**File: fie4ec73 -- Doctor David.mp3  
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START AUDIO

Interviewer: And that one’s going. I’ll do that one. Yes, so to begin with, can you tell me a little bit about the work that you do as a health professional; what is your job role and what it involves?

Doctor David: So, I work as a [job role / title] here, and my job involves looking after women during pregnancy, which can range from straightforward healthy, normal pregnancy, to a pregnancy that is affected by serious problems in the unborn baby.

And it therefore involves scanning them; often speaking to a lot of colleagues, offering them some generative testing, and trying to give them as accurate and as realistic information about what the baby has, what does it involve in terms of where do we go from there, the options for women, and then supporting them all throughout the way after getting support from other specialists.

In some cases, we will advise women to deliver here because of the excellent neonatal facilities we have. In some cases, we would actually be comfortable for women to deliver locally; sometimes we would make a plan and give to the local obstetrician.

So, it is still upon the individual women, but broadly I would look after women with uncomplicated pregnancies to various degrees of complications in the baby.

From a maternal aspect, I look after women who have got pre-eclampsia or high blood pressure in pregnancy, but by and large, anybody who is then referred to a specialist area of my remit, I would be very happy to look after.

Interviewer: Yes, so it’s quite a broad role that you play. How long have you worked as an [name of job role / title] for?

Doctor David: So, [name of job role / title], I worked for 22 years, but I have been in the UK from 2003.

Interviewer: Yes, that’s a long time ago.

Doctor David: Yes, a long time.

Interviewer: [Name of city in England] firmly your home. (Laughter). [Name of football teams]?

Doctor David: [Name of football team]. (Laughter)

Interviewer: Good choice. (Laughter) So, can you tell me, is abortion something that you come across in your job role?

Doctor David: Pretty much every day.

Interviewer: Yes, yes.

Doctor David: Yes, but I was just explaining that abortion, the way I understand in my role, is something that I agree to and facilitate in the context of baby having a serious significant health problem that we identify before birth on ultrasound.

And then it involves an in-depth discussion of what the problem is, giving the family the options, seeing them again to discuss things through again, and once they have agreed that they do not wish to continue with pregnancy, then we have to facilitate the process whilst supporting them through their journey.

Interviewer: Yes. So, if I were to say conscientious objection to you – as you know this study is about conscientious objection to abortion – what do you think that means? What does it mean to you?

Doctor David: So, when we say objection, then it means that there is an element of judgement; we are being judgemental, so we are sort of trying to work out that is a woman’s request for an abortion based on her own circumstances, which could be personal family element, or social and psychological.

And once that request comes, how much knowledge should I have, or do I have at the time when the request is brought in – I know nothing about the woman, so I don’t think that it is right for me to have any major input or say in the request, and I would – unless I knew more about the woman and the circumstances, only then I would be able to have an objection or a judgement, or a say in terms of should she or should she not have an abortion.

So, the answer that I’m saying that I do not have the ability to make an objection without knowing everything about the circumstances.

Interviewer: It sounds like you very much advocate for the woman to be able to make her own decisions.

Doctor David: Yes, and that’s how we are brought up, and we are here, we are women’s advocate, all of us in different capacities.

Interviewer: Yes.

Doctor David: I know there is a lot of – in some other countries – a lot of political debate on social media who actually people who are actually pretty much all men sitting in a committee-

Interviewer: Yes.

Doctor David: … and then they are talking about who should have an abortion, who shouldn’t have an abortion. I don’t think there is a remit for men or people who are not in this profession to decide either an arbitrary time limit or a legal limit to an abortion, because the medically facilitated or therapeutic or recommended abortions many times, that situation will not become apparent until after 24 weeks, because at 20 weeks everything looks good and it is only later.

But because of the laws in a certain place, the family is then forced to carry on, and then give birth to a child who either dies within a short time, or may actually live a very handicapped life, but there is nothing they can do about it.

And sometimes it then forces the women in other third world countries to seek unhealthy and unsafe abortion practices, and we know there are plenty of literature on that, and I have published some case reports when I was training, where women have actually died seeking unsafe abortion because the unsafe abortion practices are just unregulated.

