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START AUDIO

Interviewer: Just to begin with, can you tell me a little bit about the work that you do as a health professional, please?

Respondent: I have a dual role. I work out on the [job role], as a [job title], three days a week. So, I run antenatal clinics, post-natal visits, book patients in for their first appointment. And then, two days a week, I’m a [job title]. And, like I’ve just said, we have a portfolio, so we work on lots of [job role].

And I like having a mixture of the both, because it’s nice. I’ve always worked that way, to be honest. From six months qualified, I’ve done [job role]. Because I come from a research background, before I did my midwifery.

Interviewer: What was that, you were researching?

Respondent: I used to [previous job role]. So, although I wasn't doing any of my own research at the time, it was just what I knew.

Interviewer: So, it’s all there.

Respondent: Yes.

Interviewer: So, how long have you been working in that role as a midwife, [job title]?

Respondent: I’ve been a midwife for over [number of years] years, and worked in [job role] from [number of months] qualified. So, I’ve basically done a dual role all along.

Interviewer: Tell me, is abortion something that you come across in your job role, at all?

Respondent: Yes, to be honest. Because obviously I do the initial booking appointment for women, and sometimes I find that women come to me because they haven't had the right information when they’ve either gone to a GP or they’ve phoned up the access centre, to book an appointment. And they’ll come to me-

Because obviously mums find out really early now, I’m doing that booking visit from anything between 3 and 12 weeks. It’s very rare that we would book somebody now after 12 weeks, because people just find out so early.

So, they’ll come to me sometimes and they say, “I don’t know what I want to do, I don’t know if I want to continue with it,” and they’ll break down, because they actually feel bad, they feel guilty. And I say, “Well, obviously if you're coming to me, it’s because you're continuing with the pregnancy, and I will set up everything in motion and let you know when you need to come back and see me, make sure you’ve got all the right contact details, put all the referrals in.”

So, I’ll say to them, “It’s unfair for me to go ahead and do this with you now and let you take your notes away, if that isn't actually what you want to do. What you need to do is go away and have a chat with your family, go back to the GP, maybe contact BPAS, for a little bit more information.”

So, I will kind of- We’ve got a clinic here, so I will give them the information for the clinic here. Because obviously they’ll get counselling before anything happens. And it may well be actually they just need to speak to somebody, before they decide. But to come and see me, I feel is a bit unfair, especially for the girls who have not decided.

Interviewer: So, what do you think makes that happen? What do you think the factor that makes that happen? Misinformation, for example? The GP’s side, or the girls’ side, for example?

Respondent: Me, personally, I think both of the GPs from my particular surgery- Because how it works is midwifes are linked with the GP surgery. Both of the GPs, husband and wife, object.

Interviewer: Oh, right. So, you think that might have a-

Respondent: I, personally, without ever asking the question, think that they both object. So, I don’t think, actually, the women are- They're given the contact telephone numbers, they are given the contact numbers for BPAS, I just don’t think they're counselled at that time.

Interviewer: And should they be counselled at that time?

Respondent: Well, I think they should be given information. I personally think they should be- At least said, “It should be your decision, go away and have a read around this, contact this number for more information.” I don’t think it should just be a case of, “There’s the contact number, you will have to deal with that yourself.” And I kind of feel like maybe that might be happening, but I don’t know.

Interviewer: So, you said you’ve never asked them the question, whether or not they object?

Respondent: Yes.

Interviewer: Can you tell me what has maybe stopped you from doing that?

Respondent: I just think, because we have a really good professional relationship, working- The GPs are really good with my patients, and I have a really, really good relationship. So, if I’m not happy or I’m unhappy with a patient’s health, or I need them to see a patient, because it’s out of my realm of normal, then they would always do that. And I just feel like I wouldn’t want anything to rock the boat for that.

Because, ultimately, at the end of the day, my priority, as a [job title], is that I have somebody else to refer to, who will look after my patients well. And I just wonder whether- And I don’t know, could it be that that’s what’s worrying me from asking the question.

And, actually, it’s not every patient that would come in, in that situation, because some patients will literally just go and say, “What do I do?” In that circumstance it’s fine for the information leaflet and the number to be given. Everybody is different. I just wonder, one or two, could that have been the case when I’ve spoken to them.

Interviewer: Do you think, when that has happened, if a woman has maybe been indecisive, possibly leaning towards having a termination or an abortion- Do you think those GPs referring to you as a [job title], what impact do you think that’s had on them, as a patient?

Respondent: It’s not only the GP though, it’s obviously when the women phone up to here, they speak to non-clinical staff. It’s an admin department, so I’m not just saying it’s GPs. And that will be lots of GPs across the city, realistically, because I just feel like that might be the case. But when they phone up here – “I’m pregnant, I don’t know what to do” – that, as a midwife, I might think, “Right, okay, does she not know what to do, what the process is, or does she not know what she wants to do?”

Interviewer: In terms of her choice.

Respondent: That’s my clinical intuition, to ask a further question. And that’s experience. And that’s just being a midwife, basically. But, if you phone up a non-clinical staff and say, “I’m pregnant, I don’t know what to do” – “Okay, this is what you do, you need to book this appointment, give me some details,” ask really non-specific questions. Because it’s their job to get a pregnant patient an appointment, it is not their job to counsel a patient, and why would we expect them to?

Interviewer: No, it’s unfair, it puts them in an unfair position.

Respondent: But they would not think, if a patient said, “And I don’t know what to do.” Unless they say, “I don’t know what to do about the pregnancy.”

