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START AUDIO

Interviewer: Okay, so they are both going. So, to begin with, can you tell me a bit about your role as a doctor with regard to advising women around abortion?

Deborah: So, I’m currently [job role], and I’ve been working in obstetrics and gynaecology for nine years. So, I currently work at the [name of hospital]… the [name of hospital] part time and work at the university part time.

So my role, actually, is I lead a lot of care on labour wards and the abortions… or the women seeking termination of pregnancy, I would meet our patient who are having late terminations of pregnancy, from usually either 18 weeks onwards, so from about 18 weeks to 24 weeks, and we’ve had babies here, actually more than that, 29, 30 weeks. So, a lot of the cases that I’m dealing with are actually foeticides and babies that have undergone foeticide, for sometimes congenital abnormality or Down’s Syndrome, or any other indication for foeticide and, or… and then…

So, greater than 20 weeks there needs to be a foeticide, and then the doctors on the labour ward are asked to prescribe the medication to induce the abortion, and then before 20 weeks there isn’t a need for foeticide, doctors are simply asked the prescribe the medication. So, that’s kind of the contact that I would have day to day with patients who are seeking termination of the pregnancy. Within the [name of hospital], there is a separate unit that is run by a separate team for… which is called the [name of abortion clinic / unit], that is for women who seek care for terminations of pregnancy.

And most of the time the signatures are all done by the doctors and midwives who… the doctors who work there. Sometimes they will come down and try and find the doctor in the gynae department, to ask them to sign ad hoc. So, that would the contact that I would have with patients seeking termination of pregnancy.

Interviewer: And what is your feeling about that?

Deborah: My role for… in that care?

Interviewer: Yes, providing abortion care.

Deborah: So, interestingly, I previously… if I go right back to when I was a student in Scotland, I wanted to do obstetrics and gynaecology but I actually was put off by the fact of the… that, as a trainee, that I would have to be involved in termination of pregnancy, and that was actually something I was really concerned about.

And I didn’t apply for training in obstetrics and gynaecology specifically because of that, and actually went back to [country of birth] and did my training in [country of birth], and the reason I did that is because I didn’t want to be… I had a conscience… I do have a conscientious objection to being involved in providing abortion care due to moral grounds or personal reasons.

Interviewer: Yes, yes. Would you be happy to tell me a little bit more about those personal reasons?

Deborah: Yes.

Interviewer: Or moral reasons?

Deborah: Yes, so I would say that I am a Christian, that I’m from a Christian background. I believe in the sanctity of life, and I believe that babies are… conception begins at… or life begins at conception. So, I’ve kind of spent my career trying to protect babies and increase care for women and actually I work at the [place of work], I do here, my research is all about improving care for women who are pregnant in low resource settings, to try and improve the care that they receive, to try and improve life.

So, that was my motivation to come into this speciality. So, I suppose it’s from my own personal and faith-based reasons that I would prefer not to be involved in termination of pregnancy.

Interviewer: Yes, so if you don’t mind me asking, how does that work for you because, obviously, you have your conscientious objection, but then you work in an area that does provide abortions? So, are you happy to sign the forms, for example, or are you happy to, you know, deliver the foetuses?

Deborah: Yes, so I’m not… I have been asked on occasion to sign the forms and I’ve actually requested that they would ask another healthcare provider. I’ve explained that I’m sorry but I’m not comfortable to sign that form, and within the hospital there is an understanding with the doctors and the consultants, that if someone is not comfortable to sign the form, then you don’t have to sign the form.

But there is pressure put upon doctors who… there’s definitely a lot of peer pressure, personal pressure, there are… people say that you’ll never get a job in this speciality if you don’t provide this care for women. So much so that the Royal College president… the outgoing president for the College of Obstetricians has phrased it… refusal, a healthcare provider refusal… that healthcare providers are refusing to provide care, which I totally disagree with and I think it’s…

It puts a lot of junior doctors… it definitely would have put me off training in a speciality whenever I was a junior doctors, and whenever you’re choosing your speciality, whatever you want to work in, if I had known that there was… that I was going to be forced to provide care for something that I had personal reasons, I would prefer not to be involved with, then I would have been… I wouldn’t have chosen this speciality at all.

But I love caring for… my passion is all about improving care for women who are pregnant and giving them the best experience possible and trying to make sure that their babies and mums are well. But I don’t… so, with regards to the form, I have never signed one of the forms, and then whenever I’m on call in a labour ward then I’ve often been asked to sign the medication to induce the abortion.

