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START AUDIO

Interviewer: I’ve had that happen before today, it’s the worst, in a different project. That one is going and that one is going. To begin with, can you tell me a little bit about the work you do as a health professional?

Respondent: Currently I work as a [job title]. I qualified as a midwife in [year qualified], so [length of service] years ago. Immediately on qualifying I worked in a clinical area in a different hospital. I worked on delivery suite, antenatal ward, postnatal. Straightaway after my degree I did a master’s in research. I was working, I did the master’s at the same time and that took me two years.

On completion of that I then had a dual role, I did 50% [job role] as a midwife and 50% [job role] in another trust. That was working on a variety… I say a variety, it was quite a small trust. Various maternity and occasionally gynaecology, reproductive health it’s classed as. I was helping to set them up as a trust and recruit patients to them.

That’s what I’m doing now at [hospital name], but I’m doing that on a full-time basis now. I came here [number of years] years ago to work on a project with one of the consultants that was about a medical device he’d invented. That was a proper from concept right through to we did a trial last year using the device here in the hospital. That was more in-depth ethics applications, writing questionnaires, protocol etc. That’s finished now, unfortunately, and I’m back working with other [job role] midwives recruiting to CRN portfolio studies.

Interviewer: Yes, different ones. It sounds really varied your career.

Respondent: It is. We still get to see patients, but it’s just in a different capacity to the way we used to. We still do antenatal checks sometimes on ladies, we do bloods quite a lot, but it’s none of the shift work. It’s in a different way. A relatively varied career, I suppose.

Interviewer: It sounds really interesting. I appreciate abortion may not be something you come across very often now, but in the past.

Respondent: More previous, yes.

Interviewer: Can you tell me a little bit about how you’d come across it? If that’s the right way to put it.

Respondent: It might not be relevant, so I won’t go into too much detail. My first ever experience of it was when I was a volunteer at the [hospital name]. I was a volunteer, it was in kind of a pre-op area. I didn’t quite realise it at the time, no one had made it explicit to me. I used to go to this area, it was like a pre-theatre area. There were different bays and people would be in there coming for different things waiting to be taken down to theatre. Sometimes it would be gynaecology, occasionally there were men there for fertility things. A lot of them I eventually came to realise were going for termination.

I wasn’t a medical professional then, so I suppose it isn’t relevant. That was my first real involvement because I was talking to these people. My role was to just chat to people, if they wanted to speak to me. A lot of them were welcoming of that because it was a good distraction for them for the fact they were about to go to theatre. That was my first bit more detailed experience. We weren’t necessarily talking about the termination, but it would always become apparent to me that was why they were there. I would alter whatever my conversation topic was going to be accordingly.

Since I’ve qualified as a midwife my experience has been… In my previous trust when I worked on the delivery suite mostly because we would perform terminations there for foetal abnormalities, if you want to class them as such. You could argue whether that term is PC, I suppose. What’s an abnormality?

That was my experience of it. Either physically me personally administering agents to induce the termination, so to speak. Subsequently caring for those women afterwards if I took the care over in the afternoon if they’d been over in the morning and then potentially looking after them while they laboured. Some of them were further gestations than others and subsequent delivery of the baby as well.

Interviewer: How did you feel about that?

Respondent: Sad, I suppose. I’m quite an emotional person anyway. It’s not sad because it’s a termination as such, but sad because you’re going to get a not live birth at the end. Not a happy outcome for anybody. It’s sad even though you’ve never met these people before. I find it hard to cut off from that really.

Interviewer: You sound compassionate.

Respondent: As you should be, I suppose. I never overthought it. If I was assigned one of those ladies to look after at the start of my shift, if anything I’d be a bit like, “Oh gosh, I don’t know what to do with the paperwork.” It’s so involved and things like that. As opposed to any reluctance because of the nature of the situation.

At that point in time I probably wouldn’t let my mind go there as in, “What would I do in this situation? Can I imagine how I would feel?” I just took it on as I’m doing my job caring for a lady, caring for the family. It’s different from a 40-week coming in in spontaneous labour and we hope we’re going to get a happy outcome at the end. I still know what my role is, what my tasks are, without putting it too clinically. What I want my outcome to be is I give the woman as best an experience in a bad situation as possible.

Interviewer: Although you may have personal feelings towards the scenario, whatever the scenario may have been, you put the patient first in the sense you have your professional head and your personal head and you keep the two separate.

Respondent: Definitely, yes. What’s right for me isn’t right for somebody else. It’s easy to think how you might do things if you were in that person’s shoes, but you really don’t know until you’re there. It’s only since I’ve had a child of my own, although there was never any possibility of termination, there was never any indication. There was never any offer of a termination because there was no high risk of anything. That did make me think of things differently.

Until I was pregnant, until I had a baby and realised how I much I love them. It made me think differently than what I previously might have thought, I didn’t really know because you don’t know until you’re pregnant and you have those feelings. You see that positive test and you’ve been waiting for it for so long or you see the scan. It gives you a very different outlook to an outsider who just has their own views that are influenced by their personal feelings, maybe friends and things that other people have happened to but haven’t actually had a baby themselves.

Interviewer: I think that experience of carrying a child, it changes your perspective on the world in many respects, doesn’t it?

Respondent: Most definitely, yes.

Interviewer: As you know this project is looking at conscientious objection to abortion. What do you think constitutes conscientious objection to abortion?

Respondent: I suppose the immediate thing that comes to mind is religious reasons, is the initial one. Because of religious reasons they wouldn’t be willing to participate in any care around termination of pregnancy because it was at odds with the teachings of their faith. Religion stands out as the main thing in my brain, even though I know it won’t be the sole reason for it. I think in this day and age I suppose I see religion as being the main contributory factor. You’d hope that… It’s hard to express. I’d hope there wouldn’t be anything else these days that would influence people in that way.

I consider religion to be so archaic in many ways, so that’s the only way that something like that in this day and age would be the only reason that people would object. Brainwashed is a bit of a strong word, but they’ve been brought up in this faith that it’s intrinsic in them. People should be so educated now and there shouldn’t really be any other reason why people would object to abortion. I feel like everything comes down to religion. Maybe it doesn’t, maybe I’m naive in that.