Interviewer: Yes, which most people wouldn’t, you just-

Respondent: It’s just like, “I’m pregnant, I don’t know what to do, I’ve seen the GP, they’ve given me this number.” Because of the GPs across the city will give them the ‘choose and book’ number, because they don’t necessarily need to see them, because they just book directly with us.

So, it’s a case of, depending on who they see or speak to, for that initial appointment, is what would happen. And it’s not often that it happens, but it happens more than enough that I think-

Interviewer: Maybe something needs to be done about it.

Respondent: Yes.

Interviewer: Would you say that, when it does happen, that it has any sort of impact on the patient, at all? Or is the patient not even aware?

Respondent: I just think, if the patient isn't in a good place to start with, of course it will. Because they’ll think, “Okay, so I’m going to go to this appointment and I’m going to be able to talk about those things.” But, actually, they're going to come to an appointment to book in with a midwife. So, it’s not ideal. And, unless-

I mean, to be fair, a lot of women are really knowledgeable and will go to the internet and will look at things. So, a lot of patients will already know what processes to follow. But there are some who don’t. And there are still some who don’t particularly have a smartphone or might not have access to a PC all the time. It’s few and far between, but…

And, also, people that still want face-to-face contact with a health professional. It’s great, reading around and having an idea of what you want to do, but you still have to have that information and you still have to obviously speak to somebody and make your decisions.

Interviewer: That’s it, you want reliable information. The internet is great, but you don’t know how trustworthy it might be.

Respondent: And, also, if you're going to follow that process, if you are not wanting to carry on with your pregnancy, and you are thinking about termination, then you need to follow the right processes. You need to see a GP, you need to do all these things. So, I suppose, for some women, they’ll think, “I need to go and see the GP,” and that would be their first port of call.

Interviewer: Yes, which is understandable, really. So, as you know, this project is looking at conscientious objection to abortion. What do you think constitutes conscientious objection to abortion?

Respondent: Obviously it’s just people’s own views of conscientious objection. Me, personally, I don’t have any, I am pro-woman, pro-choice. I just feel like it is- No health professional or- Nobody else’s decision, other than that woman, herself. So, me personally, I don’t have any. I just feel like other people may be influenced by lots of different factors – family, friends, information, misinformation, religion, belief.

Interviewer: What’s helped to form your views on conscientious objection? It sounds like you wouldn’t object, so what has helped inform those views, for you?

Respondent: I just feel like I personally believe a decision like that isn't an easy decision to make. So, therefore, if somebody makes that decision, I would like to think that it is a decision made by- Because it’s the right decision for them. It’s hard, isn't it? It’s a hard decision to make, I would imagine.

But, that being said, I’ve had women come to me who have said, “I don’t think this is what I want,” and then they’ve come back, a couple of years later, and have totally been in the right place. So, circumstances, there are lots of different things that can influence that.

And I just feel like, me personally, I just feel like- I don’t know whether it’s just experience of being a health professional and just not being judgmental, but also I just feel like upbringing has played a big part. I come from a really Catholic background, so you would think that that would be the other way around.

Interviewer: No here’s your mate. (Laughter)

Respondent: You would think that would be the other way around. But, in actual fact, I come from a family, a really strong family, where you're encouraged to do the right thing, believe in your decisions, if you're unsure about something, ask. Never judge somebody, never walk past anybody without smiling. If you feel like someone is struggling, always help them out.

I just feel like background, family, good role models and, realistically, just experience of being a health professional, to just say, “I can’t judge somebody else’s decision. I may not make that decision the same as this person has made at that time, but what’s to say that I wouldn’t feel exactly the same in another day, another year, another time? I just feel like I personally believe it’s not a decision that most people will make lightly.

So, therefore, I would like to think that most people would make that decision just because it is right for them, at that time.

Interviewer: Has there ever been a time where you’ve- Sorry, maybe if I clarify first, when you have been in roles- Sorry, participated, and I use the word lightly, or broadly, rather. When you have participated in an abortion, what has your role been?

Respondent: Well, to be fair, because of my clinical as a midwife on the [area of work], I wouldn’t really have anything clinical to do with that decision.

Interviewer: I see.

Respondent: I would only be the person that they would come to. So, I would be possibly the first person that they’ve spoken to, and possibly the first person that they’ve said, “I don’t think this is the right thing for me, I’m not sure I want to continue with this pregnancy.” So, really, I would just say an initial, in-community role, just an initial counselling role.

Interviewer: Information-giving.

Respondent: Yes.

Interviewer: Do you see that role as participating in abortion?

Respondent: I guess it could be classed as that, but… Well, no, really. Because all I’m saying, “Is it sounds like you need to have more information, it sounds like you need to have a more detailed chat about this, you need to speak to the right people. I don’t think, at this moment in time, that’s me. And I can certainly put you in touch with people.”

Or, I would even- Obviously, I have, on numerous occasions, so I guess you could say participated- I have contacted the clinic here, and said, “This lady would like to come in and have an appointment. She’s come in to see me today, but she doesn’t really know if she wants to continue with the pregnancy.”

So, I guess there are some people that say that that would constitute as playing a part. But I personally wouldn’t say it’s a clinical part, but I’m just trying to do the right thing by that woman.

Interviewer: Individual. Yes, that woman.

Respondent: Just because, seeing me at that time, is not the right thing.

Interviewer: Has there ever been a time when maybe a patient has come to you and it has challenged your stance on conscientious objection? Because you sound very patient-centred and for the rights of the woman, first and foremost. I’m wondering if maybe your limits have been pushed a little bit.

