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START AUDIO

Interviewer: Okay, I have two because I’ve had one fail before.

Respondent: Okay, that’s fine.

 Interviewer: So, to begin with, can you tell me a little bit about your role, what it involves and what your job title is please?

Respondent: Okay. So, you don’t want my name on this, do you?

Interviewer: No, it’ll be anonymised anyway. Even if you do give names, we’ll anonymise them.

Respondent: Okay. So, I’m a [job role / title] here at [name of hospital] Hospital. So, in theory, my job is 50% clinical and 50% research. In truth, my 50% clinical has recently dropped right down to about 10% clinical because I’ve taken a year to increasing that research that I’m doing, but I’m restarting clinical activities in April.

 So, my social background is that I was brought up in [name of country] and I lived in [name of country] until I was 15.

Interviewer: Oh, amazing.

Respondent: Then went to boarding school, and then went to medical school in the UK and came up through medical school, training in [name of city in the UK] and [name of city in the UK], and then went out to [name of country] for a couple of years to do obs and gynae. Then came back to [name of city in UK] as a lecturer, then senior lecturer, then professor.

 So, I changed over to obs and gynae in 1993, because I started off in general practice actually when I first finished medical school, and right from the very start… so, just to finish off my social background is, I guess, that my father works for the church as a Methodist minister. So, I’ve always had an interest in religion, ethics, psychology, philosophy sort of elements, but also, straight after I finished medical school, I took a year out to do a diploma in political theology in the urban theology unit in [name of city], which was a little bit different. I did locums to pay for myself.

 So, I’ve always had quite an interest in religion. I’ve been a member of a religious community – I still am – since ’87, but it’s a, sort of, dispersed community, and in truth, we meet twice a year and have some social other contact in between that. I’m not a regular churchgoer. So, you can tell, I’ve got some interest in it, but I’m not part of the establishment of the church.

 So, in terms of termination, my first exposure to it was when I first changed over from general practice to obs and gynae. In the [name of hospital], there was a group. They were doing terminations for the very first time really, using a drug called misoprostol. I mean, this is ’93. So, really, it had only been patented in ’87.

Interviewer: Oh, so that’s really quick.

Respondent: It was right at the beginning, and there was a very innovative doctor called [name of doctor] in [name of UK city], and who performed terminations medically on the ward. I guess I was just part of that ward and I was interested in it, and in fact, my first ever publications were two publications on the outcomes using misoprostol for termination in the first and second trimester. So, that then got me interested in misoprostol, and then the potential for use of misoprostol for postpartum haemorrhage in low-resource settings.

So, my interest in global health and going back to my childhood in [name of country] meant that, actually, misoprostol has really been a big part of my research life, and when I went to [name of country], nobody really knew how to use misoprostol. It was available over the counter, but people were using the very high doses that you use in abortion. They were using them to induce labour, and you’ll remember that… well, maybe you don’t know, but you use about four whole tablets in early pregnancy to cause an abortion. In late pregnancy, you use an eighth of a single tablet.

Interviewer: Oh, God. So, a significant difference. A different dosage, yes.

Respondent: There’s a huge difference. There’s a big dosage gradient. So, the further you go through pregnancy, the less you need. The uterus becomes very sensitive to it through pregnancy, and if you overdose in late pregnancy, the uterus contracts far too strongly and you can get stillbirth or, indeed, ruptured uteruses associated with it.

 So, there was a big problem with people knowing the correct dose, and so when I went to [name of country]… in fact I wrote the [name of country] guidelines on misoprostol doses, and we realised that actually, no other country had really done this. WHO hadn’t done this, because misoprostol, you may or may not know, is actually not produced for abortion at all. It’s produced for gastric ulcers, for stomach ulcers.

Interviewer: Oh, really? I did not know that.

Respondent: So, you’re, sort of, using a side-effect of the drug, which is uterine contractility. So, when you look at the drug insert, it says ‘use one tablet three times a day for six weeks’, and ‘do not use in pregnancy. May cause miscarriage’.

Interviewer: Right, that makes sense.

Respondent: The drug company themselves didn’t want to market it as an abortion drug because of the sensitivities around that, and because you only use four tablets and it’s very socially and politically and reputationally risky to produce a drug like that, and this was Pfizer. So, this is a major drug company with Cytotec. So, whereas actually using it for stomach ulcers in rich Westerners over six weeks-

Interviewer: It’s a blessing, isn’t it?

Respondent: Is far easier. So, we were using the side-effect of the drug really, but it meant that if you bought Cytotec off the shelf and said, “Right, I’m going to have a termination using this,” and then you pulled out the insert, it says ‘do not use in pregnancy. Use one tablet three times a day for your stomach ulcers’.

 So, we wrote the first guidelines, and we evolved those. They worked into the WHO guidelines, which then became FIGO guidelines, which is Federation International of Gynaecology and Obstetrics, and also set up a website called misoprostol.org, which publicises appropriate doses for all different things. I maybe get two or three emails a week…

Interviewer: Oh, right. So, quite a lot.

Respondent: … with people requesting information about termination and about what dosage I should use and, “My girlfriend’s used misoprostol, but hasn’t started bleeding yet. What shall I do?”

Interviewer: Oh, God.

Respondent: Now, that’s all a little bit tricky because, from my point of view, I stopped doing any gynaecology about 15 years ago now, just to do late pregnancy. So, whilst I’m still doing research in misoprostol for induction of labour and postpartum haemorrhage, actually, my knowledge now of termination is…

Interviewer: It will have changed, yes.

Respondent: … pretty limited. When they first came through, my heart went out to these people a little bit who were wanting advice.

Interviewer: Understandably, yes.

Respondent: But you don’t know where they’ve come from. You don’t know which country. They may be doing it legally. They may be doing it illegally. They may be a doctor who’s doing it, legally or illegally, and I thought, “Look, this is too high a risk from my point of view.” So, I made the decision not to answer any queries at all about early pregnancy use of misoprostol, and actually, often the queries are answered on the website, but they just needed to say, “Well, if you click to this link, the answer is there.” So, I think people just saw, “Oh, there’s a name attached to this website,” like you just send it in.