Even if you weren’t a practicing Catholic now, there may be something in school or your childhood if you’ve been brought up as a Catholic would still be influencing you now that this was a sin and whatnot. I associate everything with that and the rights of the foetus. It brings me back to thinking about Ireland. I probably do think pretty much everything as being religion, either Catholicism or Islam.

Interviewer: Have you encountered or worked with a college who’s been an objector?

Respondent: I can’t recall it, no. We were talking about this in the office because we were talking about meeting with you. One of my colleagues was talking about doctors she’d worked with or she believed they would be objectors because they were Muslim. I can’t physically recall anyone in my experience. It doesn’t mean they weren’t there, it might just have been on the days I was looking after said women they weren’t on call or whatever. I can’t ever remember anybody, no.

Interviewer: Did you speak to colleagues? I asked two questions in one nearly then. Were you aware you could conscientiously object as a midwife?

Respondent: Yes, I’d say I was. It was never an issue for me, so I probably didn’t give it a great deal of thought. It wasn’t on my radar that I’d ever want to. I’d never come across another midwife or a doctor doing it, at least not to my knowledge, I hadn’t ever seen it happen. How it was approached, I’d never seen how somebody would bring it up. Would they be very blatant with it and just say it in front of everybody, “I’m not looking after them.” Or would they try and take the shift leader to one side because they wanted to say it more quietly because they didn’t want other people to know they were objecting or whatnot. It never really came up.

I’m trying to think back. Where I worked previously, which is where I did the [job role]. The midwives I worked with on delivery suite were predominantly white British. In fact, there wasn’t a single non-white midwife on that delivery suite. I think there was an African midwife, no Jamaican she was, who worked on the antenatal ward. The demographic was very different to here.

Don’t get me wrong, lots of white people are Muslims, I don’t mean that. Not just because they were white, but where we were based nobody was a Muslim. I’m not really aware of anybody being a staunch Catholic either, so staunch they would have objected to participating in their care. Doctors, again different to what I’ve experienced here. There were lots of doctors from different ethnicities, but most of them were Christian of some form or other. I don’t remember any significant conversations.

Interviewer: I was just about to say, did you speak to colleagues about conscientious objection?

Respondent: No, because I don’t remember it ever being an issue. I don’t remember knowing of anybody. You would know, potentially, because people talk, don’t they? It wouldn’t be something that would be occurring frequently, I suppose.

Interviewer: Do you think it was just implicitly understood the people you worked with, including yourself, were non-objectors to abortion?

Respondent: I’d say so. Maybe there was the one few or far between that were objectors and potentially they either managed to avoid the situation by saying, “I looked after this woman yesterday.” Somebody who’s now had their baby, “I’ll take them back.” They know them, so they managed to... We weren’t doing terminations every day, so it wasn’t a frequently occurring thing. Potentially, maybe they got out of an awkward situation by going to the toilet when they were getting divvied out or just saying they knew somebody and they’d look after them again.

Interviewer: There are ways you can see that people could quietly duck out.

Respondent: Maybe.

Interviewer: Do you think they would feel they’d have to quietly duck out if they were an objector or do you think they could feel confident to say? Do you think there’d be a bit of…? Shame seems like such a strong word, but embarrassment, maybe.

Respondent: Yes, I think potentially. Especially if the majority of people, I perceive it, weren’t objecting. If you were going to be that one voice, I think it would be very hard when everyone else is sharing a certain… Ethos probably isn’t quite the right word, but shared view. You don’t share that with them, you’re not able to be comfortable providing that care in the way that they are. I could imagine if it were me, I’d feel uncomfortable.

It’s not at odds with what your role as a midwife is, but it kind of is. The woman is your priority above everything else, regardless of what’s happening. For all the illicit drug users, alcoholics and people with safeguarding issues, you’re still there for the same job. Don’t get me wrong, I think we probably all have compassion towards certain people more than others. You might not realise it, but you probably are more tolerant of people, the non-illicit drug users and whatnot. You’d still never do harm to those people. I would anyway, still be compassionate to those people because no one is born bad as far as I’m concerned. I’ve lost my train of thought now, sorry.

Interviewer: I was just saying, would people feel embarrassed to talk about it, would there be any shame around it and things like that?

Respondent: Yes, I think you would. I really do. I think as well, it’s what your personality is like. I don’t want to say meek and mild, but delivery suite is a certain culture in whatever hospital you work on. Delivery suite is well documented in midwifery research as having a bullying culture. If you’re not a senior figure on there and your face doesn’t fit you do feel intimidated, so you would be less likely to want to speak up. That’s my experience of it.

I just have experience of the way I’ve been spoken to by senior staff on delivery suite to do with menial things. It’s been negative and it’s made me draw back, not want to be around that person and have an unpleasant view of them. To then say something so forthright as in, “I conscientiously object to looking after this woman.” I feel like that would be a black cross against your name, depending on what your personality type is and how you’re viewed by those staff. If you’re not one of them and you’re, quiet is not the right word. Not bold and brash, not intimidating.

Interviewer: Not a queen bee.

Respondent: Exactly, that’s a good term.

Interviewer: Maybe it would be perceived as controversial in that type of culture to invoke their rights.

Respondent: If you were a loud person and you said it or brash, then probably nothing would be said because people would be too scared to say something. When you’re not that person, they’d pick on your weakness and then make it an issue.

Interviewer: That sounds quite difficult if you were a conscientious objector. If that’s the way you felt and you felt quite alone.

Respondent: Yes. It’s an intimidating environment for lots of reasons. Although I never had this issue, if I did, I could really imagine feeling uncomfortable.

Interviewer: That would be quite difficult really.

Respondent: There were certain people you’d be relieved to see on a shift as your shift leader and it wouldn’t have mattered with them. Then there were certain others… It’s more than a personality clash, a lot more. If it was certain other people, you’d feel really uncomfortable.

It’s hard for me to imagine if I was an objector. Again, I keep thinking of religion. For something to be such a strong feeling in you that you felt you couldn’t provide any care for that woman. Your religion, if it was religion, must be such a massive part of your life. I suppose that must go above all else and it wouldn’t matter you felt intimidated by your colleagues because religion is part of who you are. It’s hard for me to imagine because it’s not part of who I am.