Respondent: I don’t think I’ve ever been pushed to a limit. Obviously I’ve been around people who have a different viewpoint to mine, and strongly believe that that isn't the right thing to do, and it’s wrong. And people have said, “Well, why doesn’t she continue with the pregnancy and give it up for adoption? There are lots of people who haven't got children,” this, that and the other.

And I have said, “It’s not our decision to make. I can understand what you're saying and, yes, there is an argument for that. Because, yes, there are families out there with no children. But that doesn’t mean an individual would go through a pregnancy that she obviously doesn’t want, to benefit somebody else.

So, I wouldn’t say I’ve ever been pushed, clinically been put in a position where I’m unhappy. But, obviously I’m a realist, we all will be different, we all have different viewpoints. And, as I said earlier, what I could think today, I may not think in three weeks’ time.

(Laughter)

It is circumstances, environment, there are lots of different factors that you would have to really put into place. So, yes, I think in my clinical role I wouldn’t ever be put in that position, the way I work.

Interviewer: I get you, yes. Have you ever- I know you’ve spoken about your GPs, and you're not 100% certain on them, but have you ever encountered any other colleagues who are objectors, such as doctors, midwives, nurses, anything like that?

Respondent: I’ve encountered people who have strong views, and have-

Interviewer: Sorry, do they work in abortion care or maternity services?

Respondent: Maternity services, because that’s where I’ve been. I’m not sure about previous places. And obviously at university, all being midwives, you would think that we would be against that, just because what we do is bring new life into the world and nurture mums. But, in actual fact, I think the majority of us would be pro-woman. And, unless you had a real strong aversion to that, and really felt strongly about it…

So, yes, I mean it’s come up in conversation but I’ve never really probably encountered anybody who has been really, “I would never do this.” I just think, as health professionals, that isn't how we should act. Even if you feel really strongly about something, it’s fine to say, “Oh, well I’m not going to be involved-”

Because I think, at university, we were put on gynae placements and we were given the option. If you were on a gynae placement, there will be women who were terminating pregnancies – “You may be asked to answer a buzzer or look after these, how would you feel about that?” I can’t remember if anybody said no. It’s [number of years] years ago.

Interviewer: I can’t remember what I ate for my tea last night, so… (Laughter)

Respondent: Yes, it was [number of years] years ago. But I’ve actually just thought, as well, I have looked after patients, obviously before I went out on the [area of work], women who have come and terminated the pregnancy. Mainly for medical reasons, to be fair.

Interviewer: So, is that where the pregnancy is- There are problems in the pregnancy or problems for the woman, that type of thing?

Respondent: Yes. Usually, to be fair, it’s not necessarily the woman, it will be foetal problems. So, there will be a severe abnormality or possibly a chromosome abnormality, there will be things. Sadly though, the most people that I did look after in those circumstances were possibly from [country name], most of them would have been from [country name], and have had to come here, to do that.

Interviewer: Yes, it’s quite difficult.

Respondent: And that carries its own extra issues, if you like, because they're probably here without any knowledge of anybody else, and they have very little support. Personally, that would make me ensure that the support they got while I was looking after them was as good as it could be. As I say, I don’t object at all, I would just support a woman, no matter what.

Interviewer: It sounds like you're very patient-focused and you almost put the patient before your own views, as such, even if you weren’t very happy doing something. Has it ever been- You mentioned there that you did have some one-to-one care, or some involvement, close involvement with women who were undergoing abortion for foetal abnormalities. How did that make you feel?

Respondent: It didn’t make me feel sad or disagree with what they were doing, it just made me empathise with the women more, to think- Because I would say the majority of them that I’ve looked after have been from [country name]. Again, it just would have made me feel really sad for them, that they would go through this.

And I actually remember speaking to one woman in particular, I was very newly-qualified. I’m pretty sure there mustn’t have been anybody else to look after this woman, otherwise I probably wouldn’t have been in there. And I said, “Obviously, under the circumstances, there’s not a lot I can say to change what is about to happen. I just want you to know that, if you need me for anything, just let me know.”

And I remember speaking to her husband as well, and she said, “The only person I want to speak to right now is my mum, and she doesn’t know. And I’m never ever going to be able to tell her this.” And I remember coming away, thinking, “God, I am so lucky.” Because I could tell my mum or family anything. Even if I was in that situation, my family would understand and would be supportive of my decision.

And I just thought, “That’s sad.” And that did stick in my mind, that was sad.

Interviewer: The patient must have felt quite lonely, really. At least she had you, like you say, there.

Respondent: Yes.

Interviewer: Who rights do you think- Like I say, this project is around conscientious objection, as you know, and, for example, in some places, such as Sweden, health professionals aren’t allowed to conscientiously object, it’s unlawful. And then, at the other end of the spectrum, there are other places, such as Italy, where whole institutions will invoke their right to conscientiously object, and actually won’t offer, for example, abortions.

And I was just wondering what your feeling is around- Or what you think around whose rights come first? The rights of the health professional or the rights of the patients.

Respondent: It’s a bit of a hard one, that, because that’s like- I feel really strongly that the patient’s rights should come first, because that’s obviously how I practice, that’s what I feel health professionals- Our job is to look after somebody and to provide as much care and information and whatever it may be within our role, that we can provide.

But, that being said, it doesn’t mean that it’s right, for somebody who doesn’t agree with something, to be made to feel like they have to go against their will, to look after somebody.

So, I kind of feel like I’m- Me, personally, I think the patient’s rights would come first, because it would have to be something pretty bad for me to think, “Oh, I don’t know whether I want to look after this person.” But I would still probably provide the care, because that’s what we do.