And they are being done in third world countries, in rural areas with all sorts of toxic chemicals, pesticides, foreign objects, sharp objects; it puts women’s lives at risk.

Interviewer: Yes. And I suppose it was the type of thing that went on in this country before abortions became available through the NHS really.

So, have you ever encountered any colleagues who conscientiously objects? It sounds like you don’t conscientiously object yourself.

Doctor David: Yes, yes.

Interviewer: So, have you ever encountered any colleagues who conscientiously object to abortion?

Doctor David: So, because my sphere of work involves people who do quite a similar job as I do, and yes we sort of have these discussions where we think that we all have broadly a similar moral compass when it comes to talking about the therapeutic abortion, because if it’s a serious clinical anomaly for either heart, brain, kidneys or in general and we think that baby hasn’t got a chance of a good quality of life, then yes, we have a duty of care to be open and honest and give the exact facts.

And it is not in our remit to tell the family what to do; they will often ask, “What do most women do in their situation?” And we can be quite open and honest about that. Sometimes families will put us on the spot as well, and they will tell us- ask us, “What would you do if you were in my situation?” And again, it is a difficult one, and we have to say, “Well actually, I don’t know because I have not been in your situation.”

But if they really push you, then what I’ve said on a couple of occasions is that if I had the same problem as your baby, then I think in my circumstances, I would not continue with the pregnancy.

Interviewer: Yes, which is an honest opinion.

Doctor David: Yes, which is an honest opinion, and we have with ourselves in the room, a senior fetal [medicine 0:07:48] midwife who is also a woman as well, okay; then her job is to not only support the woman, but also support whosever is there with the woman; their family, and even give a voice to my counselling.

And sometimes it can be very, very difficult, and you then need sort of a friendly voice or a friendly hand to just add to your voice, and sort of take over a little bit and smooth things over and give them a break.

Interviewer: Yes, no, that’s understandable.

Doctor David: Yes. But going back to your question, have I ever seen someone who has had a conscientious objection to abortion; my honest answer is no.

Certainly I haven’t seen anybody who at the outright, or at the outset would say that they are against abortion, not that they are not, because we know a lot of abortions happen because the pregnancy is unplanned, or contraception didn’t work, and therefore they have a right to seek social abortion or termination of pregnancy, and that’s why the law in this country and in most countries will allow women to seek that option.

Interviewer: So yes, do you know of any midwives, for example, or doctors, or nurses who wouldn’t be happy to be involved in patients-

Doctor David: Yes. So, I work with some colleagues who actually – now thinking back on your last question – who would not be happy to sign the certificate-

Interviewer: Oh yes, the form.

Doctor David: … the form, and actually some of the people I have worked with them in the past, and even here, and that I think their personal holistic spiritual and philosophy kind of view, and it’s very sensitive and it’s sort of uneasy for me to say, “Oh, why are you not signing? What’s the objection?”

But generally they have sort of said that they believe in a cycle of life and things happen for a reason, and there is something greater authority, a greater power, and if the universe intended the family or baby to have that suffering, then that’s for a reason, and they would not want to alter the course of destiny.

This is sort of the grounds of-

Interviewer: So, like a spiritual religious, maybe?

Doctor David: Spiritual, yes, yes. In fact, there are families actually, where even if you are for termination as a medical or a therapeutic option because of a serious problem in the baby, the families actually have a conscientious objection to abortion, so it is more the patients I would see who have a conscientious objection to abortion, rather than the doctors.

Interviewer: Oh right.

Doctor David: And these are families again from certain ethnic backgrounds, certain faiths. And if the baby passed away, you know that’s fine because then nature has taken its course. And unless the mum was gravely sick, unless the mum was gravely sick, they would not allow the pregnancy to be ended.

Exceptional cases in these families tend to be the ones who have migrated here and have been brought up and mixed with the culture, and they have sort of become Westernised in their thinking, so a bit more liberal whilst still sticking to the grass root and core fundamental principles.

Interviewer: Yes, of their faith, yes.

Doctor David: Yes. And there is actually good qualitative research in those religions, and their views on seeking abortion practices.

Interviewer: Oh right, so it’s a really interesting area actually.