Interviewer: Yes, it would have to be a significant part in your life. There again, the other end of the stick or the spectrum is maybe you’ve encountered something you’ve not liked about the procedure or some sort of experience I wonder.

Respondent: It’s not pleasant by any stretch of the imagination. It varies depending on gestation of pregnancy. The further along the gestation the more unpleasant it is, I suppose, for want of a better word.

Interviewer: Has there ever been a time, particularly in your earlier stages of your career, where you were involved in abortion or termination…? Sorry, we’re using the term abortion. I don’t know if that makes a difference.

Respondent: It doesn’t make an issue for me, no.

Interviewer: Sorry, I’ve lost my trail of thought now. When you’ve been involved in a termination or abortion has there been a point where you’ve thought, “No, I draw the line here.” Or, “I’d like to draw the line here.” I don’t if a woman is on her 15th abortion in 15 years, that type of thing.

Respondent: I can’t recall any cases. That example you gave is quite a good example when I think about my personal thoughts. Although I don’t recall looking after somebody… I wouldn’t have looked after somebody in such circumstances because ours were never social abortions, they were always for medical indication. I suppose in one sense you can class it as social because it’s still the woman’s choice to have an abortion, but there’s something been detected in the foetus that has given rise to that choice.

When you talk about multiple abortions in spaces of time, when I see stuff in notes if I’m looking through notes for things and you see that. There are times when I’ve come across it, although I’ve not been directly involved in care. It is probably the one thing that makes me go, “Oh.” To me, abortion shouldn’t be an alternative to contraception.

I’m sure they are very rare, but those rare circumstances where women are having multiple abortions for social reasons. Those women are then undoing work that has been achieved for women to have the legal right to have an abortion up to this gestation. For whatever reason, whether it just be because they’re not ready to have a baby, they haven’t got enough money, they’ve been raped or whatever. Where people are having multiple abortions, it’s difficult because I feel that’s not the reason abortion is there when they’re doing it that often.

Interviewer: Yes, it’s not a form of contraception. There are plenty of forms of contraception, aren’t there?

Respondent: Yes, exactly. The problem is contraception often comes down to women, very wrongly. I don’t know people’s individual circumstances, having multiple abortions is very extreme. To be able to do that and come back repeatedly and do that you think they must have some personality disorder, like a sociopath or something, to be able to detach themselves in that way.

You don’t know the history and you don’t know the background and she’s getting pregnant by some man however many times. Is it the same man? I don’t know. Does she have access to contraception? Is she a prostitute? There are all kinds of things, aren’t there? The responsibility is always on the woman at the end of the day, it’s her responsibility to stop herself from getting pregnant. Then if she does get pregnant it’s her responsibility to deal with the consequences most of the time.

Interviewer: It’s quite a parochial society really.

Respondent: It is, me included, we kind of go along with it as women, we don’t question it. I hope it’s not a man transcribing this. We know that men aren’t reliable in the same way that we are. We know what the consequences of pregnancy are when you don’t want the pregnancy at that point in time. The consequences are for the woman more than they are for the man. You don’t let a man deal with contraception because he might not deal with it properly and then you’ve got to deal with the consequences. We just deal with it if we can. Maybe these women can’t deal with it. That’s the one thing that does make me, not lose my sympathy, but lessens my empathy.

Interviewer: If you’d encountered a lady in that situation or if you went to [job role] now again as a midwife, abandoned your [job role], would there be a scenario where you were faced, whether it be a late termination for a social reason or a lady who was coming back for 100th abortion. Huge extreme, but that type of thing. Would there be a limit you’d put on or would you keep those two heads separate, your personal and your professional?

Respondent: I think I’d probably keep them separate. I think I’d try to not let my mind stray in too much detail or too much depth. If it did, it could then give me internal conflict at that point in time that I’d have to wrestle with. I can wrestle with it when I go home once I’m done and dusted, once I’ve done whatever my role is for that day. It’s hard to say because it’s so extreme.

Maybe not so much the late termination, but the repeated abortions. I suppose it depends on the circumstances at the time, but I’d want to try and speak to this woman to know. I’d feel like part of my role would be preventing this from happening again if it was that circumstance to try and find out why it had got to that point. I don’t feel like it would stop me from assisting her. Although there’d be somebody else to hand because there’d be another midwife working who would just take over from me, I think part of me would think, “If everybody refused, where does that leave that woman?”

Interviewer: It has an implication for patient care.

Respondent: Where does it leave the baby, foetus, if she doesn’t then get the termination because everybody objected and nobody would perform it? It doesn’t mean I don’t have conflict or that I’m comfortable with it, but maybe I feel a bit powerless.

Interviewer: It sounds like you put the patient first before your own beliefs or your own feelings. You sound patient centric.

Respondent: Yes, definitely. That, to me, is what we’re meant to do. You have your right to conscientiously object, but there’s part of me that thinks if you become an obstetrician, gynaecologist, midwife, nurse who’s dealing in reproductive health, when you come into the role your eyes should be very wide open as to what your role is and what the expectations of your role are. To me, that doesn’t involve conscientiously objecting to participate in abortion care. This is part of your role, these are what the expectations are of you. This is what you’re employed to provide, not to pick and choose.

Interviewer: Do you think objectors can work in this environment?

Respondent: I suppose if there’s someone else there to pick out the pieces they don’t want to deal with, then yes. I think it’s probably more difficult in larger units like the [hospital name] because it’s more frequent. There’s a bigger patient population, so they do a lot more terminations than [hospital name] or wherever else. I wouldn’t know whether objectors, although they wouldn’t participate in the actual abortion care, when they were looking through somebody’s obstetric history and there was a woman who’d had two terminations, three terminations, one termination or whatever. Would that influence their treatment of the woman?

I don’t know how far it goes. Whether it’s just they can’t participate in it or whether the fact this woman has had a termination they weren’t involved in, but the fact this woman has had a termination is enough. It’s at odds with them, so therefore they’d treat her differently. In their mind she wasn’t as worthy a human being on the planet.

Interviewer: I think it’s different for different people to what they conscientiously object to. For example, in Italy there are whole institutions that will invoke their right to consciously object. They’ll offer gynae and maternity services, but they won’t perform terminations. That’s quite well-known. There are countries where conscientious objection is actually unlawful, Sweden and I think Iceland maybe or something like that.