But it doesn’t mean that somebody who doesn’t agree with something is wrong, or should be made to feel wrong. It’s kind of a hard one. I, personally, would say that the patients’ rights should come first. And, if they can’t get care in one facility, for the reason that people conscientiously object, then they should be facilitated to go somewhere else.

It should be that place’s responsibility to say, “We will not do that, but this is somewhere who will, and this is how you will contact them.”

Interviewer: Would you see- Because some people who conscientiously object would say, “Actually, referral to abortion services-” They feel that that is participation. And I suppose the thinking behind that might be that the end result is going to be the abortion, and that’s what they're objecting to. So, would you see referral as participation?

Respondent: I guess it kind of is, in the fact that you are facilitating that to happen, because you’ve given them the details. But, as a health professional, I strongly feel that you can’t leave a patient in limbo, without at least directing them. It is fine to say, “I will not do that,” and you don’t even have to give a reason. If that is how you feel, I am 100%, that is absolutely fine. I will not do that, but others will.

And even if you don’t personally hand the information over, there should be at least a box, with leaflets, with contact numbers or something, that the patient- Just saying, “I you want further information, there are information leaflets there. I will not give you one, but you can take one.”

I just think there are other ways around it. You are pinpointing them to somewhere they can get the information. Obviously, the issue is then, if women feel that they can’t go anywhere else-

Interviewer: Where do they go?

Respondent: Exactly. And who do they see? And will there then be a burden in other areas?

Interviewer: Do you think- I was going to say, actually- My next question was going to be- But you’ve kind of answered it. What the impact on the patient would be, if somebody didn’t refer on. So, for example, if someone was a conscientious objector and they didn’t refer on, what do you think the impact on the patient might be?

Respondent: Well, it’s- I would really say that they're being denied care. It’s fine to not do it, but you have to at least kind of allude or point them in a direction of some sort. Obviously, it’s a severe chance of increasing mental health problems for women, women don’t know who to turn to, women don’t know where to go. I don’t think very many women would find themselves in that situation in this day and age, to be fair.

But I feel, as a health professional, if we don’t at least pinpoint them somewhere, signpost them somewhere, we’re not really doing our jobs properly. And, obviously then, the women are being- I would go as far as to say denied care, and obviously are left in limbo – “What do I do? Who do I speak to? Where do I go? Does that mean, if they don’t do it, what I’m doing is really bad?”

Interviewer: It leaves the with a lot of questions, doesn’t it?

Respondent: Yes, questions, and who is going to answer them?

Interviewer: Yes, I see. I don’t know whether you heard, actually, a few years back, 2014, there were two midwives and they were conscientious objectors and they worked in a hospital up in Scotland.

The service that they provided originally didn’t do terminations, or abortions, rather. And then they were introduced and they invoked their right to conscientiously object. And they created a list of 13 things, a list of different things – I’ll just reel a couple of them off – which they said they felt was participation in abortion, and I’m just wondering what your view is.

So, they listed these things. They won the case, to begin with, just to give a bit of background. They won the case, to begin with, but then they were taken to the Supreme Court by the NHS Trust, and the ruling was overruled, and they lost, ultimately, as the judge ruled that abortion should be constrained to hands-on- Or, participation in abortion is hands-on activities only. And I’m just wondering what your views are on a few of these things.

So, they said things like management of resources within the labour ward, including taking telephones; providing a detailed handover within the labour ward to the new labour ward co-ordinator coming on to shift; acting as a midwife’s first point of contact, if the midwife is concerned about how a patient is progressing; ensuring that midwives on duty receive relief; answering a buzzer, providing patient guidance.

Do you see those elements as participation in abortion, or do you take the view of the judge, for example, who ruled that it was hands-on activities only.

Respondent: I would probably say it would be the hands-on activity. Purely because, as a health professional, the other things are just things that we do on shift, every shift. You can’t not answer a phone in case it’s somebody with a question like that. You can’t not answer a buzzer, in case it’s an emergency behind the door. I would strongly be on the side of the judge, and I think the judge was right.

But then I also feel like the two midwives did have the right to say that they were not happy to do that. And I guess their place of work should have facilitated them another way to work, that they didn’t have to be around that, as such. But it depends what type of a maternity unit you're on, how small it is, how big it is. Are there other areas these midwives could have gone to? I don’t know.

Interviewer: Do you think it’s possible to be a conscientious objector and work as a midwife or work in maternity services?

Respondent: Yes, I do, because you can just say, “I don’t want to do that, but I’ll take the next labourer. I’m not going to go in with the termination, but I will maybe go around to induction suite or I’ll do other things.” And I probably would imagine that there probably are, across the shop floor, that just say, “I don’t want to do that, I would rather not.”

And I’m sure there are gynae nurses that probably say, “I would rather not.” Probably few and far between, because our role as a health professional, just- It’s what we do. But, yes, I would imagine there probably is.

Interviewer: Do you think that would have any impact on colleagues? Say, for example, I worked with you and I worked in those services and I said, “Actually, [name of respondent], I’m not going to do that,” do you think that would have any impact on yourself or any of your other colleagues?

Respondent: It could put added stress onto us in an already obviously overstretched maternity service, or any gynae service, any service across the NHS. Yes, of course it can.

But, at the end of the day, if you are a realist, you’ve got to be able to accept that people do have different views, and it is absolutely fine, if that’s what they think. I don’t personally agree with that, I come from a totally different viewpoint, but I wouldn’t say that somebody was wrong because that’s how they perceive things to be.

I just think, obviously then, it may come down to the manager, might just have to say, “Well, I’ve got to respect her right to not want to do that. I’m not a shift leader or a manager. I probably haven't had to think about that from anybody else’s position other than my own.