Doctor David: Yes, yes.

Interviewer: So how do you feel about participating in abortion? What are your feelings?

Doctor David: I see part of my role – my role as a doctor is to provide care within my sphere of activity in terms of alleviating pain and suffering, and it is difficult to quantify that; you can see physical pain, physical suffering – you cannot see – unless you’re a psychologist-

Interviewer: (Laughter) Well, that’s debatable.

Doctor David: … emotional or a mental suffering.

Interviewer: Yes, yes.

Doctor David: But quite a lot of what I do is an educated guess or a judgement about the physical and mental state based upon the events in pregnancy, and whilst nobody knows exactly what somebody is thinking, it’s trying to guess.

And you get that feeling from the consultation; the body language and you know; most people are fairly on the page when you explain things.

Interviewer: And your experience alone-

Doctor David: Yes.

Interviewer: … you know, the amount of experience, the amount of patients that you will have seen in consultations, you will have developed a rapport through your working life and know when to identify those, you know, when the feelings are there.

Doctor David: Hmmhmm.

Interviewer: So, what’s helped form your views around abortion?

Doctor David: So, my views are pretty much formed after the assessment of the condition and when I’m asked to give an opinion, so it is entirely- so mine, it is not to do with social abortions where it’s a requested abortion because of unwanted or unplanned pregnancy; my remit is abortions when I have to offer abortion as an option because something is seriously wrong with the baby.

And from my knowledge and the nature of the condition, if I feel that continuing of pregnancy is going to be not in the long-term best physical or mental interest of both mother and the baby, then I would feel comfortable because I know that it is difficult and unbearable what the family are going through now.

The longer you keep it dragging by walking away from that option, or not offering the option, would mean then you’re prolonging the suffering and agony.

Interviewer: Yes, yes.

Doctor David: So, I see myself as sort of in a facilitating in bringing things to a closure sooner than later and starting the healing process from there.

Interviewer: Yes, yes. So, prior to becoming a doctor and becoming and [name of job role / title] did you have a particular view about abortion before you came into the profession?

Doctor David: I didn’t know much about abortion to be honest, before; I vaguely heard about it and I sort of thought, okay, that’s people’s choice, that’s what they – because I was never in a situation of having to ever encounter that situation for myself or my family, or never been put in that situation, therefore I don’t think I’ve ever engaged my mind or engaged with that process.

Interviewer: Yes. It sounds that you very much seem – like you said earlier – advocate for the woman and the rights of the woman to choose.

Doctor David: Yes.

Interviewer: What’s helped form those views around you seeing it as a woman’s choice, or a patient choice?

Doctor David: I mean, when you say woman’s choice, what I’m trying to say is that the woman is not alone; it’s a family, it’s a unit of two people. It’s-

Interviewer: It’s like you’ve got two patients, really, haven’t you?

Doctor David: … yes, wider members in the family.

You could have pregnancies that happen unwantedly, you know, people can be in difficult relationships; pregnancy can be not planned, not thought through, forced upon someone, so I think people are the best judge of when they think they want to bring a child in this world.

And you know, it’s such an emotive and such a phase of life that should be enjoyed; it should be nurtured, it should be cherished because those memories live with you throughout your life.

And there was a time in my training when, as part of becoming an [name of job role / title], I used to do social termination of pregnancy – we used to call them ‘camps’.

Interviewer: Camps?

Doctor David: Because we had an afternoon where you bring people who have attended previously, and you brought them pretty much to do termination of pregnancy or abortion. And most of these were actually sterilisation camps.

Interviewer: Oh, right.

Doctor David: So, to get sterilisation, you have to ensure that the woman is not pregnant, and these are generally pregnancies under 12 weeks – maximum 14 weeks.

Interviewer: So quite very early on.

Doctor David: Very early, so you do it under sedation or general anaesthetic and you do a medical – sorry, a surgical termination – and then at the same time you do a laparoscopic sterilisation.

And it’s quite driven by the social structure and the health policy in that area.

Interviewer: Okay.

Doctor David: Because of the population and education and employment, there is significant interest that if people are not sterilised, you cannot trust them to use effective contraception no matter how much you educate them.