 So, I made the decision, but that’s my main link with termination at the moment.

Interviewer: Yes. So, you’ve touched on it a bit with regards to your experience of abortion. We’re using the term ‘abortion’, because some people, well, that we’ve interviewed, have used the term ‘therapeutic termination’. So, we’ve chosen to use ‘abortion’. So, can you tell me, as your role as a doctor, both now and in the past, what sort of role have you had with regards to advising women on abortion?

Respondent: So, when I first started working in the [name of hospital] with [name of colleague], they first sat us down right at the very beginning when we first joined the scheme, and I remember it very… because it was an interest of mine. Of course, with my religious background, I was, sort of, quite interested in all this, and they said, “Right, now then, all the new doctors are here. We’re on our induction,” and they said, “Now, we just need to make a list of those of you who are prepared to help with termination services. It doesn’t matter if you do or if you don’t, but we need to know because we need to rota you on the service that we provide.”

Interviewer: So, you almost had to declare your objection.

Respondent: You had to declare at that stage whether you were prepared to be involved or not, and I think they put it that way, rather than, “Okay, who conscientiously objects? Okay, who…?” you know? It was more a, “We just need to know what your… you know, it doesn’t matter if you don’t, but we just need to organise the rota accordingly.” There, it was very clear-cut that those prescribing the abortion drugs… they were given by the nurses, but those of us who prescribed it, there were only certain ones of us who prescribed it.

 If there were problems, if there were complications with the termination, then we were all expected to do it and you couldn’t opt out of, “Somebody’s bleeding heavily. They need an urgent evacuation.” You couldn’t opt out of that, but you could opt out of the initiation of the process, and actually, that was tricky for me.

I guess there’s a religious tradition of objection to abortion, and yet I’d seen from my time in [name of country] so many problems with botched abortions, with unsafe abortions, and I guess of really difficult lives in which, yes, people are trafficked, people are bought and sold, people end up on the streets. I’m thinking in [name of country] terms really, rather than here, but I’ve seen so much the problems with that, and a lot of it related to parents who can’t cope or who struggle. So, it was a difficult decision for me actually to say, “Well, you’ve always said, ‘Oh, you don’t like abortions,” and I still don’t like abortions, but it was then a difficult decision. I’ve got to come down on one side of the fence or other. You can’t-

Interviewer: Yes, you can’t have your feet in both camps.

Respondent: You can’t. You can normally be wishy-washy, but are you going to sign that consent form and are you going to prescribe the drugs or not? Either you don’t, in which case, really what you’re saying- it’s not good enough to me to say, “I’m not going to sign it, but somebody else should sign it.” You’ve got to say, “I’m not going to because I don’t think anyone in society should sign this,” in which case we’re going back to the situation, for example, where I work in [name of country] where it’s illegal, and where maternal death from sepsis and from either botched abortions or from sepsis related to abortion and hysterectomy at a young age are really very common.

 Also, the knowledge that the rate of unwanted pregnancy is very similar in different countries, and actually, the rate of abortion is very similar in different countries, whether it’s legal or illegal. So, then my question came down to, if the rate of abortion is pretty much the same in [name of country] or here, and if we don’t provide it, women will seek backstreet abortions, in which case they’ll be botched, in which case you’re going to end up with people…

Interviewer: … dying.

Respondent: … paying for it with their fertility because they’ve had hysterectomies or dying because of it, what’s my part in this going to be? So, I decided that no, I was going to provide abortion services and so I did, and it’s a grubby horrible business actually.

Interviewer: It sounds like you almost have a professional head and a personal head, and, like you say, it’s a grubby business. It’s not something that you like. I can’t imagine that anybody would particularly like to be involved in abortion, as such, but it’s not something that you like but you accept that it happens.

Respondent: It’s a necessary… necessary evil, is that the right word? I don’t know. Yes, but I think for the greater good, and I don’t… I mean, there’s some people who have the feeling that, as soon as conception occurs or, at some stage, all life is equal, and I’m not one of those. This is probably getting a… yes, this is getting a little bit personal, but-

Interviewer: No, don’t talk about anything you don’t want to.

Respondent: Well, no, it’s fair enough to mention it. My mother now has quite bad dementia and is 85, and we’ve just signed a ‘do not resuscitate’. We haven’t signed it, we’ve just said that if she were to become very unwell, would we want to resuscitate, and her life is worth a huge amount.

Interviewer: Oh God, absolutely.

Respondent: But is it worth as much as, say, one of my children’s? These are horrible things to discuss, and you don’t want to and, in some ways, it’s cleaner just to say, “All life is equal right from the start to the end,” but the question is, is my mother’s life worth as much as a newly-formed embryo? Is it worth as much as my son’s, or is it worth as much as me at, what, [age of interviewee], and I’m afraid I don’t think my life is worth as much as my son’s or my daughter’s are, but probably worth a little bit more than my mother’s is.

I mean, if she were to die, she’s had a good life, she’s nearing her end, and equally, I think to class my life in the same value as an embryo, which large numbers of them are getting shed naturally anyway, to me there’s quite a gradation. I don’t quite know how it works, but it doesn’t feel that all lives are equal, of equal value.

It’s a difficult and it’s a dangerous thing to say, but I think that’s the truth of it, and so the question is then, are you going to terminate a healthy pregnancy, whether it’s at 8 weeks or 28 weeks or 36 weeks? Are they equally valued and what is the cost of terminating the pregnancy at, say, 15 weeks at a time where, socially, it’s very difficult for a family, say, the child has some kind of handicap. That’s even more difficult for the family, and instead replace it with a different life, because actually, to continue with that original life denies a later life, because you probably wouldn’t get pregnant and have another pregnancy. So, it’s horribly complicated, isn’t it?

Interviewer: It is, it is. It’s a very big question, and I suppose we’re concentrating more on the conscientious objection and, obviously, conscience is informed by beliefs and by experience.

Respondent: Indeed.

Interviewer: Would you say, for yourself, what informed your beliefs regarding conscientious objection to abortion, and the decision not to object?