So, again, I’ve said that I would prefer not to sign, I would prefer not to prescribe the medication, and there are often maybe four or five doctors on call in the ward, so there are other doctors that are available. But I am sometimes concerned that I may… my refusal may put other people not under pressure, but I do find it difficult every time I’m asked to have to justify myself and there are undertones, I [believe 00:06:18] that there are undertones from other healthcare providers as to… they kind of roll their eyes and they’re like, “Why can you not prescribe this medication, it’s straightforward,” but I have personal reasons that I would prefer not to.

Interviewer: And you’ve expressed them haven’t you, yes.

Deborah: Yes. So, I’ve actually… I’m not 100% sure what the legal stance is, actually, with conscientious objection, I just know from working in the departments in different hospitals, I’ve worked in about eight different hospitals over the years and… sorry, I trained in [name of UK city], so whenever I was training…

Interviewer: \_\_\_[00:06:47]?

Deborah: Yes. Whenever I was training in [name of UK city], abortion wasn’t available, so I wasn’t… I didn’t need to be involved in… I wasn’t involved. But whenever I moved to [name of city in UK] to do my PhD, then I started to work part time at the [name of hospital] and that when I was exposed to it a lot more regularly.

Interviewer: Yes, so you mentioned a few different things. So, you mentioned that you do worry about your other colleagues, can you tell me what you’re worried… it sounds to me that you’re worried that the impact that you have on your colleagues of saying no to signing them, it sounds like you might be worried that it may affect them in some way, and I was just interested in how you…

Deborah: I would rephrase that, actually that, I probably just feel that then they judge me.

Interviewer: Oh right, oh, that’s not fair. Yes, that’s not fair. I see. I see. Has anybody ever discussed conscientious objection with you?

Deborah: I have some friends who have similar backgrounds, or similar faith-based understandings, so I know that other doctors have asked… I don’t think it’s called refusal, but they’ve asked to be…, “I would prefer not to prescribe this medication, would you mind asking the other doctor who is here to prescribe the medication?” So, I don’t think it has a massive impact on the other colleagues, I just feel that they are bothered a little bit, they’re like, “Why doesn’t she do it? Oh, right.” And then I feel a little bit judged, actually.

Interviewer: Can you think of a way that, maybe… because we are thinking about how conscientious objection can be accommodated, I suppose. Can you think of a way… it sounds like, that that… like you say, it’s not nice, you’re caught kind of justifying your position every time you’re asked to do something, but you’ve been clear from the start that you’re not comfortable to do that and it sounds like there’s an understanding between your colleagues, but it sounds like it comes with a bit of judgement. And I’m just wondering if you can think of a way that maybe conscientious objection could be accommodated so that that didn’t happen for you and for other colleagues?

Deborah: So, I appreciate different people have different views and backgrounds and understandings and personal views. So, I think the way it works with the [name of abortion clinic] where it’s kind of a separate team, but it’s a team who are passionate about providing care for women who are seeking termination of pregnancy and they are comfortable with that care and they’re happy to provide that care.

So, the patients… my thoughts would be, actually, whoever organises the patients to come onto a labour ward, and it’s usually a specialist, the foetal medicine specialist, usually, the person who is going to screen or… it’s usually after a patient has been diagnosed with an anomaly. The patient has already seen the specialist beforehand, so I wouldn’t have any qualms about them prescribing the medication that, then, the patient will receive when she comes to the ward.

There are arguments that the midwives could prescribe, like you could have a designated midwife who specialises in termination of pregnancy care for babies who are after 18 weeks, because they are the babies that need to be born on a labour ward, and less than 18 weeks I think… different units will have different cut offs, but less than 18 weeks then the patients don’t need to come to the delivery suite there, they can go to the [name of abortion clinic].

So, my thoughts would be to have a designated healthcare provider who is comfortable with that care and specialises in that care and is able prescribe the medication. So, I have absolutely no qualms of looking after patients once the process starts, I’m very comfortable with that and I’ve dealt with that, I just have a conscientious objection to starting the process.

Interviewer: Yes, just so I can understand, you say that you’re happy to care for the women, it sounds to me that your limitations is to participation in abortion, which is what we’re quite interested in as well. It sounds like your limitation is you don’t want to be involved in the active processes, so would I be right in saying prescribing and administering the medication?