Respondent: That’s quite interesting.

Interviewer: I was just going to say, what are your thoughts about that?

Respondent: It’s funny you should say. I think it’s Iceland, they have 100% abortion rate for Down’s syndrome diagnosis. I’m sure it’s Iceland.

Interviewer: I think maybe one of the early interviewees might have mentioned something like that.

Respondent: That’s quite interesting. Whether there’s any correlation… Why is it that they can’t? Sorry, I’m not meant to ask you questions.

Interviewer: That’s fine, you can. I don’t know the background if I’m absolutely honest with you. The Abortion Act in this country was introduced over 50 years ago. When abortion was introduced or made lawful at that point it was a surgical procedure. As time has evolved, so has the abortion procedure evolved. What was a surgical predominately isn’t anymore, it’s medical.

People may take pills and the people who are involved in the procedure have also changed with midwives, nurses and pharmacists having a greater role. Whether that instigated something in those countries, I’m not too sure. There was a case, it’s quite a popular case, you may have picked up on it in the news at the time in 2014 of two midwives from Scotland. They invoked the right to conscientiously object because they were working on a maternity ward.

Respondent: I vaguely remember this, yes.

Interviewer: They hadn’t been involved in abortions and then they were introduced, that’s my understanding anyway, they objected. They took the case to court and they ultimately lost. It ended up at Supreme Court, they lost and the judge ruled that abortion should be restricted to hands-on activities. They’d created a list of 13 things. Is it alright if I just read a couple off and see what you think about them?

Respondent: Yes, go for it.

Interviewer: I’m trying to find the list now. They were things like taking telephone calls, booking patients in, providing support to midwives who had hands-on activities with the patient.

Respondent: They had to do that.

Interviewer: Yes, they had to do that. That’s what they felt would be participating in abortion.

Respondent: The midwives felt it was participating, wow.

Interviewer: Those two midwives. Answering buzzers, they felt that would be, emergency buzzers. Maybe their argument would be, “We don’t know what we’re walking into.” Taking telephone calls, providing family support, providing support to colleagues, advising colleagues who may be providing that one-to-one care, they were senior midwives. There were 13 points they did raise. I’m just wondering what you think about that. Would you perceive that to be participation in abortion?

Respondent: I wouldn’t really, no. I think of participation as you actually administering the agents to induce the foetal demise and then to… I suppose just the foetal demise, not then the labour or the delivery. When you were talking then I just thought, “Wow, selfish.” It just cracks me as selfish that they’d want to refuse to do those things to somebody in need. Things that are so trivial, to a certain extent. You’re not going to answer the buzzer because she needs a jug of water. You’re not going to pick up the phone because she’s having a crisis of confidence an hour before she comes in about whether she’s doing the right thing.

Likewise, they can say, “We don’t know what we’re stepping into when we go into the room. We don’t know what they’re going to say on the end of the phone.” It could be quite the other way as well. Just because they’re having an abortion, why does every need have to be centred around the fact they’re having an abortion?

Their needs are still the same as any woman who isn’t having an abortion, psychological, physical, medical, emotional, those needs are still the same. They’re not less deserving of that care. Their needs are still as important as anyone else’s, so why is it they should be able to not meet those needs? Especially with senior staff. No, I just find that trivial. Those examples are trivial as far as I’m concerned.

Interviewer: It seems to sit quite uncomfortably with you really.

Respondent: I just don’t understand how people can come into a job and then think they can pick and choose like that. Not just pick and choose, but they’d willingly see people in need, in strife, in distress and would leave them like that because it was against their personal beliefs. Even though my own perception is that by participating it would be when you’d be giving agents to induce foetal demise.

Interviewer: It sounds like you take the view of the judge who ruled on it that actually abortion isn’t this process from the booking in, taking the phone call, booking in and all these different stages that ultimately lead to it. It seems you see that participation in abortion is just literally that hands-on moment.

Respondent: I’d say so, I really would.

Interviewer: It’s quite an interesting distinction really. I suppose that’s where people see it from different perspectives. Some people see it as a big process and then some people see it as a hands-on activity. You mentioned earlier you feel people who may object they should maybe have the foresight to consider what their role is going to be when they come into this type of job. I know you didn’t encounter any objectors personally earlier on. I’m just wondering what you perceive the effects of an objector may be on colleagues.

Respondent: It puts colleagues in more of a corner, I suppose, doesn’t it? Maybe it’s going to be the same people looking after these ladies time and time again, which might be fine. Obviously, you have bereavement midwives and things who often are the ones to take on this care. Just from an emotional perspective because it’s so draining. You might not be an objector, but you don’t necessarily want every shift… Not every shift because it’s not that frequent, but you know what I mean. To always be the go-to person because you want the happy moments as well.

I think there’s that potential that objectors, by them objecting it’s putting an extra… The work has got to go to certain other people who don’t object. What the ratios are for objectors and non-objectors, maybe I’m being a bit extreme in that example.

Interviewer: It sounds like you’re saying there could be a bit of burnout amongst those people.

Respondent: Yes, because they’re repeatedly getting those really stressful cases to deal with. When you become a midwife, you know it’s going to be part of your job and I think you need to accept that. It’s not what you would think the main part of your job was going to be. What you’re taught, what you see and whatnot is the happy healthy outcome. There might be complications along the way, but the end goal is a live healthy baby, a live healthy mum and that they all go home together.

I suppose it could create conflict if you were working with someone who was an objector. I’d go home and think, “I wouldn’t expect that from them.” I’d want to know more. It’s a fine line really. Have I got a right to ask why? I haven’t, but it’s my personality that I’d have to suppress, I would really want to… Not necessarily to shout somebody down, I don’t mean it like that, but sometimes intrigue.

Interviewer: Maybe just to understand it?

Respondent: To understand. To see, “What am I missing here? Why don’t I feel like this?” Especially if it’s somebody you get on with, you respect as a colleague and you have a view that’s very at odds with them. I want to try and understand how they’ve got to that point because it is very far-removed to how I feel.