Respondent: My wife and I decided when she was pregnant not to go through any of the testing in early pregnancy, because we felt that we were adequately well-supported and we were adequately well-informed and well-paid ultimately, that we could support a child if they had a disability, and we’d, sort of, like to support a child if it had a disability. So, we felt lucky to be able to do that, and that we would accept a child as they were, irrespective of their difficulties and their…

Interviewer: … challenges, maybe.

Respondent: Yes, however they come, and I guess we’ve all got some kind of disability of some sort, haven’t we?

Interviewer: Oh God, yes. No-one’s perfect.

Respondent: There’s none of us who are completely perfect. So, we decided that, and yet I assist people with terminations, and you might say, “Hang on, [name of interviewee], you’re bonkers,” and I don’t think that’s the case. I think that is a logical progression, in that I think for each family, they need to decide what they can do to support a child under their care. Ultimately, if a child’s going to end up unloved and in an abusive relationship, then I wouldn’t want them to be killed as they grew up, but if you could somehow prevent that by a termination, then I think that’s probably a preferable thing for that child, and to replace it- can you replace a life? I don’t know, but instead, to support another child who could have a better life.

Interviewer: Maybe wanted. Yes, more wanted.

Respondent: So, the other thing that informed it, my early interest in this, was I moved to a different hospital, and there, there was a consultant who did terminations, but only after very detailed counselling.

Interviewer: Oh, right. Okay.

Respondent: In truth, most of us don’t do the detailed counselling, and we can come back to that, but he did very detailed counselling and spent maybe an hour with each person who came up for a termination…

Interviewer: It’s quite a considerable time.

Respondent: … and had a counsellor next door, had statistics on adoption services and support services. Ultimately, after that, they decided they wanted to go ahead. He would do the termination, but only after that, which I always felt was a very ethically sound thing to do. So, he didn’t conscientiously object, but there’s a sense of paternalism in that as well, and that’s why I didn’t counsel people in detail when they came up for terminations.

I think that the steps that they’ve been through to get there have often been so long and it’s such a complex decision on their part, that I’m not then to say, “Right, now have you thought about it?” Duh. You know, how patronising is that? “Now, have you thought about the alternatives?” So, instead, what I would do is say, “Tell me about your decision. Are you sure about this? Do you want time to think about it? Do you want to discuss it further?” and there’d be some who really genuinely didn’t know and I would spend hours with, but I didn’t routinely do that. I offered that to women.

Interviewer: No. It sounds like you allow them to explore with you, if they wanted to, what options were available.

Respondent: Indeed, indeed, and there’s only once that I’ve refused to sign the forms actually, and I still am not sure whether that’s right that I didn’t, and, of course, somebody else just signed it. So, it was, sort of, not an issue, and it was because I didn’t like the person, which sounds an awful thing to say.

Interviewer: It’s very honest.

Respondent: But she came in and I said to her, “Have you thought about-?” “Well, of course I’ve thought about it. How dare you,” and I said, “Well, look, you’ve had four previous terminations. That seems to be your standard form of contraception.” “Don’t you come telling me what I should do. I’m not going to be dictated to by doctors. You get on and do my termination.” You could argue that that’s exactly the sort of person who’s so angry with society and angry with what life has thrown at them.

I couldn’t explore because she wouldn’t discuss it, and maybe that’s exactly the person, whereas it’s more the literate person who would quote you the different guidelines and things. Maybe they’re the ones who I should object to, rather than those who are angry and were very confrontational, but that was the only person.

I’ve sometimes met people like that and I would then say, “No, that’s fine. If you’ve made your decision, that’s fine, but I just need to be sure that you know about all the services available, and that we sort out contraception afterwards because clearly…” but this person had already had four, and this was her fifth one in a row. Clearly wasn’t using contraception, didn’t, sort of, seem interested in it, and it just felt that she was so disrespectful to an embryo, and I just wanted to say, “For goodness sake, you do realise what you're doing?” but then that’s patronising.

Interviewer: No, but it’s the truth of the matter at the same time.

Respondent: I think it’s a little bit more difficult as a man as well, as a gynaecologist, because you're aware that you’re a man in a woman’s space and that there is a lot of misogyny out there. There’s a lot of male chauvinism, shall we say. There’s a lot of gender imbalance, and is it really right for a man to tell a woman what to do with her body or to try and educate a woman? You know, there’s all that dynamic, which is complex. I mean, I think some men don’t think about it at all, but I often do.

Interviewer: No, but it’s quite nice that you do.

Respondent: I, sort of, pussyfoot around a little bit, thinking, “Oh God, is this chauvinist? Oh, I bet this is chauvinist. Damn.” So, it brings in an additional complex layer, which I don’t think would be so much there if I was a woman.

Interviewer: Did you refer the woman onto the different doctor who could maybe sign the forms?

Respondent: Yes, yes, yes.

Interviewer: So, you still provided that option for her, if she wanted.

Respondent: But I think that’s right in the service, and that will be the same with GPs. If you’re not prepared to sign the form, then you refer to somebody who’s prepared to and humble enough, I guess, to recognise that my feelings are not the only way to do things, and that if other people have got other ways of doing it, then [okay 00:25:55].

Interviewer: Do you see referral as participation in abortion? So, in terms of what constitutes abortion and what elements health professionals or doctors, for example, should be allowed to refrain from? Would you see referral as part of the process?

Respondent: Well, it’s facilitating the process, and so it is part of the process, but then, equally, not standing outside the [name of hospital] with a placard saying ‘do you realise you’re killing your baby?’ and being quiet about it is, sort of, also facilitating the process. You know, there’s a wide spectrum isn’t there, from those who are very opposed and spend their whole life opposing, through to those who are actually doing the tough job at the end of actually doing the terminations and there’s a wide spectrum.

I guess for most people, they don’t really need to make the decision. You know, there may be one dramatic time in their life at which they have to come down one side of the fence or other, but the majority of the time, it’s actually an awful lot easier not to think about, because I’m not sure there is a right or a wrong to it. I don’t know, maybe when I die, I’ll find out what the right answer is, but I don’t think as humans we necessarily know what the right answer is, and we’ve got to try our hardest to work it out.

