thinking back to when I was training and did gynae theatres, they had one theatre dedicated to the terminations, and they always gave you the choice, “Did you want to have a day in there?” And I didn’t. I didn’t want to see or be involved in it.

So I think if I predominantly just worked in an area and that was their sole purpose I would feel uncomfortable and wouldn’t ever want to be solely working on that type of area.

Interviewer: Obviously there are ways to avoid working on those areas, aren’t there?

Respondent: Yes. And I think that’s right that you should always have that option if you didn’t want to be there. Because, as I say, there would always be staff members that would, because they don’t object to it. It’s not like the woman or patient would ever miss out on any type of care just because you didn’t agree with something.

END AUDIO

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