Deborah: Yes.

Interviewer: Can you tell me what your limitations would be, then… or, sorry, maybe rephrase that. Sounds like that’s your limitation but you’re happy to provide care afterwards. So, how would you see the abortion process? Would you see it as elements of leading up to the abortion or would you see it as just the hands-on activities?

Deborah: I suppose it’s all about the decision-making, yes, in my eyes it would be who is making the decision. I suppose the big thing is around consent and counselling. So, for me, that’s covered that all that I don’t want ethically and for personal reasons, I don’t want to be that person, I don’t want my name on that form. I don’t want to be responsible for starting the process and the same with prescribing the medication.

I don’t want to be that person who is responsible for inducing the abortion. But once that process has started then it’s inevitable that the process is going to continue, so I’m very happy to provide the care for a woman and I’m totally non-judgemental in my approach to the women I care for, and totally empathetic and I’m happy to… I’ve delivered the baby and often what happens in these cases is the placenta doesn’t come away afterwards, so patients sometimes bleed a lot and sometimes they need to go to theatre, so I’ve dealt with a lot of those cases.

And in all of those cases I’m totally non-judgemental and empathetic to… I appreciate what the woman is going through is totally traumatic for her, for her partner or for her family and extended family. I appreciate it is a traumatic experience and I still want to provide the woman… I want to give the woman the best care I can, but I do have limitations to starting the termination of pregnancy pathway and for consent. But I’m comfortable to do post-mortem consent afterwards and I don’t provide debriefs for women, that’s not my role necessarily, they all see the specialist that they’ve seen before.

Interviewer: So, you sound very patient-focussed, your focus is on the patient, it’s just that you want to invoke your right to conscientiously object, as is absolutely your right. So, you perceive any impact that your refusal may have on any colleagues at all, in terms of refusal to participate in the, you know, the administration of medicines and whatnot?

Deborah: I suppose it probably, for some… midwives have definitely rolled their eyes at me whenever I’ve said no, and they’re kind of like, “Oh, for flip’s sake,” because then there’s a bit… there may be a slight delay before they can… another doctor is free to prescribe the medication.

And I suppose my refusal, or my preference not to prescribe the medication, it may… I think sometimes in life things just become so routine that it may actually catch them off guard, or it may force them… I don’t want them to question what they’re up to or what they’re doing, or whatever they’re doing, but they may be… it may cause them to think.

I don’t know. But I kind of think, sometimes they’re like, “Oh, you’re from [name of country of birth],” so there’s a little bit of stereotyping that goes on, “Oh, you’re from [name of country of birth], you’re obviously… you must be from a Catholic background,” which isn’t necessarily true and so they kind of… that’s… I feel like that’s a bit of a get out clause, actually.

Interviewer: Yes, that’s a huge assumption to make of someone, isn’t it, as well?

Deborah: But it definitely happens.

Interviewer: Yes, yes, yes. Do you perceive any impact on the patient at all that may occur as your preference not to… sorry, your preference to conscientiously object?

Deborah: To date I don’t think there has been a negative impact on the patient. This conversation usually happens outside the room, so the conversation doesn’t happen with the patient, the conversation happens with the midwife who is looking after the patient.

Interviewer: The patient is oblivious, then.

Deborah: The patient is totally oblivious, yes. There may be a delay for ten minutes, fifteen minutes… there’s no… that won’t impact necessarily on the whole process.

Interviewer: And I suppose, as a patient, you would never know how long this type of thing, you know, you’d never question the fact that someone takes ten minutes, or five minutes, or twenty minutes, would you?

Deborah: And then… midwives would never, I don’t think any other healthcare provider would ever say, “Oh, the doctor doesn’t want to prescribe this medication,” I’ve never heard of that, or I’ve never… I think we’ve got enough mutual respect for each other that we would expect, hopefully, respect each other’s views. But I think that’s changing and that’s what I’m worried about actually and as a consultant I worry that I’ll be… I am worried that both myself and junior doctors will be forced to sign… to start the process when we’re not comfortable with it.

Interviewer: Are there some noises going on that indicate that that might the case?

Deborah: Yes, so, as I mentioned, the outgoing president of the Royal College of Obstetricians and Gynaecologists was a female for the first time in 80 years, so she really took it… it was her agenda to… my thoughts were, to stamp out conscientious objection, and she was very successful in bringing abortion… she was the lead to bring abortion into Northern Ireland.