Interviewer: Yes, and this project isn’t about the rights or wrongs of abortion. It is about the conscious element.

Respondent: But I think in terms of consciousness, to not be part of the solution is to be part of the problem. So, if you’re not active politically and you’re not standing with placards outside, and the majority aren’t, thank goodness, most aren’t, but in the sense, letting society decide that abortions are acceptable and normal, it’s standing to one side and letting things go.

It’s not as much as referring somebody on to somebody else to do it, but it’s a little bit like that, and then more the spectrum is, “Well, I’ll sign the consent form, but I’m not going to get my hands dirty and do the termination,” and then there’s actually, “Yes, I will do terminations, but only on an individual basis.” Then there’s, “I’ll do terminations, but only up to first trimester,” and then there’s people who will do anything.

I’m not sure. I mean, where does my cut-off come? My cut-off comes right up on the right-hand end here somewhere, and I don’t think I would want to take part in a termination over 20 weeks. I find it very difficult with terminations for foetal abnormalities. We get quite a few here, and the law says that you can terminate a pregnancy because of abnormality up to any gestation, but that means that you would be terminating a baby with Down’s Syndrome at 32 weeks, or something, who would be born then alive. So, the routine is that they terminate the pregnancy in uterine. So, inject potassium into the baby, so it dies in utero, so that the baby is born dead.

That, I find very difficult. I’m glad that I’m not involved in that, and that’s a cop out really because I’m glad I don’t have to make the decisions about that, because I think I would find it extremely difficult because…

Interviewer: Well, it’s life, isn’t it?

Respondent: I’d like to think that, once you get beyond, sort of, 24 weeks, once you get to a baby state as it were, even if it’s in utero and, for me, I guess, sort of, 20, 24 weeks does represent a watershed in terms of human development. So, once you get to that level, there is a substantial difference in termination at that point, and when there’s people around who are desperate to adopt… it would be easier if there weren’t lots of people around desperate to adopt, but I think because there…

Interviewer: There’s lots of people that want babies.

Respondent: … and we’re a rich country, and we can afford care, and there’s people prepared to care, then I don’t think that we should be terminating babies at a late gestation.

 Having said that, the process here, sort of, takes it out of our hands, so that when I’m on the delivery suite and we deliver babies at, I don’t know, 28 weeks with Down’s who’ve had a termination for foetal abnormality – which, thankfully, happens very rarely because we pick them up now earlier and earlier, thank goodness – when we were having to do in utero potassium injections followed by termination, actually, you could care for the woman and be alongside her in that horribly traumatic situation.

Interviewer: Oh, yes. It must be awful.

Respondent: It’s, sort of, odd, foetal abnormality. Because Down’s is the most common, it’s actually a very… it tends to occur with slightly older women. It tends to occur not to those who are, sort of, careless with contraception and working class and not very well able to express themselves, but tends to occur more to pretty educated people who are a little bit older, and, therefore, are hugely traumatised by the whole process themselves, and completely divided themselves as to whether they should be terminated or not. So, because all the drugs and everything are done separately, and I don’t have to take part in that, I can concentrate on being alongside that woman in her hour of need, rather than being the one who presses the red button.

 So, I’m very glad about that, because I think I would find it very difficult to be the one who wrote up all the prescriptions or the one to inject the drugs.

Interviewer: Yes. So, it sounds to me that you do see conscientious objection as a process, and either yourself or somebody else probably more to the case, if they were an objector, do you think they should be able to object to every part of the abortion process then?

Respondent: ‘Every part’ is a loaded term, isn’t it?

Interviewer: It is, it is.

Respondent: I think they should be allowed to object to pulling the trigger, as it were, which is to actually write up the drugs or to inject the drugs. To my mind, that’s fairly uncontroversial, straightforward that you should object to that.

I don’t think you should be able to object to referring somebody to somebody else if you object, because I think that’s about a bit of humility, about your ethical viewpoint, and that recognising that this is a very divisive question, and that the position which I come to… well, maybe my position is, sort of, the majority position, probably, in that I don’t like it, but in circumstances, I feel I have to do it. Maybe most people are like that in that most people don’t like it, but actually, you know, if you’ve got… I don’t know. I don’t know what the figures are. Maybe 25% of all women have gone through a termination.

So, then clearly they are comfortable enough with it to go through it themselves. So, I think a bit of humility and being prepared to provide healthcare services to people, and the recognition that if somebody’s your GP, then you don’t really have a choice as a person.

I mean, it’s easier with bigger practices, but if you just happen to get an appointment from the wrong person, then I don’t think it’s acceptable to block it. I think you do need to be able to refer to other routes, and, of course, you can do what your conscience allows you to. So, it may involve giving somebody a leaflet or just saying, “I don’t do them. You’d need to contact other services,” and, of course, you could easily find services online or whatever now.

Interviewer: Oh God, yes, definitely.

Respondent: If that, sort of, solved your conscience by actually not giving a number or a leaflet, and just by saying, “You’ll have to look yourself online...”

Interviewer: Google something.

Respondent: … yes, people would find it. So, I don’t think the conscientious objection should go to not referring somebody onto somebody else.

Interviewer: You mentioned, you know, what’s informed your views and the practice that you’ve had. Have your views changed over time at all?

Respondent: I don’t know that they have, actually. I think there’s times of crisis, and then there’s times when you settle down into a comfortable steady state with your views, and they’re not challenged. I mean, I haven’t discussed this for donkey’s years.

Interviewer: Thirty-three years, yes.

Respondent: You know, I mean, it’s interesting that you come and talk to me now, but this isn’t my daily topic of conversation because I don’t have to deal with it every day. If you went down to the foetal medicine unit downstairs, they have case conferences about exactly this, and should we terminate, should we not. Somebody coming, I don’t know, with a baby with a cleft lip, is that enough of an abnormality to justify termination, and there was, of course, a famous case, it must have been 20 years or something ago now. Maybe you don’t-

Interviewer: Oh no, I don’t know this one.