So that was like the only way to control the population explosion, and therefore some health services will be incentivised to do that, and some women will choose to have it voluntarily because their family is complete.

So, I have done social abortions and terminations as part of my training, and it was only when I came here that I have been able to do the training programme again.

I then met colleagues who would voluntarily not do that aspect, purely because of faiths and certain ethnic backgrounds, and it is fine; it was well respected, which meant that they would be doing the other aspects of women’s gynaecological and obstetric healthcare, except the abortion side of things.

Interviewer: Yes, and I suppose there are quite a lot of other aspects to deal with along with it.

Doctor David: Because I don’t do gynaecology anymore, if I was doing gynaecology – which I gave up 12 years ago – I probably think I would still be doing them, and I would just see that as part of my role in a non-judgemental way.

Interviewer: Yes, yes. Do you think – you mentioned there that you’ve got colleagues who are conscientious objections – do you think it’s possible to work as an obstetrician and be a conscientious objector?

Doctor David: To abortion?

Interviewer: To abortion.

Doctor David: Yes, of course, because the role as an [name of job role / title] is to look after an ongoing pregnancy, so I think if you are a conscientious objector to an abortion, I think that certainly it doesn’t hamper you; I don’t think they are interlinked and they are sort of quite mutually exclusive.

Because if you are against abortion, then surely the only way you can make up for it is to help-

Interviewer: Before life. (Laughter) Yes.

Doctor David: … before, yes, yes. So, you then support somebody who is then growing a baby.

I’m just saying that, but I don’t mean it literally that way. But yes, I don’t think that stops people from looking after women.

Interviewer: Do you think as a doctor, if someone was to conscientiously object, do you think it has any impact on other colleagues such as doctors or nurses, or midwives?

Doctor David: It is a difficult one; it depends on the team mix and what view backgrounds they have. I’ve seen people who object conscientiously to be actually in minority. And if they are in minority, and if they have made it clear and they have expressed that loud, then it’s just something that is never discussed with them again.

So, we sort of tend to go on and still provide a service around them; so, if one of my colleagues I know who will not sign a particular form, or a particular clause, you just never ask them again.

Interviewer: Yes, that’s fair enough, isn’t it?

Doctor David: And then they carry on with their work and we carry on with our work.

So that’s sort of a general statement; I mean what I’m saying is what we never know is that in an extreme situation, if those people were asked again, they might change their mind, we just don’t know.

Interviewer: Yes, yes.

Doctor David: I think – moving on from this – you probably – I don’t know if such a study exists, but a good thing would be to actually just do 100 people interviews who actually are conscientiously against the abortion, and ask them, “Actually why you are against the abortion; tell us.”

And that would be an interesting piece of work to see why people say no to abortion, why would they say no to abortion?

Interviewer: Yes, because I think there’s the assumption that religion really denotes why people object, and like you say, there’s the spiritual reasons why, which might be quite different to the religion.

Or there’s people who have experienced or witnessed things that actually, you know, have been quite traumatic and have made them sort of against abortion through their medical practice.

So, just coming through these interviews even now, you do hear of things, you know, that experience more so than religion seems to denote why people object. And it would be quite interesting to find out.

If any of your colleagues do conscientiously object, do you think that impacts on the patient care in any way?

Doctor David: No, because it doesn’t because you will have people who will agree to, and the woman will get the abortion that she is requesting, or we are offering.

If we offer as part of the medical treatment, then it is my duty to find two people who will sign the form. And it’s on me; it’s not going to- and I have never, ever seen a treatment being delayed because I couldn’t find enough people to agree to an abortion.

Interviewer: Yes, and I suppose, like you say, you don’t ask those people who you know are going to refuse; you would go to the people who you know are going to be willing to sign the form.

Doctor David: Yes.

Interviewer: So, what do you think are the limitations to participation in abortion are? So, perhaps if I refer to a case – I’m not sure if you’re familiar with it – it was two midwives back in 2014, they were up in Scotland and they worked in a hospital similar to [name of the hospital], and they invoked their right to conscientiously object to participation in abortion.