In my experience there weren’t objectors I was aware of or if they were very few and far between. I could imagine they’d have stood out like a sore thumb because the majority weren’t objectors. Therefore, the one that was you can imagine whispers behind their back and things being said, derogatory things. I suppose similar to things I’ve said when you come into this job you know what you’re getting into. I wouldn’t be somebody who’d ever put it across like that, that’s not who I am. I’d want to try and understand if I could. I certainly wouldn’t be making public comment with other people about it negatively.

Interviewer: You mentioned earlier on the impact an objector may have on patient care and on your colleagues. I’m just wondering whose rights come first. Trump doesn’t seem quite the right word. Do you think the rights of the patient come first or the rights of the health professional come first?

Respondent: I think when the patient walks through the doors of the NHS or to a healthcare facility they’re giving over their care to us, we’re responsible for them. We’re the professionals at the end of the day. They can’t access support, this care or this treatment anywhere else other than through… Obviously, it’s not always NHS, it could be private potentially, but through medical professionals. If we didn’t provide that care, what could the outcome be? Would she go and access something somewhere else illegally, potentially? I know that’s probably quite extreme in the UK.

Thinking it out, to me, the right of the… I was about to say, to me it’s the right of the patient would come first. Then as I was saying that or about to say that… There are other things that pop into my head, not necessarily to do with abortion. You can just think of women you’ve looked after and things like that. I’ve never objected to look after anybody, but you can kind of imagine certain things where you’re less happy to look after certain people and whatnot. Why should you always want to go into a room and be comfortable with what you’re doing or happy?

Interviewer: It’s so challenging, isn’t it?

Respondent: It’s hard. It’s like saying, when you come to work your rights go out the window.

Interviewer: Thinking of conscientious objection then, just think of that example. Do you think the rights of a conscientious objector come first before the patient?

Respondent: No, I think the patient comes first.

Interviewer: I was just wondering what the different distinction is in terms of that healthcare professional’s rights and that patient’s rights. Is it the conscientious objection around abortion or is it their rights to…? I suppose that’s an arbitrary question really, isn’t it, their rights to anything and everything. There seems to be a bit of a distinction, it sounds like you’re saying there’s a bit of a distinction that actually healthcare professionals’ rights don’t come first when it comes to conscientious objection, but there might be other scenarios where it might.

Respondent: I can’t even give you an example of a scenario.

Interviewer: I can’t think of one.

Respondent: There’s something there in my brain, but I can’t even think of an example that my rights would need to come first because there are no other scenarios where you’d object.

Interviewer: I’m just wondering what it is or whether there is something that’s different around conscientious objection to abortion to other cases.

Respondent: Like I said before, I feel as if it’s part and parcel with the job. If you weren’t going to be comfortable with this that you’re in the wrong profession really. That your motivation, your ethos is to… Whatever way you want to word it, is to provide care, to have women as your centre, to keep people healthy. Don’t get me wrong, I know that terminating a baby with Patau syndrome or whatever else isn’t keeping a woman healthy, but maybe it is mentally. Maybe it will be physically in the future if she was looking after a child that had this condition.

It’s hard for me to answer, but to me it’s part and parcel of the job, women’s health. It’s not always going to be happy. It’s not always going to be what they want to be pregnant. It’s not always going to be a healthy pregnancy. I’m not saying their reasons to have an abortion, without going into personal things, I don’t necessarily know whether it would be for me. That’s just my job because it’s someone else’s choice, it’s not my choice. It’s not my baby at the end of the day.

Interviewer: Have your views changed at all or what’s informed your views?

Respondent: I think when I was younger I always thought, again it changes when you get older and when you get pregnant. I always thought I could have an abortion if the circumstances were right. This means socially, if it just happened at the wrong time. Probably when I was about early 20s that changed a little bit, I’m not sure why. I just didn’t necessarily think I could go through with that. Luckily, it never happened.

Interviewer: It was a non-issue for you.

Respondent: It was a non-issue for me and that was great. Now it would probably depend on the circumstances. I don’t think I could ever have a social termination, I really don’t. I am lucky to have a good job, a partner with a good job, I’ve got a house and a good family, so it’s not as if there’d ever be a financial issue. I’m not rich, but it wouldn’t be a financial issue, it wouldn’t be a childcare issue, it wouldn’t be a support issue. To me, at least at this stage in my life, never now to have a social termination. Plus age is a thing, I’m [age] now.

Interviewer: You’re a baby.

Respondent: In relation to having children it’s not, there’s only a little window left. It’s not as if I’ve got 15 years left where potentially accidents would happen or whatever else. I think in regards abortions following a diagnosis of something… Without boring you or going into it too much. When I did my master’s, I did my master’s on why pregnant women had screening tests for Down’s syndrome. What influenced them to have screening tests for Down’s syndrome?

I’d always been interested in Down’s syndrome a bit more in particular. I’d observed it through work and as a student when I was working as a midwife that I didn’t think people understood what Down’s syndrome was properly. The women didn’t understand what it was, nobody counselled them on it. They had this certain idea in their head of it being life limiting, negative etc. Probably the health professionals did as well. Therefore, if you did have a diagnosis that termination would be the way to go.

Interviewer: The option.

Respondent: The option, yes.

Interviewer: Things have evolved though, significantly.

Respondent: They have, to an extent. I won’t go off on a tangent. I went on a Down’s Syndrome Association study day about four weeks ago that was run here by a midwife whose daughter has Down’s syndrome who’s 21. She’s done some research, qualitative work, that she shared with me because we want to try and do something together. Some of them were an antenatal diagnosis of Down’s syndrome, a lot of them were postnatal. It wasn’t known in pregnancy they were carrying a child with Down’s syndrome, postnatal diagnosis.

The negativity, the language used by the staff, “I’m sorry to tell you your child is Down’s syndrome.” The attitudes are still there, the negative attitudes and the perceptions of it’s not what your child will achieve, “It will go to school, your child will get married, your child will have a job of some sort.” It’s, “They’re not going to be able to read and write. They’re going to be mentally impaired.” Were the words she used.

Interviewer: Which isn’t necessarily true.

Respondent: No, not at all anymore. It probably isn’t as it was, but I think there probably are still a lot of people who have abortions for Down’s. I think it’s something we promote a little bit here to an extent. It’s a medical view in this hospital at the foetal centre, which is where people go.