Respondent: You don’t know about this, but there was a young female vicar, I think in the Anglican church, who took a case to court, and I can’t quite remember what the legal bits were, but it was somebody who had had a termination for disability in late pregnancy, but it was because of a cleft lip. Yes, and so it was actually quite a drawn out court case. It was quite a, sort of, famous case and, in truth, I can’t remember what happened in the end, but there was a lot about it on television. You know, what is a disability and how much of a disability is a disability?

 Of course, they go from the, sort of, largely incompatible with life through to well, compatible with life, but only for the first few weeks, through to compatible with life but only for a year, through to surgically rectifiable…

Interviewer: … cosmetic issues, almost.

Respondent: Yes, yes. So, actually, where you put that slider, at what point is tricky, and my guess is they deal with this pretty much every day down at the foetal centre, and I’m very glad I’m not the one making those decisions. It’s a cop out from my point of view, but it’s a very uncomfortable decision, and actually, I wouldn’t feel comfortable with making either decision, because are my ethics more important than the ethics of the woman who’s come seeking a termination? Should I be paternalistic and say, “No, you can’t”?

 Well, that’s not quite right either, because that’s a problem, ethically, to be paternalistic in that way, but equally, it’s an ethical problem to actually carry out the termination as well in the situation where you wouldn’t want to.

Interviewer: Yes. Whose rights do you think come first in situations like this, the rights of the patient or the rights of the healthcare professional in terms of whether-?

Respondent: Or the rights of the foetus, I thought you was going to ask me, you were going to add that in as well.

Interviewer: That’s another ethical question in itself. It’s important, but for you, what would be your thought process if I said to you, okay, in that situation, whose rights come first, the rights of the patient that has made that choice, or the rights of the healthcare professional to say, “Actually, I’m not comfortable with the situation. I’m going to conscientiously object”?

Respondent: I don’t know that I can give an answer to that question, which I agree is a cop out, but it’s also because I think in different situations, different people have different rights.

Interviewer: That’s very true, yes.

Respondent: I think there’s a societal permission. Society needs to work out what they’ll permit and what they’ll not. It’s not the government. Yes, it’s society actually. Society needs to work out what it’s going to do in that situation, and I’ll contribute to that debate and other people will, but society needs to make that decision.

Interviewer: Yes. It’s not very black and white. There are definite shades of grey along the way.

Respondent: It isn’t. There’s definitely rights for the woman to act within the parameters set by society, and society needs to give fairly wide boundaries for actions. I think within those parameters, both women and healthcare professionals have their rights. I think for the healthcare professional, you do have a right to object and you should have a right to object, but I think the woman then also has rights to be able to act within the parameters that society allows.

 The awkward point is, of course, that different countries have different societies, and so I may be in Southern Ireland where there’s particular laws, and I may decide to come across [name of city in UK] where we’re acting under different laws. Now, that’s not really right either, that actually the wealthy have a choice and the poorer don’t. That’s not right. I’m pretty clear that you shouldn’t be able to buy rights.

Interviewer: No, absolutely not.

Respondent: So, that’s the awkward thing about those parameters, is that those boundaries shift a little bit depending on which country you live in.

Interviewer: And the cultures and beliefs, yes.

Respondent: But, notwithstanding that, I think that within those boundaries, both women and their doctors have rights, and the foetuses have rights as well, and newborn babies have rights, and actually, women with fertility problems, or couples with… they come into this as well.

They have rights as well, and I think one of their rights is that if there are unwanted foetuses/babies, and they would be prepared to take care of those, then I think they’ve got, also, rights to be able to look after that child. For that child or foetus or embryo not to be killed off because it’s a bit of a messy problem and it’s quieter just to shut the theatre door and just do a termination, and it’s all done quietly. You know, that’s not right for society to do either.

 So, it’s a complex mix. I can’t give you a straight answer to that.

Interviewer: No, that’s fair enough, and the more I talk to people about this issue, the more that I come across… oh, I’m sorry. Am I taking too much of your time up?

Respondent: No, you’re not taking too much time. I’m just checking on my next appointment, but that’s alright. I’m still within time.

Interviewer: So, yes, talking to different people. Well, you know, what I’ve come to find is that there are definite shades of grey, and I suppose you're always going to get that with humans and human behaviour. You mentioned earlier about limitations and how you wouldn’t want to work on a foetal medicine unit.

Respondent: Yes.

Interviewer: Where would you put the limitations to your participation in abortion? You mentioned 20 weeks, but also 24 weeks as a particular limit that you would place a woman coming multiple times for [her thirteenth 00:43:40] abortion. I can’t really think of scenarios.

Respondent: This is my own personal…?

Interviewer: Yes, absolutely. Yes, your personal view.

Respondent: Okay. So, we’ve got a termination unit here, and I do visits for doctors coming from overseas who come to study at the [name of medical research institute], and I do a tour of the hospital. One place I always take them is up, just outside the [name fo fertily clinic]. Do you know the layout of this hospital?

Interviewer: Not really. I had one of my babies here, but yes, a very vague recollection of [name of department].

Respondent: So, if you go up onto the second floor, which you won’t have done, but the second floor is gynaecology.

Interviewer: Oh, I went to the [name of department] place, where they do the NIPT. So, I think I might’ve gone through a bit of the [name of department].

Respondent: Oh, maybe. Is that where they’re doing the NIPT?

Interviewer: I think so. I think so. It was one of the upper floors. I remember getting the lift.

Respondent: Well, the second floor anyway, there’s the huge fertility unit, but then there’s, sort of, an anonymous set of doors to one side, and that’s the termination unit, and the two doors are…

Interviewer: … next to each other.

Respondent: … right beside each other, and so I take people, largely from Africa, these doctors, and we stand in there, and I say, “This is fertility central. You turn left if you can’t get pregnant, and you turn right if you’re pregnant and you don’t want to be pregnant,” and it’s a very bizarre…

Interviewer: It’s a stark contrast that, isn’t it?