Yes, if it was absolutely bouncing, you’d think, “I just wish that you would be okay to just do something.” But it’s fine, if they don’t.

Interviewer: It sounds like you're saying that you feel that it could be accommodated but just needs maybe a little bit more forethought. I just wondered-

Respondent: The thing about it is we’re never going to say to somebody, when we come for interview, “Are you a conscientious objector?”

Interviewer: I was just about- That was actually going to be my next question, are you asked?

Respondent: No.

Interviewer: Has no-one ever asked you?

Respondent: Nobody has ever asked since I qualified but I remember, at uni, we were given the opportunity to- They did make it clear that, if we didn’t want to do something, if we felt that we didn’t want to go on the gynae ward where terminations were taking place, that was okay, we would go in another area of gynae or possibly go on another placement. So, we were given that opportunity then.

But, as a qualified midwife, I can’t remember ever being asked the question, other than in conversation. It was never a clinical question from a manager’s point of view or, at the interview, “How do you feel about this?”

Interviewer: Do you think it should be a question that you're asked?

Respondent: Possibly in gynae. If you're working on a gynae ward, maybe. And I guess we are doing obviously terminations for medical or chromosomal problems.

Interviewer: Do you think people would answer the question, if they were asked? I know that sounds silly. Do you think people would answer the way that they want to answer, or do you-

Respondent: I don’t know. If it was in an interview situation, they’d say what you wanted to hear.

Interviewer: Yes. (Laughter)

Respondent: Because you want a job. Unless you felt really strongly about it, then you would say, “Well, actually, no, I would not do that.” No, I don’t think that’s relevant at the time, especially of an interview. No. I get why it would be useful, to know that information, because then you could ensure that you're allocating your staff into the right place. But I feel like, because we’re health professionals, we are expected to do a range of different things.

Working in maternity, fine, there is new life everywhere. But, actually, not everyone will get to that stage. Some people, obviously for medical reasons, if they go on, they probably may not get to term anyway, if it will- The pregnancy will terminate itself, often they will miscarry.

But, if they decide to terminate for a medical problem, issue, whatever it may be, I don’t- I think if- For example, the shift leaders would be the people to allocate the work out. If they were to allocate that to somebody, if they were to conscientiously object at that time, I would think that the shift leader would say, “Okay, that’s fine, I’m going to ask such-and-such if she’ll take that patient and you can take hers.”

I can’t see that it would be a problem, so I can’t- Even if it was absolutely bouncing, I don’t think that we, as- We couldn’t make somebody do something that they didn’t want to do, so I think it’s kind of irrelevant to ask the question at interview, or when employing somebody.

Interviewer: Maybe just if there was a private- It sounds like you're saying at interview it’s a bit unfair, because the interviewee is going to say what they think, as an employer, you want to hear-

Respondent: I mean, there is a potential that that would happen. It may not. People might just be quite happy to say, “These are my feelings on it. I don’t object,” or, “I do object.” It could be quite a straightforward- Because I would just- The way I feel about it, I would say, “Okay, I don’t have an issue with that.”

Interviewer: Have you ever spoken to your colleagues, about how they feel around conscientious objection to abortion, or if they are objectors themselves?

Respondent: I mean, there have been conversations, where people have said, “I wouldn’t- I object, I don’t agree with it.” I just think I’m really open-minded, in that I kind of just accept that other people have different views. I would probably say- I’ve asked, I’ve asked, “Why?”

Interviewer: And what did they say?

Respondent: “Is it religion, is it this?” I’ve asked, I’m a bit nosy like that. I would say, “Oh really, why?” And then I would say, “Why, or don’t you want to talk about it?” because I wouldn’t want to put somebody in a difficult position. But I think the ‘why?’ would come out before I’d even thought about it, to be honest.

Interviewer: (Laughter) Me too. So, when you have asked the question, have people been willing to tell you why?

Respondent: Yes, some people have just said, “It’s just something I wouldn’t do, I don’t agree with it.” And some people have said, “It’s religious reasons. What will be will be,” those types of things. I haven't had anyone really strongly conscientiously object, where I’ve thought, “That’s not nice.”

Although, just in my own church, they have pro-life campaigners outside, giving cards and collecting, and I just think that is really- I know the Catholic Church have a viewpoint on it, and I have said to my mum-

My mum is in the [organisation name], and I have said to my mum, “I am going to speak to the priest about that, because that is unfair. You never know somebody’s circumstances. You never know why that might be the right decision for somebody. So, I don’t feel like that is the right place for them to be.”

Absolutely, if that’s their view, they are well entitled to it, but I don’t think they should be giving that out. Somebody who is possibly considering it may be going to church just for the, “I just need some answers, I just need some space, I need some quiet.” They may be going-

Interviewer: Might want some reflective time.

Respondent: Yes, absolutely, and then come out and get handed that and think, “Oh my God, it’s a sign, I can’t do this.”

(Laughter)

You know? I just don’t think it’s the right place. And fine, that people have that opinion, and I absolutely am, but I don’t think anybody’s opinion should be forced on anybody else. I just think we all just have to be accepting and mindful of other people.

Interviewer: So, it almost sounds like you have your own personal beliefs, you respect everybody else’s beliefs, whether they object, whether they don’t object. But, actually, you accept that abortion care is part of maternity care, also, and that’s just the way it is, really.

Respondent: I would say not necessarily maternity care, because ours would be usually terminations for a reason, like a medical- Usually a medical reason.

Interviewer: Would you differentiate between a social abortion and a medical abortion?