It ended up in court, basically. I think they won originally because they had developed a list of 13 things that they felt would constitute participation in abortion, and that was things like answering emergency buzzers, booking women in, providing support to colleagues - they were very senior midwives – so, providing support to colleagues who were providing care to women who were undergoing abortion; supporting the women who were undergoing abortion and their families. They felt that was participation in abortion. So, lots of peripheral, if you like, elements or parts of the role.

So, I suppose we’re going back to my question, would you see those elements as part of the abortion process, or would you see abortion as just a hands-on activity?

Doctor David: I think it’s a package, because when you say abortion, it needs a lot of planning. And for any procedure, for that matter, you know, anything like the simplest of the simplest procedures that can be done even in a GP surgery, it needs some planning, you know, appointment has to be made, process has to be followed, the guidelines have to be followed, the SOP has to be followed. In this case some legal paperwork has to be done.

And then as simple as it might seem, people have died seeking abortion, so you have to make sure you’ve got, in any facility, facilities for resuscitation, access to blood products, antibiotics, surgical theatre, anaesthetics – all of those things have to be done, so I don’t see it as an element, I think it’s a whole process, and if you have to support, you have to support it wholeheartedly.

Interviewer: Yes, so if somebody was to be a conscientious objector, do you think they have the right to object to every part of that process, or just the hands-on activities?

Doctor David: Yes, so I think if they are objecting, then it really doesn’t matter; they are objecting to the pregnancy being ended, and a pregnancy being ended is not just the time that the pregnancy is ended, it’s everything leading up to that point.

Interviewer: Yes, yes. So, it’s almost like the pregnancy wouldn’t end if these other parts weren’t in place?

Doctor David: Yes, of course. If you didn’t book an appointment for theatre, if you didn’t get the paperwork done, you didn’t give the medication, abortions just wouldn’t happen.

Interviewer: Yes, I see, yes. That makes sense. So, it seems like you have quite a broad perspective of what abortion involves.

Doctor David: Yes.

Interviewer: Are there any limits to abortion that you would sort of place? So, for example, a woman who may be on, I don’t know, her 55th abortion, for example; is there any sort of circumstances that you would consider to refuse an abortion?

Doctor David: To refuse, I would sort of- sorry just give me that question again.

Interviewer: Yes, so is there any circumstances or any situation – for example, this is quite an extreme one – someone who is on their 55th abortion, for example, would you ever consider refusing anyone an abortion?

Doctor David: Well, if certainly they are doing it on grounds of gender, and that was the only reason, so that’s an absolute no for me; that’s where I would have conscientious objections. If I knew that this is the reason, then that’s like a \_\_\_[0:25:51].

Interviewer: Yes. No, that’s understandable.

Doctor David: I mean, if I think through, I might think of one or two more, but at the outset if this is the only reason – I’m not against social unplanned and sort of failure of contraception termination-

Interviewer: Yeah, those things happen, don’t they?

Doctor David: … those things happen, and we know that contraception isn’t – but even after sterilisation people can get pregnant-

Interviewer: Of course, yes.

Doctor David: … so that’s not 100% guarantee. So, I haven’t got objections to those where people seek objection when abortion is part of their day-to-day living and care, which is their right.

So that is where I would- and also, if say, there was a problem with the baby, which whilst it’s not perfect, the baby could have maybe a finger missing or a couple of his fingers are – even a forearm missing or a leg missing – and that could be corrected to a good functional outcome.

And we have those where for cosmetic reasons people have requested again, abortion for a cleft lip or a cleft palate, so those ones which are perfectly compatible with a good life and a normal neuro developmental outcome, and we know that with surgery – yes nobody wants a child to have surgery – but if that’s the case, and if we can have a fairly good outcome in the end, then I would object to those abortions.

Interviewer: Yes, yes. I don’t think there’s any such thing as a perfect human or a perfect baby, really, but I can see where you’re coming from.

Have you ever experienced a woman who is seeking abortion who has been refused abortion previously?

Doctor David: So, refused abortion from elsewhere?

Interviewer: Yes, not from yourself.

Doctor David: Yes, so we do get asked once in a while – when I recollect a lady with a heart problem from Newcastle who was refused abortion because they didn’t think her problem was serious enough, and the parents and family somehow were left to believe that the heart problem was quite serious, and therefore they wanted an abortion.