Respondent: Having the two juxtaposed like that is very tricky, and they say, “So, why do you call it the [name of abortion clinic]?” and I say, “Well, because ‘The Killing Babies Clinic’ doesn’t quite sound right. It doesn’t quite have the right feel to it,” but it’s horrible having the two side-by-side. It’s true. I mean, it’s absolutely true. That’s a reality of it, and maybe we’d like to hide it away and pretend that they’re not happening together.

I find it quite traumatic having the two side-by-side, and seeing all the people desperate, with psychological upset because they can’t get pregnant going through to the left, and all those with psychological upset turning right. Actually, you can’t quite get the two together. It is really very difficult, but on the [name of abortion clinic], because I had an interest in misoprostol, I did some of their misoprostol guidelines for them and, in fact, I used to go and sign consent forms for them.

So, they would come and have people who were coming for terminations, and they’d have a list of the sheets, and they’d have them all set up with the consent form and with the consent form that the woman had signed, but they needed the blue form signed by two people. It’s been signed once by the GP, and it needed a second signature, and I would go and do a long list of signatures, not having seen the women, no contact with them whatsoever, didn’t know them, apart from their name.

The basis on which I did that was partly what I discussed earlier about actually, the woman won’t have come to this lightly. Actually, I’m not sure this is a doctor’s decision to judge her morally as to whether this is a good case or not that she’s making, but also because actually, the wording of it is that continuation of the pregnancy constitutes more risk than the termination of the pregnancy, and that’s always the case on a population level.

Interviewer: Yes. Oh God, yes.

Respondent: So, it’s a, sort of, bizarre thing to ask, because you’re asking me is a termination or a pregnancy safer? Well, termination is, duh, you know, on a population level. So, it was very easy to sign it on that basis.

 So, on those, I didn’t look at their medical history. I didn’t go into the judging on whether they were right or wrong.

Interviewer: Yes, but did you consider to conscientiously object at any point?

Respondent: No, I didn’t. No. I made the decision at that point that, actually, there was a service, there was a counselling service, the gynae nurses were very well-trained in the counselling.

There was a whole process set up there and that it’s a rather foolish medical paternalism thing that says, “Ah, we’ll check your doctor. Your doctor will judge on your morals and decide whether it’s appropriate for you to have a termination or not,” and I think, “Well, I’m not comfortable being the judge of this person’s character, as to whether a termination is appropriate or not.” So, I felt comfortable, actually, that there were adequate processes in the clinic which were being gone through, and I signed, in a sense, supporting that clinic, rather than… yes.

Interviewer: So, of course, this project’s around conscientious objection to abortion. What impact do you think your fellow doctors’ conscientious objection… so you mentioned the hospital and the clinic up in [name of city in UK]. What impact do you think their conscientious objection had on their other colleagues?

Respondent: Well, it increases the workload for those who… I mean, here it’s a bit different because we’ve got dedicated people who do the termination, so surgical terminations, and then the medical terminations are all done by the nurses. So, to a large extent, the doctors don’t really need to be terribly involved. You need people who can write the guidelines, like myself. You need people who can prescribe the drugs, sort of, online, but actually, you don’t need the day-to-day care that doctors would provide.

 The more difficult bit, I guess, are the terminations which come onto the delivery suite where they’re having terminations for congenital abnormalities, and in truth, I’ve not asked, but I don’t know of anyone who’s conscientiously objected to seeing people on the ward, on the delivery suite.

Of course, it is more difficult. When we were all obstetricians/gynaecologists, you were dealing with gynae and you were dealing with obstetrics, and you, sort of, move from one to another. You’d have to deal with the terminations, as well as the late pregnancies, and you had to reconcile those two different parts of your practice, but now, most of us either do gynaecology or we do obstetrics. If you just do obstetrics, you actually don’t have to get your hands dirty at all with the terminations. So, then you do go, “Oh, I don’t do… I save babies. I don’t act in their destruction,” and you can, sort of, be clean.

Interviewer: So, you could almost be an objector working in obs…

Respondent: … obstetrics, yes. Yes, yes. Yes, indeed.

Interviewer: … and omit the gynae bit, and that would be a place for an objector to work almost.

Respondent: Yes. Yes, yes, and many of us do and, you know, I don’t know about my colleagues. I don’t know how many of them get involved in terminations.

Interviewer: Is it something that you think people are happy to discuss, or just something that people are a little bit worried to discuss, or maybe just it doesn’t come up?

Respondent: [Or 00:51:44] it doesn’t come up. I don’t know that we have long discussions about it. I think that when you’re going through your training, you do have those conversations, but actually, as your training goes on, you’ve had those discussions when you first join obs and gynae and when you’re first sorting out your career. You have those times of conscience and your, sort of, psychological traumas that go with it when you first do it, and then actually, you work through that. So, you get used to the process and you go into a steady state until something disrupts it when you may alter your position a little bit, but then you continue in a steady state without thinking about it day-to-day, I think.

Interviewer: Yes. It’s when those things challenge you that maybe you reflect on where you stand in an argument, and, of course, as time moves on, then I suppose the argument changes as time moves on.

Respondent: Yes, yes, yes.

Interviewer: So, you mentioned that if a colleague was to object, it would increase the workload for other colleagues. Can you see any problems or any issues arising for the patient? So, if a doctor was to object to a patient, what impact do you think it would have on them?

Respondent: None, I don’t… in our services here, within the context as I work, it really wouldn’t have any problems.

Interviewer: It wouldn’t, no. Well, I suppose-

Respondent: You wouldn’t though. I suspect what would happen in reality would be that if I was the consultant doing a ward round on labour ward, and I said, “Right, next on the ward round is room three,” if somebody conscientiously objected, they’d probably stand just at the back of the group of doctors, and then, sort of, not go in and not participate in that care. If I said to them, “[Woman’s name], can you write up the drugs?” and they’d probably say, “Hmm, I don’t feel comfortable doing that. Is it okay if I pass that on?” and it really wouldn’t be an issue at all.

Interviewer: That’d be the end of it.

Respondent: Because there’s enough of us around, and because I think conscientious objection probably is… I have no idea. I’d be fascinated to know how frequent it is, but my guess is it’s maybe one in five, something like that, maybe 20%, 25%. I don’t know.