Respondent: I wouldn’t differentiate from it but what I’m saying is I would not see women having a social abortion in my area of practice, just because they would go to a gynae ward or they would go to an outside service. So, I wouldn’t necessarily see somebody who was having an abortion for a social reason or because it was their choice, I just wouldn’t see those women.

Interviewer: Yes, I see. That makes sense.

Respondent: I don’t object to what they're doing and I don’t have any feelings either way, their decision is their decision, made by them, because it’s the right one for them. That’s their choice. But I wouldn’t see them in my area of clinical practice. So, I would differentiate in that it’s two different things. Ultimately, it’s still a termination, an abortion, however you want to term that, but I wouldn’t see social, I would probably only see medical.

Interviewer: I see, I get it now. Is there any limitation- Well, no. I was going to say, would there be- Well, you can still have an opinion on this. Sorry, that’s my thought process. You might still have an opinion on this. So, would there be any limitation on an abortion for you. So, if you had a patient, for example, who were on their 15th abortion to you, or would one be a limitation for you?

Respondent: It wouldn’t be something that I think is advisable, I think at some point somebody should have said to them- Possibly picked up does this patient need any counselling, is there anything going on? And if it really is just a choice, we can’t deny somebody that choice. The service is there, the service will offer her what she wants.

My only concern as a health professional is, is there anything else going on in this setting? Do we know enough about this patient? Is there any social worker involvement? Is there a risk of sexual exploitation? My health professional brain would be seeing other things, if that was put in front of me. Is everything okay?

And if everything is okay – not know to Social Services, in a long-term relationship, has been in a long-term relationship, or in a relationship with each of- You know, it may not be the same. I just feel like, if that’s a choice, then that’s okay.

And I wouldn’t particularly think that that was a good idea, to have that many, but it’s not my choice. And, if that’s her choice, and she’s made that decision with the right information put in front of her, then it’s a choice.

Interviewer: Again, the patient makes that choice.

Respondent: I just think, as a health professional, my mind would be thinking other things. Is she okay? Is she under pressure from somebody to do that? Is it what she really wants? Has she been counselled well enough? Do the people who have counselled her for this particular abortion know that previous history? Have they asked why another one? Is there anything- Have they explored that? Are they even aware of the previous…

Yes, so I would just have to- Would be happy that they’ve okayed that, as long as they know everything else. And, obviously, it’s not a midwife’s decision to sign that paperwork, that is done by a medic. So, as long as the medic is happy that she’s been suitably informed and it’s the patient’s choice, I don’t have a problem with it.

Interviewer: Have you ever refused abortion being- Referring a woman on for abortion, or considered refusing?

Respondent: I have never been put in a position where I’ve had to do that. However, I do remember hearing that there was a patient who was considering an abortion because the baby had a cleft lip and palate.

And I remember thinking, "I am pro-choice, I’m pro-woman, but I actually really feel like that is not a good enough reason for me.” Because there is nothing wrong with the baby and, if the baby didn’t have a cleft lip and palate, she would have proceeded with the pregnancy, and was really happy to be pregnant.

So, if- And I don’t think we hear at the [hospital name]- That is not a medical reason for termination. Whether she then went away and did that privately, somewhere else, which is absolutely her choice- But that is probably the only time, whenever it’s been discussed or whenever it’s been- I’ve seen it. It’s probably the only time that I’ve thought, “Oh.”

Interviewer: Yes, that’s quite challenging, isn't it?

Respondent: There is nothing clinically wrong, that is a healthy baby. And, yes, the baby would have to undergo-

Interviewer: Potentially operations.

Respondent: Yes, and be in a lot of pain and everything else. I personally just don’t think that is a good enough reason, just because everything else is healthy. And not even that, just because I knew that the woman wouldn’t have done it, if it wasn't- If the baby didn’t have that problem.

Interviewer: So, would you have- If you had been the midwife responsible for that lady’s care, would you have maybe passed her on to someone else and stepped away from caring for her.

Respondent: Again, it’s a medic’s decision. It’s a medic’s decision, so it wouldn’t be me who would ever have that conversation with her. I would never have the conversation, because she would never be under my care, because we would never offer it for that. If there was something else, a chromosomal problem, any other issues, like a heart problem, then yes, that could have gone ahead and would have been sanctioned- That’s not really the right word.

Interviewer: I know what you mean.

Respondent: But that would have come under the realms of a medical abortion.

Interviewer: It would have met the criteria, if that’s the right way to put it. (Laughter)

Respondent: Yes, I think that’s what I’m trying to say. But obviously that wouldn’t meet the criteria here, but it may well, somewhere else. And if the woman wanted to go away and explore that avenue, then there’s nothing to stop her from doing that, and that is her choice.

And, although it wouldn’t ever be a reason that I would think, “Oh yes, I don’t think I could proceed with that,” and I think most people wouldn’t, but that’s not to say that she was absolutely wrong in her decision. You don’t know. She may have a family member who has that and has struggled all their life, or…

I just feel like you have to be open to knowing her circumstance. Or you have to at least be open to think, “Well, there could be something that I would never find out or never get to the bottom of, which would make somebody really hell-bent on that is why it’s such a good reason for them to do it. So, I guess I just understand that it’s not all black and white.

Interviewer: Yes. Life isn't though, is it, in general? (Laughter)

Respondent: I would imagine that’s the only time- I do think that’s the only time where I’ve ever though, “Oh.”

Interviewer: That’s challenged you a little bit.