So, that was on her agenda for three years, and that was what she wanted to see. So, she is an inspirational woman, but I was concerned and I heard that she wanted it to be termed as healthcare refusal and then for… to take the clause out of the curriculum, so in Northern Ireland there is… because the care is not… it has changed now, actually, but because you do have… there is part of the curriculum that you don’t need to be signed off to become a consultant, but that may change.

Interviewer: Oh, gosh. Do you feel listened to as someone…?

Deborah: Absolutely not, no. I feel… no. I feel totally judged by peers and I think the agenda has moved on abortion has become so commonplace now that it’s not even on the agenda to question it or to, kind of, express your views if they’re different to mainstream views.

Interviewer: What impact does that have on you? You know, I’ve spoken about the impact that it has on patients and other colleagues and it seems like, actually, that’s quite well managed, but I’m interested to know what impact that must have on you?

Deborah: So, I suppose I’m quite confident, I’ve thought this through and processed this as a junior doctor and because, maybe, I was protected from it in [name of UK city], I didn’t have to engage, I didn’t have to have that… I was kind of protected, so I kind of… and then I came to [name of city in England] as a senior doctor, so I had the confidence to speak to the midwife and say, “Actually, I prefer not to.”

But every time I do that, I feel under pressure, so… and I think it… as I mentioned before, the midwives sometimes roll their eyes and it seems like a bit of a nuisance, and different views to the mainstream. But if I was a junior doctor and was asked to prescribe the medication then I think I would have felt a lot more pressure to… I wouldn’t have had the confidence to speak up for my own personal views.

Interviewer: I suppose with the experience that you’ve gained and then, obviously, you’ve served your time, for want of a better expression, that gives you confidence in any job role, doesn’t it? So, I can see how, maybe, a junior doctor coming into it would feel pressured.

Deborah: But I am… Yes, I am, \_\_\_[00:18:00] applying for consultancy posts and I’m anxious that if they were to ask me at interview, for example, “What are your views about conscientious objection?” then I would… I think it would be… consultants don’t want to work… my kind of thoughts would be that it would be very negative, if I expressed my views on conscientious objection.

Interviewer: So, do you think it would have a negative impact on your career trajectory?

Deborah: Definitely, yes, definitely.

Interviewer: Have you ever been asked if you are a conscientious objector?

Deborah: Not outright.

Interviewer: Have you not? What are your thoughts on that?

Deborah: I think actually that’s a good point that, perhaps, at the start of placements, that there should be… so all doctors have educational supervisors, and we have competencies and we have training and appraisals as we go along, so I think there should be, there could be a recommendation that all junior doctors, at the start of their training, or at some stage, it’s a tick box on their portfolio, and they say, “Would you like to express any concerns about this care? Would you like to…?” and then tick that box and then it’s kind of like…

Interviewer: Dealt with.

Deborah: It just is highlighted to their supervisor that they would prefer not to be involved in that care, and therefore their supervisor should be in a position to support them through that.

Interviewer: Yes, I mean, obviously, like I said earlier my background is psychology, so I haven’t got all the medical knowledge that you have, but in your training, are there any other areas of patient care which you have the option to opt out of and it’s not so much questioned?

Deborah: I don’t think so, actually. Probably… I definitely think euthanasia will come in.

Interviewer: Yes, I suppose that’s quite similar isn’t it? It’s that life argument. It does make a difference to [maybe 00:19:54] other areas.

Deborah: It’s kind of like the other end of the spectrum, but I personally haven’t been involved in that type of thing. So, I can’t actually think of… I can’t think of any other medical care…

Interviewer: Yes, scenario.

Deborah: Apart from euthanasia which I don’t think is… it’s not legal at the minute.

Interviewer: No, no, not here. No. Definitely not. I’ve asked that. So, maybe if I refer back, I don’t know whether you’re familiar with the case of the two midwives up in Glasgow in 2014, and they were very senior midwives and, to cut a very long story short, they invoked the right to conscientiously object.

So, they were working on a delivery ward and they were practicing Catholics, so I suppose there was that religious element there, not that you should, like you say, should assume, but they invoked the right to conscientiously object, and they created a list of 13 items that they felt they conscientiously objected to. And it was things like providing information to patients, taking phone calls, answering the emergency buzzer, providing support to colleagues who may be, you know, more junior midwives who may be supporting the woman through the abortion.