Interviewer: [Name of researcher] did some work around it. Oh no, this is more about the number of abortions that a midwife would come across, but she has done a systematic review on it for midwives, and it’s not actually that commonplace as people may think. Do you know, I should know these results off, like, the back of my hand.

Respondent: But it’s one of those things where it’s not common. If it was the vast majority of doctors who conscientiously object, then actually, it will be far more difficult because you’d be the one left doing all the work related to those patients, but also you’d be a bit of an outlier, baby killer, you know? There’s a sheep mentality, “Well, everybody else is doing it. It’s probably okay to do,” whereas if you had to be a lone voice, and then you’d incur something… not quite the wrath of the others, but the, sort of, “Blimey, that person’s a bit…” you know, well-

Interviewer: Yes, \_\_\_[00:55:09].

Respondent: You know, then it would be far more difficult to do, and I think there’d probably be a tipping point in society. At the moment, it’s probably a little… is it difficult being a conscientious objector? I don’t know if it is because I think most people are sympathetic with it, and I think most people, you know, would… I don’t know that there’s anyone who likes terminations.

Interviewer: No, no.

Respondent: You know, it’s not a nice subject, and, dare I say, it’s a little bit like working in an abattoir. I don’t know. There may be some people who enjoy the killing of animals.

Interviewer: I don’t think there’s many who’d enjoy it.

Respondent: Well, there’s people who do it as a sport, aren’t there?

Interviewer: Well, yes, I suppose.

Respondent: I guess there’s people like that, and there’s some people who maybe enjoy that sort of power side of it, but I think for the majority of people, they want to eat the meat, but they don’t really want to be the one actually doing it. So, for the majority of the population, equally, they’re, sort of, comfortable that it happens.

Interviewer: Ignorance is bliss.

Respondent: They don’t quite know how it happens, they don’t really want to know the mechanisms, but actually, if you had to be the person actually doing it… and doing terminations can be very traumatic.

Interviewer: No, it is. Yes.

Respondent: I’ve been the… and I won’t tell you the gory details because it’s, sort of, not at all nice, but it’s the stuff of nightmares sometimes when you’re dealing with some mid-trimester babies and they won’t come out properly and you’re trying to deliver them. They’re, sort of, stuck and you have to deal with them so as to deliver them. It’s really, sort of…

Interviewer: It’s traumatic really.

Respondent: Pretty traumatic, and it’s the sort of stuff which could easily lead to PTSD and stuff like that, because it’s not a nice place to be.

Interviewer: No. Actually, it’s interesting you say that because, you know, as a research team, we discussed our views on the team, you know, [name of researcher] herself and then [name of researcher] as well, [name of researcher], and they’ve got opposing views with regards to the rights and wrongs around abortion.

Hearing their experiences, coming from a [academic discipline] background, you know, you come into the project knowing where you stand. I know where I stand. I’m very much for the rights of the woman, and then [name of researcher] just said, you know, “What is the right of the woman?” and I said, “Well, the right to choose,” but then hearing their experiences of witnessing abortions and, like you say, the graphicness of it, it does challenge those beliefs. You know, you do find yourself going, “Well, I’m not sure I’m comfortable with that.”

Respondent: But, to be fair, that also happens in spontaneous births, and it’s more traumatic actually with somebody where there’s been an intrauterine foetal death, and you then induce the labour and the baby gets stuck and you end up with a damaged baby trying to deliver it. That’s maybe more traumatic actually because it’s a loved and wanted baby who the mother sees as, you know, her darling Harry, and-

Interviewer: Yes, all the hopes and expectations that come with that.

Respondent: Indeed, and suddenly you’ve got a damaged baby who’s come out because you’ve had to force it out, and that’s probably even worse actually, but that’s, sort of, the territory a little bit. You have to be able to disconnect a little bit your emotions from this. I mean, empathy is good, but equally, you need to be able to separate yourself off from some reactions.

I mean, that was certainly the case in [name of country] where, you know, at one point there was a baby who, in fact, we had to remove the head off prior to delivery. It was a fully-grown baby, a shoulder dystocia, you know, the head came out but the body couldn’t, and we couldn’t get it back in, we couldn’t get it out. Then we ended up doing a caesarean section, but we couldn’t get the head back in, so that the head needed to come off and be sewn back again, which is, blimey, not what you want to be doing. That’s, yes, the stuff of nightmares, but equally, that was nature rather than…

Interviewer: … than, yes, imposed or… yes.

Respondent: … imposed. It wasn’t something that we had forced on her. So, you do deal with horrible things in obs and gynae…

Interviewer: Do you think-

Respondent: Yes, and this is part of it, I would was going to say.

Interviewer: Yes, definitely. No, it must be very difficult, and then, like you say, you see those types of scenarios and it’s nature’s course, if that’s the way to say it, and then you see those scenarios and it’s not nature’s course. It’s that life issue isn’t it, the natural… you know, however long a life is meant to be, and then the not so natural side of it.

Respondent: Yes. It’s easier when it’s nature rather than you’ve actually pulled the trigger for… I mean, that’s the same with euthanasia isn’t it, at the end-of-life issues. It’s a lot easier if somebody gets an infection and you don’t treat it, than it is actually giving a drug to kill somebody. They’re, sort of, the same, but they’re also not the same.

Interviewer: No, there is a lot of crossover isn’t there, yes.

Respondent: I mean, I’m thinking all about this with my mother, and I’m not thinking of injecting her with anything.

Interviewer: No, of course not.

Respondent: But, you know, there’s a time of life at which, suddenly, these things start to come up and, yes, it suddenly brings it into stark reality when you're starting to think, “Well, are we going to sign a ‘do not resuscitate order’? Are we going to give that?” So, what’s the difference between that then and giving a drug, and what’s the difference between saying, “Well, you know, let’s then just not give treatment for an infection,” or something like that? So, it’s all very tricky.

Interviewer: It is. A huge ethical debate.

Respondent: Yes.