Respondent: Yes, and it did- But, again, it would never come under our realm. So, even if that was something that I- I don’t know if that woman decided to do that, if she did go on to do that somewhere else, then she may well have done, for various different reasons. Or simply because she wasn't happy to continue with the pregnancy the way it was.

Interviewer: Who is to know? Only that lady knows.

Respondent: Yes, exactly, only the lady will know that. And I just know that it wasn't something that was medically indicated, so I’m pretty sure it didn’t take place here.

Interviewer: Do you know of anybody who has objected, like a colleague who has objected or refused to participate in an abortion?

Respondent: Not particularly, but, again, I’m sure it has happened. And the thing is about it, in any area or any place of work, that person shouldn’t have to stand up, unless they really want to, and say, “I’m not doing that because…” That person should be able to go to somebody, to say, “I don’t want to do that, I know my views may be different from other people’s.” They should just be supported in that.

Interviewer: So, it sounds like you're quite open to the idea of objectors maybe working within the service, but it just needs a bit of open conversation and- You know, both sides to be trustworthy.

Respondent: I don’t think it’s the perfect service to work in, if that’s your viewpoint, but- Because you are going to come across things that will challenge you and possibly, maybe, probably not on a daily basis, but you are going to come across that. If you work up on the gynae ward as a nurse, you will come across that, because there are people on the ward who are having a termination, who are having an abortion, possibly for social reasons. Obviously, we would see the medical ones.

So, you will come across that and you will see that. But, if you're prepared to work in that setting without feeling that you can be supported in that decision, then that’s okay. But it’s probably not the greatest setting to work in. But, then, that midwife, for example, or nurse will hopefully just plough herself into something else – “I’m not going to do that, but I will take the induction suite and I will look after those women.”

So, that’s not to say that, because she objects to one thing, she isn't an absolute amazing midwife and she isn't a great colleague to be with, just because they have a different view.

Interviewer: It sounds like you feel that, if somebody was an objector, they’ve still got a lot of value to add.

Respondent: Oh, absolutely. I would imagine- We all bring our own things. So, an objection to something shouldn’t be a reason- And I think other colleagues should never ever be in a position to say, “Well, I’m not going to work with her because she won't answer that buzzer if that goes off, and that’s really unfair, we’ll get all those cases.” I would just think, ideally, that isn't how we should be as people, let alone colleagues. So, I just think I’m probably different to a lot of people.

Interviewer: (Laughter) No, it’s just who you are.

Respondent: I’m really open-minded and will respect people’s opinions.

Interviewer: Well, we should, shouldn’t we, really?

Respondent: I don’t have to like them, but I can really possibly think, “Hmmhmm, well I wouldn’t do that,” but I would never voice that, I would just think, “Well, that is their choice.” Because, actually, they might not like a decision I’m about to make, but it’s my choice.

Interviewer: So, sort of on the same area, but thinking of abortion as maybe a process, so from the referral to the booking in, potentially taking phone calls, potentially administering medication, do you think there is any part of the process that a midwife should be able to refrain from, if they were an objector? Or even if they're not an objector, for that matter.

Respondent: Me, personally, I just think, for example, we would have women that would go to the foetal centre because we deem that there’s a problem. It’s been picked up at scan that something doesn’t quite look right. Or women may go through genetics because there’s a risk of a genetic problem for the baby.

Midwives will counsel those women in foetal centre. And I kind of feel like midwives can be best-placed to do that. Because, ultimately, they are pregnant, they would expect to see a midwife, we are not going to put them in a room with somebody else.

Because, actually, they may say, “Yes, I’m aware of that, and I know what that- You’ve said there’s a heart problem, I’m going to continue and just see what happens. I am well aware that, actually, the baby could die in-utero.” Because they're counselled really well – “I’m well aware that the baby will probably need life-saving surgery at delivery, I’m well aware of that.”

Then they are- As a pregnant patient, I have responsibility. I couldn’t say, “Well, I’m not going to prove you any care.” So, I think midwives are best-placed while they're making that decision. When they’ve made that decision, depending on the gestation would be where they would go, to make that. I just feel like I don’t think midwives shouldn’t do it, unless they don’t want to, unless they actually do object and just don’t want to be involved in it. But I just think-

Interviewer: It sounds like almost- This is me, I could be wrong, so please correct me, if I’m wrong. But would you say that, if you were a conscientious objector- You know earlier on, you said if you are a conscientious objector, you have to kind of think about the job that you're doing.

Do you think, related to that, they would have to almost cherry-pick the areas that they would fit in with, where they wouldn’t have any sort of contact with anybody, even potentially, that would go on to maybe have an abortion?

Respondent: I think you could choose areas that you're unlikely to see that. Obviously, antenatal, post-natal wards, you wouldn’t be in a position where you would be asked to do something you disagree with. So, yes, you could technically cherry-pick. But that’s not required. It should be okay to say, “I just don’t want to do that, I’m just not going to go in and do that.” It should be fine, they should be supported in that decision.

As I say, I just think maternity and gynae are hard areas to be in, if you don’t- If you conscientiously object. But the area is so vast and busy and there are so many other things to do, that actually it shouldn’t make a difference.

And, yes, I suppose if you did conscientiously object, you may not want to work in foetal centre, because you are going to come across women who are given the information as to a prognosis – “What would you like to do? There is an option of termination, if that’s what you want. We will support your decision, no matter what.”

So, yes, midwives there will be seeing that often, because they're only getting sent there because there’s a potential risk factor. So, yes, I suppose a conscientious objector would not want to be in that area and would be well within their rights to say, “Well, that’s not for me.”