If they had screening that had come back high for a syndrome, they’d then be offered diagnostic tests and it would be the foetal centre they’d go to. It is very much a medical model there. It’s not the counselling about the condition. Don’t get me wrong, there probably is their view of counselling of the conditions. Not speaking to anybody who’s got a child with this condition for them to tell you realities. My perception is an advocacy towards abortion.

From a personal perspective, when I had a baby, when I has screening tests, which was three years ago, almost. I didn’t have screening for Down’s syndrome because I knew if my baby had Down’s syndrome I wouldn’t terminate for it. I had screening tests for Edward’s syndrome and Patau syndrome. I don’t know whether I feel this as much now, my perception was that they were life limiting. I didn’t consider Down’s to be…

Although I know it is life limiting in the sense your life expectancy isn’t going to be as much. I felt with the other conditions the implications were far huger and what the capabilities of the child would be. That sounds really clinical, I don’t mean it like that. It was much more extreme.

I don’t know whether that perception is right anymore, but that was what I believed. I screened for them and they came back low risk, which doesn’t actually mean anything because the screening test is a just a screening test, so it’s garbage really. I’d never have an amnio, I don’t think. I’d never risk losing a baby through it just so I could know a few months earlier. I suppose that means I wouldn’t terminate.

Interviewer: It sounds like your views have changed in terms of when you were younger it was more black and white. I think that’s true of everyone, isn’t it? Life is black and white when you’re young. Then the experience of growing older and your medical experience in your [job role] or your [job role], but also your personal experience of having a child. Life does change when you have kids, definitely.

Respondent: You’d never willingly want your child to either have Down’s syndrome or Edward’s, Patau’s, whatever else chromosomal issue. You’d never willingly want that. By the same token, I don’t know whether I would terminate for one of those conditions that I consider more severe. As I say, you’re only going to be offered a termination if you have a diagnostic test. Don’t get me wrong, NIPT now, isn’t there? It’s not as invasive.

I feel as if, I could be wrong, I’m sure I’ve heard people in the foetal centre that even if you’ve had a NIPT that came back with 99.9% that they advocate they have an amnio. I could be talking rubbish, but that’s in my head somewhere. I just don’t think I’d ever have an amnio.

Interviewer: It’s a definitive test the amnio, isn’t it?

Respondent: Yes.

Interviewer: It comes with a load of risks.

Respondent: My cousin had high risk on her quad test, this is two and a half years ago. Had an amnio and had a miscarriage from the amnio a week later or three days later. The baby did have Down’s syndrome when it was born, Phoebe. She’s had a baby subsequently, but she had no tests because she said, “I’d never do that again now because I wouldn’t do anything. I wouldn’t have terminated.”

She wouldn’t have had an abortion if it was a Down’s syndrome. She just went along with that and it had a terrible consequence because she miscarried that baby. It was more than a miscarriage because she was 19 or 20 weeks pregnant. She then had to come in, have her labour induced and give birth. It took that for her to realise that she wouldn’t, “Why was I doing this?” I’m going off on a screening tangent now and I’m sorry.

Interviewer: No, it’s fine.

Respondent: It took a dire outcome to make her realise there was no point to any of this. “There was no point to the screening test because I wouldn’t have done anything.”

Interviewer: It is interesting. It’s almost like the experience denotes your views on abortion. For you personally, maybe not so much someone that you’re caring for.

Respondent: I think you’re right. I remember somebody I cared for years ago, a woman who came in. She’d had an amnio a few days before and she came in with abdo pain. Again, it was probably around 18 weeks pregnant or something like that. There was a foetal heart there and we ended up sending her home. I remember she came in the next day and the baby had died. I met her again subsequently and I know it was a similar thing. She had, “I didn’t have tests in this pregnancy because of the outcome. Why would I risk having an amnio to lose the baby?” Whether it be ‘healthy’ or not.

Interviewer: It’s all relevant and all interesting. Have you ever refused or considered refusing, earlier on in your career, participating in abortion?

Respondent: No. I’ve been apprehensive because I hadn’t done it before.

Interviewer: More about doing it right.

Respondent: Doing it right, how to act around the woman, what things to say. It’s not your normal topics of conversation, you’re not going to talk about the light-hearted things you’d normally talk about. How much should you talk? Do you talk at all? That type of thing. I would never refuse.

Interviewer: I’ve asked that. Blooming heck, I’ve asked more than I thought I had. (Laughter) You didn’t work as a midwife here, did you?

Respondent: Not [job role], no.

Interviewer: In your other [job role], were there any guidelines for you on conscientious objection or were you made aware of them?

Respondent: I’m not aware, no. Again, there may have been, but because it wasn’t an issue for me, I wouldn’t have known. I would say it was a medium sized unit, 4,000 deliveries a year. It’s not a progressive unit. I think when people think of a progressive unit they think of somewhere like here because it’s a centre of excellence and people come from all around for treatment here and things.

The trust I worked at there was a certain type of mentality. It was doing things a certain way and it was the [hospital name] way, it was the [hospital name] way of doing things, which wasn’t always evidence based or at least the up to date evidence. It was, “This is how we’ve always done it and this works, so we’re going to carry on.” It’s not like that as much now, but there’s still definitely an element of that there.

I would be surprised if there was a policy or a guideline about conscientious objection because it was hard for them to keep up with other things that needed guidelines doing. Things that needed them, so management of certain conditions and things. I would be quite surprised if there was anything like that. I’m just thinking of maternity mentality. Whether there was something more trust-wide…

Interviewer: Yes, more generic maybe.

Respondent: Yes, more generic. There could have been.

Interviewer: Have you ever been asked or have you ever had to declare if you’re an objector?

Respondent: No.

Interviewer: Do you think maybe you should be, you should have to if you were? If something did change, do you think people should be asked if that’s their position?

Respondent: I suppose it would do away with those issues I mentioned earlier of people’s reluctance to speak up depending on the environment, who they’re speaking to and things. It could avoid those situations. Whether I agree with it or not, it would make sure those people’s views were heard and them not having to speak up when they’re potentially the minority and the majority might not agree with them or might not support them. There’s that uncertainty whether they’d be supported by their colleagues when they spoke up about it. Whereas if they were asked, it’s more open, it’s more transparent.