Interviewer: If somebody was a conscientious objector working as a doctor, do you think that they should have to declare their objection, especially in the area that you work? I’ll say ‘obs’. I won’t even attempt to say ‘obstetrician’. (Laughter)

Respondent: I think only when necessary. I mean, the vast majority of the times, you don’t have to declare it. You know, we’ve all got our private beliefs, and often they’re very contentious. So, we don’t have to declare our religious beliefs. We don’t have to declare our sexual likes or dislikes or our orientation. There’s all sorts of things which are, sort of, private that you don’t have to declare, and it will be exactly the same about termination. I don’t see that you would have to declare it, unless it becomes necessary.

I think if we were running a termination service here, like [name of colleague] did at the [name of hospital] in [name of city in the UK], where you had to be part of the service or there was a service which needed running and they needed to know who was available to run it and who wasn’t, then, clearly, you need to make sure the right people are there to run it. So, you then would need to declare your beliefs, but, day-to-day, I don’t think you need to at all.

Interviewer: I think we’ve pretty much covered everything that I needed to with regards to the project. I suppose the last question that I’d like to ask is, as it stands, as you know, the clause is there, if that clause was to be scrapped or removed, what do you think should replace it, if anything, or do you think it should be left open?

Respondent: A clause for conscientious objection?

Interviewer: Objection, yes, around abortion.

Respondent: Why would you want to remove it? I don’t see that you would want to remove it. I think it’s an important thing to have there.

I don’t think it’s fair to ask people to do things which are very out of line with their own personal morals, and the same would come if we came to euthanasia or something like that. I don’t think you should say, “Okay, everybody needs to be the one injecting the drug,” or indeed, if we suddenly adopted capital punishment, we shouldn’t all take it in turns to be the one to inject the lethal injection into prisoners. You know, there’s a point at which you will have to be prepared to stand on your beliefs, and I think that’s a facet of a civilised society that you have had.

I mean, my father is a pacifist, a card-carrying pacifist in fact, and so wouldn’t fight in a war. I have to say, it’s one of those things actually where I’ve never actually had to… I think it’s a lot more real for people born in the ‘30s, you know, when he was a child. He was born in ’35, and so lived through…

Interviewer: … the war, yes.

Respondent: … the war, and then you had to make a decision. Would you fight or would you not fight? Would you kill or would you not kill, and I think it’s exactly the same with termination, in that, you know, for the majority of people, they don’t have to make the decision about termination because it doesn’t refer to them. They don’t have to be the one who signs off the drugs or anything. So, everybody else can, sort of… but there comes a time in obs and gynae, as a gynaecologist, where you either sign it or you don’t sign it. You can’t just say, “Oh, I’m not sure. Can we leave it another few weeks?”

 You’ve got to make that decision. You have to go down on one side of the fence or the other, and that’s probably the case for my father in terms of signing up to conscription or not. I’ve, thankfully, never had to do that. I’ve never been faced with that.

Interviewer: Oh God, yes.

Respondent: If you said to me, “Would you be conscripted to go and fight and kill Afghan civilians?” I would conscientiously object, I think. It’s very difficult to know and I’m thinking of this just off the top of my head. I haven’t thought about it, but he had to make that decision. So, I think conscientious objection is one of the hallmarks of a civilised society, and so we need to be prepared to allow that, and I would be very against removing it because I think it’s a right and it should be enshrined in law.

Interviewer: Yes. Do you think it’s possible to have some guidelines around conscientious objection to abortion…

Respondent: Yes, yes.

Interviewer: … or do you think, the way it stands, that it’s good that it’s left a little bit open and left to interpretation?

Respondent: To be honest, I don’t know what the guidelines are. I know what everybody does.

Interviewer: They’re very woolly. No, I don’t think any exist, and I think that’s where the issues come up. There is just literally the Abortion Act, the clause within the Abortion Act, and when things have been tested in law, obviously, there’s some cases. So, there’s the case of two midwives from Glasgow, and the judge ultimately ruled the abortion… because basically, they came up with a list of 13 things that they felt constituted participation in abortion, such as answering telephone calls, supporting other staff who might be involved in abortion.

The judge ruled against them ultimately, and said, “Actually, no, when the Abortion Act was envisaged, it was envisaged for hands-on activities only.” So, that’s where the clause applies, just for those hands-on activities, not those, sort of, peripheral things.

Respondent: Yes, covering somebody because somebody else is going into the room to see them. So, you say, “Yes, okay,” or referring on. I see what you mean, yes, yes. Yes, I think it probably does… the thing is, these things are never enshrined in law until they’re needed really are they usually, and so, at the moment, here in [name of city in UK], I don’t see there’s a problem. I think if there did crop up a problem, then we would write guidelines on it, and I think we’d probably write guidelines so that everyone was clear about it, so that it didn’t depend on which manager you spoke to about it, but I don’t think there is a problem.

It’ll be interesting if you spoke to some people who were opposed to abortion, and I don’t know of anyone, but that’s just because we don’t discuss it. I don’t know who would be. I could give you some names of people who you might contact to have this conversation with them.

Interviewer: Oh, that will be wonderful. Yes, please.

Respondent: But I’ve no idea what their religious views are about it. I could try some of my Irish colleagues. That will be interesting…

Interviewer: Oh, that’d be wonderful, yes.

Respondent: … because they may be a little bit more liable to be people who would be opposed to abortion, but yes, I don’t think there’s a problem, or if there is a problem, it’s hidden. So, yes, I think we probably don’t need guidelines. I’m very happy to write guidelines if they’re needed, but I think everyone, sort of, seems to agree that, if you conscientiously object and you’re happy to, then we would just get somebody else to do it in your place.

Interviewer: Yes, like a quiet implicit understanding.

Respondent: It’s an implicit guideline rather than explicit guideline, indeed, and there’s no, sort of, disagreement, I don’t think, about it. So, everyone’s happy to continue with this, sort of, vague mutually tolerant situation.

Interviewer: Thank you so much. That’s everything. We’ve caught everything.

Respondent: Is it? Good, good.

Interviewer: Is there anything more you want to add at all?

Respondent: No.

Interviewer: Brilliant. I’ll stop these then.

END AUDIO

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