But then the foetal centre does so many other things. They do a pre-term clinic, they do lots of other things. So, in actual fact, it’s still an area you could work in, it would just be way more difficult than anywhere else. But it’s still feasible, I think it just depends on support and other people’s awareness of other people’s views, basically.

So, it’s hard, but it’s manageable. Because maternity is so vast, that- Potentially then come out on the community, and you will only- You will potentially then be in a position where I have been, in that mums come to you because it’s the first port of call, because they’ve been directed in that position. But that is few and far between, that doesn’t happen very often.

Interviewer: It sounds like it is almost an unavoidable-

Respondent: Yes.

Interviewer: And maybe, as a conscientious objector, there would need to be maybe some processes in place, to manage that. Does that make sense?

Respondent: I just think, if you're a conscientious objector, you should be well within your rights to say, “I don’t want to do that, but I am absolutely happy to do everything else.” And I would feel, personally, as a health professional, a conscientious objector may object to actually physically providing care at the time of an abortion, but I would find it a bit more difficult to think that they wouldn’t provide any post-natal care.

Interviewer: Oh, right, okay.

Respondent: I would find it difficult that they would say, “I’m not going to go into that person,” afterwards. I mean, they could and, if they did, that’s their choice, but I just feel like… I don’t know. Maybe I would find that a bit more of an issue, to think, “Well, I don’t feel that that is fair.” But, again, I wouldn’t- If somebody said, “I really don’t want to, and I feel strongly about it,” I would respect that decision.

I don’t necessarily- I would say I don’t probably agree with that part of it, but it’s fine. It is what it is and, if that’s their decision, then they should be supported. But, as I say, maternity is so vast, that there is always somewhere-

Interviewer: Someone can do something somewhere. (Laughter)

Respondent: Yes, that a pair of hands would be needed, so it shouldn’t be an issue. And I probably don’t think it’s relevant to ask the question. But then you could argue, if you were a conscientious objector, that you are then put in a position where you have to acknowledge that to be the case.

Interviewer: Yes, it’s like you're putting your head above the parapet.

Respondent: And do you separate yourself from other people then? “Well, they're prepared to go and do that, but I’m really not, and I have to say I’m not.” So, I don’t know. From their viewpoint, if you- And it will be interesting to see the research, to see if they actually come from the standpoint, “I would have liked somebody to ask. I think it’s important that people know.”

But, realistically, in the day-to-day, when you look at an off-duty, are you going to write ‘conscientious objector’? Who knows? Who has the right to that information. And I think, to protect a conscientious objector, they are probably best to have to put their head above the parapet.

And you don’t have to say, “I’m not doing that,” in handover, but you could, even if you get handed it, go and speak to the shift leader quietly, to say, “I don’t agree with it and I don’t want to do that, can we swap, I will take somebody else’s caseload?”

I just think that is probably the only way it could be managed. But, as I say, it would be interesting to see if a conscientious objector would like to be asked the question.

Interviewer: Yes. Because it would take a lot, really, to say, really, wouldn’t it?

Respondent: I don’t know. It would be interesting.

Interviewer: (Laughter) I think I’ve almost covered everything, if I haven't already. You’ve been brilliant, thank you very much. Sorry, I’m just quickly going over-

Respondent: Yes, go on, no worries.

Interviewer: Do you know if there is potentially a referral system in place or a procedure, that needs to be followed if somebody, or you, were an objector? Are there any procedures for the hospital?

Respondent: As far as I’m aware, no. I don’t know. It’s never come up in conversation, I’ve never asked that question. There could be, but I don’t know.

Interviewer: Because the act or the law is quite woolly, it just says along the lines of people have the right to conscientiously object, unless a woman’s life is in danger. So, if that clause was scrapped, what do you think should replace it, if anything?

Respondent: I’m not sure it would ever be scrapped.

Interviewer: What makes you say that?

Respondent: I just think that you have to give people the right to choose what they want. And, if they are a conscientious objector, whether you agree with that decision or not, I don’t think you could ever stop somebody from not doing what they felt was the right thing to do.

Obviously, I know it does say if somebody’s life is in danger, and I would very much hate to think that there was a conscientious objector out there within a healthcare setting that wouldn’t provide emergency care to someone, because we just wouldn’t and definitely shouldn’t.

I don’t think- I personally just don’t think it can be scrapped, because you're not- Then you're kind of withdrawing somebody’s rights away from them. They have a right to that decision, for whatever reason-

Interviewer: It sounds like you're saying the patients and the healthcare professional both have rights.

Respondent: They do, yes. Obviously, it’s very obvious where my- I understand-

Interviewer: Yes, you're very patient-focused.

Respondent: Yes.

Interviewer: And it sounds like the patients come first and, even if you're uncomfortable with something, you maybe separate the professional and the personal.

Respondent: I wouldn’t be uncomfortable with this particular issue but there may be times when I am, and I feel like I am justified then to say, “I’m not happy.” Like I’ve refused to look after a- Not look after a patient, but I’ve refused to be around a patient’s partner who was abusive. So, we have to have- We have to be able to say, “I don’t feel comfortable and I’m not going to do that.” And I’m not going to put myself in that position. So, for that reason, I probably think it wouldn’t be scrapped, but who knows?

Interviewer: You’ve covered everything, thank you so much. Is there anything you want to ask me?

Respondent: Yes. When you’ve analysed it and it gets published and everything, I would really like to receive a copy, because I think it’s really interesting. And, as I said before, I would think that there are probably way more conscientious objectors out there that just don’t talk about it. So, we’ll see.

Interviewer: That’s brilliant. Thank you so much. Thank you so much.

END AUDIO

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