I suppose so. It might sound a little bit in conflict with stuff I’ve said before about how it’s the women’s rights that come first. When you put it like that, I certainly don’t see it being as harmful as somebody asking if anybody objects. I suppose it doesn’t have to be said really explicitly to make a big deal out of it. It doesn’t have to be, “Is anybody here a conscientious objector of providing abortion care?”

Interviewer: “Please stand up.”

Respondent: It could just be, “Is there anybody here who’d rather not look that woman or has got an issue with dealing with that woman?” It’s not putting the spotlight on people as much, it can be done in a more roundabout way.

Interviewer: How do you think conscientious objection could be accommodated in the job role? I know earlier you said there’s some conflict there, especially when I read off what the midwives were objecting to. I’m wondering if there was a role for an objector, how could they be accommodated?

Respondent: You mean, how could the be accommodated, what else would you get them to do, you mean?

Interviewer: Possibly, yes.

Respondent: In relation to that woman’s care?

Interviewer: Yes, how would it work?

Respondent: If they had to be involved because there wasn’t enough staff on. How would you make it as…?

Interviewer: If I came to you, I came for a job and I said, “I have a conscientious objection to abortion, but I want the job.” How would that work? How they could be accommodated within their job role and not have to participate, could that happen?

Respondent: Yes, I think it’s definitely possible. The things you read out before seem quite extreme to me, so it would depend on if they defined that as participating in abortion care, like the answering of the phone etc. That makes things more difficult because you can’t screen those things, you don’t know who’s on the end of the phone. You know when the woman is there in the room, but a lot of other things are very unpredictable. I don’t know how you could control for things like that, so that would be more difficult.

If they didn’t class all of those things as being involved in the care, then I don’t think it would be… I think the numbers would be so small and it’s not going to be the majority of people, it would be quite easy to facilitate because there are lots of other choices of members of staff to go to.

I think one of the biggest things wouldn’t be so much midwives because you’ve got multiple midwives on shift. It would be doctors, wouldn’t it, I suppose. You have on person on-call and that would be more difficult to facilitate. With midwives because of the numbers and things, I don’t think it would be too hard. Your colleagues will always step in. Not necessarily step in for you, but step in for the woman. Everyone else is going to make sure the woman gets what she needs and everything is performed as it should be.

The reality is, it’s the other elements of your role that are more frequent than these elements. That person is still going to do 95% of what the job description is, for example, but that 5% they’d have to do something else. That’s only going to be something else that someone else would be doing anyway. It’s just making sure they do it all the time.

Interviewer: It sounds like if conscientious objectors were to be… There will be conscientious objectors, of course there will, working. Maybe if there was a bit more transparency in management. It’s about a bit of forethought.

Respondent: I think, as with anything really, the more it’s talked about the less uncomfortable it is.

Interviewer: It’s not stigmatised then, is it?

Respondent: If you don’t talk about these things that’s when it becomes the elephant in the room, doesn’t it? People don’t want to speak up potentially and are probably reluctant to because they don’t know how they’re going to be perceived by their colleagues. If it is more transparent… It could be even things like when you sign your contract when you start, you have to sign a form to say what your views are and things like that. That’s a stupid example, they’re not going to check that every shift, are they?

Interviewer: It’s interesting you say that in a way. I attended a nurses meeting and a couple of people brought up the issue that they were told they couldn’t conscientiously object.

Respondent: Oh, really?

Interviewer: Yes. The other end of the spectrum almost, at their job interviews. How do you feel about that? You seem a little bit taken aback, surprised maybe.

Respondent: Yes, surprised. You talked about rights. Regardless of whose rights I put first, you’ve still got your rights and your beliefs. Some people can’t go against their character or whatever you want to call it, hence why they do conscientiously object.

Interviewer: It’s a challenge, isn’t it? What I’ve found, you have your view on it and then you get all these different dimensions or it’s prodded a little bit and you think, “Hang on, I’m not sure -.”

Respondent: Now I feel like what I’m saying is really contradictory to what I said 20 minutes ago.

Interviewer: To sum up what you’ve said, the patient comes first. It sounds like from your perspective you’re very patient centric, even if that’s at odds to your personal beliefs that’s something different and you’ll process that when you go home.

Respondent: Yes, I’d never inflict my beliefs on somebody else.

Interviewer: You’ve got that aspect of the patient comes first, but when it comes to conscientious objection the patient comes first, but it seems like you’re saying you can be a conscientious objector if they’re managed well. Maybe it’s not wrong for them to feel like that. It’s not contradictory at all.

Respondent: Okay, I’ll take your word for it. (Laughter)

Interviewer: Are there any elements of the abortion process you feel midwives should be able to refrain from? Thinking about your role as a midwife, do you think there’s any part that people could conscientiously object to, should be able to conscientiously object to or do you think midwives shouldn’t be able to?

Respondent: I think the risk with not being allowed to conscientiously object, I just mean by this the induction of the foetal demise as the participating in care. I don’t mean any of the answering of the buzzer or the phone because that isn’t it to me. I think the risk of not being able to object to the women, then having somebody looking after her who is going to be not compassionate, not caring, won’t treat them with respect, will be derogatory towards them, potentially inflicting their views. Maybe not as explicitly as that.

The woman’s experience, which is obviously going to be dire anyway because of the reason she’s there. If she’s being looked after by someone who doesn’t want to be looking after her because they don’t agree with why she’s there and they don’t believe they should be involved. The impact on the woman could be so horrific, something like that.

Interviewer: Take the example of Sweden where conscientious objection is unlawful. If you have people who work in that scenario who want to object to something, for whatever reason, it could be religion, it could be experience, it could be what’s going on here. Actually, that would have implications for patients’ care.

Respondent: Yes, I believe it would. If there was nobody else available who wasn’t an objector, so you had to have this person, I can’t believe it’s going to be as pleasant a… Pleasant isn’t the right word, but as comfortable an experience for the woman as it would be if she had somebody who didn’t conscientiously object. I feel like it’s protection of the woman more than the rights of the person to conscientiously object. I’d just be fearful of what the repercussions would be for the woman if they weren’t allowed to.

I think what I perceive as the small as well. I think there are small numbers of conscientious objectors influences what my responses are. If it wasn’t small numbers and it was much larger numbers, I’d be worried. I’d say, no, they haven’t got a right to object because who’s going to look after all these women if 70% of people are going to conscientiously object? Because I know it’s not numbers like that, I kind of think, although I don’t agree with it, it’s not me and I put the rights of the woman first. There’s another flipside that makes me go, someone else can do it. Again, I feel like it’s at odds with what your role is, why you come into the job.