I think… I believe they initially won, but then they were taken to the Supreme Court, and then they lost in the Supreme Court because the judge ruled that when the Abortion Act was envisaged abortion was taken to be just the hands-on activities, not the peripheral roles. I’m just interested to know what your thoughts on that might be, would you agree with the midwives that those peripheral roles contribute to the process of abortion or would you feel that it was more the judge’s… or agree with the judge’s \_\_\_[00:21:42]?

Deborah: I suppose it’s a good question, something I haven’t reflected upon, necessarily, but in my… my kind of thoughts would be, I’m very happy to provide care for women, that’s my duty of care to the woman, but I’m not happy to... I’m happy to give information, but I make sure that’s in a non-biased… so, I’m conscious, I am conscious when I meet a patient who is undergoing the pathway of termination of pregnancy, that I don’t be judgemental because that’s not… I don’t want that to come across to the patient at all.

But I still… I think it’s more, for me it’s more about the consent process and about actually inducing the abortion, so starting the process or doing the operation. But I’m happy to provide the care afterwards and so in an emergency \_\_\_[00:22:29] taking phone calls for whatever, the communication that’s around patient care pathway, but it’s just, for me, I just don’t want my name attributed to… I don’t want to be the responsible healthcare… the healthcare provider responsible for starting the abortion.

Interviewer: Yes, that makes sense, I can see that. I’ve lost… you said something, and I’ve just completely lost my train of thought. Oh, yes, that was it. So, you mentioned there that you remain completely non-judgemental, you’re neutral, it almost seems that when you’re presented with a woman in that situation, you see your role… you still meet your duty of care because the patient’s right seem to be coming first in the sense that you give them all the information. Would you see referring that woman onto a different healthcare professional, would you see that referral as participation in abortion?

Deborah: No. So, I appreciate… no. You have to live, you have to work, you know, a legal… I have a duty of care as a doctor for good medical practice and I have to work within the limitations, the legal framework that I live… the current legal framework, so I’ve absolutely got no qualms about referring patients to other doctors to access care. I’ve never… that’s why I mentioned about the GPs, because I’ve never been in a position where I’m the first person…

I’m not the first person the patient meets, I think that’s probably quite a pivotal thing, because that will have an impact on the patient’s experience of how they’re treated or the attitude or how they feel, the first time they meet someone. And then the GP, usually… I think… my thoughts would be that a patient undergoing termination of pregnancy has seen a lot of healthcare providers by the time they meet me on the labour ward. So…

Interviewer: It’s almost like you’re saying that they will have gone through such a process of decision making already that the decision is made. It’s almost, you know…

Deborah: Inevitable.

Interviewer: Yes, I’m just thinking terminal, I’m thinking that was a terrible expression, but inevitable that that’s going to happen, no matter what. I see. Whose rights do you think come first, the patient’s or the healthcare professional’s?

Deborah: The patient’s. As a healthcare provider our duty of care is to the patient.

Interviewer: Yes, it must present a conflict of interest, though, and I’m just interested to know how you, sort of, manage that, I suppose.

Deborah: So, I suppose, to date, how I have managed is that there have been other healthcare providers who are willing to do the… to provide and prescribe the care, no problem. I just feel that I, as a conscientious objector, I do feel that I am discriminated against, but in subtle undertones, no one has ever challenged me face to face.

Interviewer: That almost makes it a little bit worse, then, doesn’t it? Because it’s, I don’t know, just to take a different scenario, it’s almost like an academic mobbing situation where it’s very discreet and almost, if you challenge it, people challenge you back, going, “What do you mean?” Must be very difficult.

Deborah: Yes. But I do… there is maybe, it’s a \_\_\_[00:25:47], especially in England, Scotland and Wales, it’s different in Ireland and I’m not sure what’s going on in Northern Ireland at the minute. And I don’t know whether there are people… there are more people who will conscientiously object in Northern Ireland because the law has just changed. Whereas I think in England, Scotland and Wales abortion and termination of pregnancy have been part of routine care for quite a long time, that for anyone to conscientiously object is almost seen as a total anomaly.

Interviewer: Yes, yes. Do you feel alone as a conscientious objector?

Deborah: Yes. I’ve got one… I suppose it’s not really something that, it’s like miscarriage, it’s not something that people are very comfortable talking about.

Interviewer: Yes, do you think there’s any shame around it? Around conscientious objection and around abortion?