Interviewer: Maybe have a bit of forethought. Even after that forethought, if you still really want to do it, it could maybe be accommodated. It’s interesting you say that about such small numbers. There is some evidence, very limited because it’s quite an untouched area in many respects. There is some evidence to suggest from midwives and nurses, certainly midwives anyway that it’s quite a small proportion. It does require people to talk about it.

Respondent: You wouldn’t know, would you? People don’t want to say.

Interviewer: Is it that small number who are maybe brave enough to go, “Yes, I am.”

Respondent: Maybe it is much bigger and you just wouldn’t know.

Interviewer: We’re coming to the end now. The Abortion Act was introduced such a long time ago and the clause in the act is quite woolly around objection. Anyone can invoke the right to object as long as it doesn’t endanger the life of the woman or the patient. If that clause was scrapped, what do you think should maybe replace it, if anything?

Respondent: So that nobody could object you mean?

Interviewer: If there was a rethink on the law, what do you think that law should be?

Respondent: That’s a stumper that one, isn’t it?

Interviewer: It is a challenge.

Respondent: Let me just think a sec.

Interviewer: That’s okay. I’ll just read over these while you have a little think. I’ll make sure I’ve asked everything.

[Break in conversation 1:12:19 - 1:12:35]

Respondent: I suppose if you’re going to conscientiously object… I can’t get my words out.

Interviewer: We say CO. (Laughter) It’s a mouthful.

Respondent: If you were of that view, I find it hard to imagine if you were to put some different clause in to amend the law, to amend the clause somehow. I can’t imagine that satisfying those people because I can’t imagine if you were to dictate and say, “You can conscientiously object to social termination, but you can’t conscientiously object to a termination for medical or genetic or chromosome disorder. I can’t imagine that would satisfy those people. Again, it’s a sweeping statement.

In my head or what my perception is to them that foetus is a human life at the end of the day. Again, probably bringing the religious element in. Things that come into my head, if there was a genetic disorder or something people saying things like, “God’s will.” Things like that.

It’s hard to think from their perspective what an acceptable clause would be. As far as they’re concerned my perception is that none of it should be happening at all, whether it be an abortion because you’re just pregnant at the wrong time or an abortion because your baby has got a syndrome, anencephaly or whatever else. As a midwife you don’t do social terminations at all, unless you went and worked somewhere like…

Interviewer: BPAS.

Respondent: Yes, BPAS obviously have midwives working for them. In the NHS you wouldn’t be doing social abortions unless you were nurse trained and went and worked in that area. You could go as a midwife and work at BPAS and obviously you would be. It’s hard to answer because for me I’m not having to perform social abortions. I find it really hard to answer that. This is totally contradictory because I’ve said I had screening tests for certain conditions, although I didn’t know what I’d do. If you were to say you were going to put a clause in and say you can object to social abortion, but you can’t object to an abortion for a condition, is that a bit like eugenics?

Interviewer: I was trying to think of the word.

Respondent: That it’s okay to abort in those conditions because we’re trying to get rid of incidents in the population, the incidents of this occurring. I think that’s a really fine line, I really do. I don’t know how, maybe I’m missing something. My brain is struggling to process what kind of clause there could be to…

Interviewer: Maybe just keep it the way it is.

Respondent: Yes, potentially. This is going to be one of these I go downstairs later and I’ll start thinking and I’ll be like, “Oh my goodness [Crosstalk 1:16:30].”

Interviewer: You can always email it over.

Respondent: A lightbulb moment.

Interviewer: Do you see referral as participating in abortion? A conscientious objector really could say or should say, “I object, but here’s someone who will do.” Do you see that as participation?

Respondent: I can see how they would argue it in the sense that you’re facilitating that woman to then go onto that next step. If you weren’t there, she wouldn’t be able to go onto that next step. You’re her access point, kind of thing. Facilitating is the key word, I suppose. You are facilitating it, when I think about it like that.

If I was to think about it from what their guilt must be or something for why they object, then no, I’d still take it back to the foetal demise. I can appreciate that you’re the stepping stone, you’re part of the puzzle to eventually get them to that point. If none of those prior points existed the woman would never get there, would she? She needs everyone else to do A, B and C to communicate to get her there to plan this. I can understand that.

Interviewer: But you don’t see it like that.

Respondent: No.

Interviewer: Which is fair enough. That’s what we’re interested in, we’re interested in what you see and what you bring from your experience. I think I’ve asked everything, to be honest, that I needed to ask. I’m just quickly going over them. Is there anything you want to add or anything you want to ask?

Respondent: I don’t think so. Talking about BPAS, I’ve looked at jobs at BPAS before just for a career change, not in the last couple of years. I don’t know if I’ve ever sat and thought long enough about how I would feel if this was a more regular part of my day-to-day job. It’s not now because I’m not working [job role]. Even when I was, it wasn’t a frequent occurrence I was having to do it. It was never for social reasons. I don’t know.

I could imagine it would be a lot more darkness and that influences your perception, to an extent. You’ve got to be massively comfortable, for want of a better word, with womentermination and abortion to go and work somewhere like BPAS. (Laughter) You definitely couldn’t be a CO there, could you? (Laughter)

Interviewer: I’d hope not. (Laughter) Unless you infiltrated it or something.

Respondent: You probably are influenced by the fact that working in this role it’s few and far between. The majority of things in the role are the pleasant happy outcomes. Don’t get me wrong, there’s loads of stress and whatever else in-between. It would be a different scope working for somebody like that because it’s seeing it from the total other side.

Interviewer: It would be interesting maybe to interview some people from that perspective really. Although you’d maybe think there weren’t objectors, maybe that personal professional internal conflict is different.

Respondent: I actually know somebody who works there, you can contact her if you want. She’s only just started though. She was a midwife here and she’s gone to work there. I’ll contact her, I’ll get her email address off somebody.

Interviewer: Thank you. I’ll stop this. Is there anything else you want to add?

Respondent: I don’t think so, no.

Interviewer: Thank you.

END AUDIO

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