Deborah: Oh, definitely, yes. Yes. And I feel totally judged if I were to express that because it’s against the mainstream view at present.

Interviewer: Yes, that must be a challenge. So, as I said earlier, the clause is quite woolly, for want of a better expression. If the clause was to be scrapped as it exists at the moment, what do you think should replace it, if anything? So around conscientious objection?

Deborah: I think the way the health system is set up at the minute, that there is enough scope within the healthcare system to protect healthcare providers who are not comfortable to be involved in termination of pregnancy and there are enough systems in place that designated teams can look after patients who are willing to provide the care. So, I do personally think that there should be an ability for conscientious… for healthcare providers to conscientiously object to termination of pregnancy, and it should be a lot more clear.

Interviewer: Do you think it’s possible for up and coming junior doctors and doctors, as it is, and I suppose midwives and nurses, do you thinking it’s possible for conscientious objectors to work in abortion care?

Deborah: No, that wouldn’t… it doesn’t make sense for a conscientious objector to work in abortion care, but I suppose it’s just these kind of small number of cases that come to the labour ward which isn’t… so, as I mentioned, at most hospitals, they have a designated termination of pregnancy unit, or abortion unit or [name of abortion clinic], for example here, and it’s only the, kind of, more… it’s towards the… the late termination of pregnancies, beyond 18 weeks that are the more difficult ones. But the labour ward isn’t an abortion unit, necessarily, it’s just they pick up a few of the more complicated cases.

Interviewer: So, your bread and butter is delivery of babies and then obviously you will have incidents. Do you think it’s possible to work in that scenario as a conscientious objector?

Deborah: I think it is, yes.

Interviewer: Do you think there would be any impact on career development within that role, working as a conscientious objector?

Deborah: Well it’s all about communication and communication with your colleagues, communication with the people… other people who… the midwives, other healthcare providers, I think as long as it’s clear, as long as the healthcare provider has access to other people who can prescribe the medication, then I don’t think that’s going to impact patient care.

Interviewer: What impact on wellbeing, because we mentioned there about career processes, but wellbeing and anything else, actually, that you can think about, do you think working in an environment where conscientious objection is judged, what impact do you think that has one objectors?

Deborah: I think it’s tough, actually. Working in obstetrics and gynaecology is a difficult speciality, on reflection, because you are literally dealing with life and death every day. And I have heard of a few junior doctors who have decided to leave the specialty because they look ahead and they look at the registrars and they look how many hours they work, and they look at how stressed they are and they’re like, “Life is too short to deal with this.”

Because a lot of the… even the obstetric care, which is the delivery of babies, whenever things go wrong, it’s often, even though healthcare providers do their utmost to stop adverse outcomes, there are still cases where babies don’t survive or babies are damaged through the process of childbirth. And most of the time there is no negligence, it’s unfortunately part of the process, despite everyone’s best care.

So, there are a lot of cases where most doctors in my position will be involved in some serious adverse incidents, cases where the baby has died and you’ve been referred to the coroner’s case, and patients… or cases where junior doctors have to go to court and give evidence, where babies have died.

So, it can be a really stressful environment and so, the thing that I can see, as a junior doctor looking ahead at specialties, if you’re looking ahead and see, “Oh, if I was a conscientious objector…” it would look too difficult to get involved and I think probably that has put a lot of junior doctors off, and I know that some doctors have decided that it’s too hard and they’ve opted out and gone to GP.

Interviewer: Yes, oh that’s a shame because we need you, \_\_\_[00:31:05].

Deborah: But it’s a serious thing, burnout amongst doctors in different hospital specialities, and it results in defensive practice.

Interviewer: Yes, which is difficult. Going forward, how would you like conscientious objection to be dealt with, for want of a better expression? Going forward, what would be your preference with regards to it?

Deborah: So, I suppose it would be nice to have some legal statement, personally I would like the legal statement to be that healthcare providers to have a legal right to opt out to provide specific care around termination of pregnancy and that that should be respected. And then, for junior… it’s a bit deal for junior doctors, that junior doctors are able to express that view and it doesn’t have to be challenged every time that they want to express that.

Interviewer: Yes. I’ve asked everything really, that I needed to ask. I can’t think of anything else, while I have a little scoot through these is there anything else that you want to add, or you think that I might have missed?

Deborah: No, I’m okay with that.

Interviewer: Well thank you so much for your time.

Deborah: No worries.

END AUDIO

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