And with the best expertise available locally – a cardiologist, obstetrician – they felt it wasn’t justifiable because that heart could be corrected by surgery and the baby could live a normal life.

But because it couldn’t be resolved locally, therefore it was sent to us for a third opinion, and we agreed with our professional colleagues, so we couldn’t facilitate that; we couldn’t agree with it.

But that was a perfectly like a medical, surgical judgement, you know.

Interviewer: Yes, yes, and I suppose obviously with all your experience, you’re best placed to make that judgement.

Doctor David: Yes.

Interviewer: So, I’ve asked you that already. Would you happen to know if, as an [job role / title], do you have to declare if you’re a conscientious objector at all to anyone, whether it’s HR or other colleagues?

Doctor David: We haven’t been asked. I’ve worked in a number of hospitals and trusts; the only place I know where I was training, once in my training, was that because as registrars and senior registrars, we were expected to do social terminations, we didn’t have a dedicated [abortion clinic], so they would just go on a general gynae theatre list.

Interviewer: Oh, so you could have anything from a general abortion, right through to-?

Doctor David: Yes, so everything, to hysterectomy, yes. So, if we were conscientious objectors, then the rota person would want to know so that they just don’t put you there.

Yes, so that’s the only place. So I had no problem doing all the lists; I did them, but some of my colleagues who had objections – it wasn’t all – I mean, it’s generally quite obvious because when the rota is made and they just tell them, “Oh, just so that you know, I don’t do abortions,” and then they never go to those areas.

Interviewer: Yes, which of course is their right; it’s their right.

So, there are some places in the world where, as a health professional you can't conscientiously object, so I believe Iceland and Sweden healthcare professionals, they can't conscientiously object to participate in abortion.

And then there’s other places in the world where whole institutes will invoke their right to conscientiously object, so places like Italy; whole institutions, whole hospitals, they won’t offer abortion whatsoever. What’s your opinion on that as such?

Doctor David: So, I mean it’s a strange world we live in, isn’t it?

Interviewer: It really is, certainly.

Doctor David: I still feel that the right to abortion should be predominantly- it depends on the context; if it’s medically indicated, then I think Italy, Sweden and Iceland should be the same anywhere.

Because it can't be different if there is a serious problem with the life of a child or continuing of pregnancy can cause a significant risk to the physical and mental health of the mother, then all women, and all babies should get the same standard of care.

So, the laws – and I know that hasn’t happened in a lot of countries, for even the worst. And we know from news that there was a lady who died in Ireland even though she was having quite bad sepsis because of the delay in facilitating, and going through the forward, backward argument about abortion, not abortion laws and objections, the situation became so bad that the woman died.

Interviewer: Yes, and the baby died.

Doctor David: And the baby died. So, I think from that aspect, when it comes to women and babies and the health of the unborn child, I think there needs to be some clarity across different healthcare settings, different cultures, continents and regions.

I don’t think it’s right – and this is my opinion on it – for a government or institution to take a moral stand and force people to live the way – that particular way.

Interviewer: Yes, yes. Well, I suppose that’s what El Salvador has done, for example, isn’t it, where women who may have a miscarriage, they’re put in jail because there might not be evidence to prove that they didn’t induce an abortion themselves. And of course, abortion is outlawed there, so that must be quite difficult over there.

Whose patients do you think- sorry, whose rights do you think override whose – so, do you think the rights of the patient comes first, or do you think the rights of the healthcare professional comes first with regards to conscientious objection?

Doctor David: So again, we have to see what context the objection is. If it’s an objection just against any abortion, then it’s a difficult question to answer, because a woman will go somewhere else, and somebody else will facilitate that, so her right is to seek abortion whatever the circumstances may be.

And the individual’s right is to say no to abortion, and he will know every circumstance.

So, I think you can't say which one’s rights come first; they will both say – if they were both to argue – they will say, “Well, it’s my right,” and the other person will say, “It’s my right.”

Interviewer: Yes, yes. So, you seem very patient-focussed. You seem to me it seems like your duty of care overrides, sort of almost-

Doctor David: Yes, yes.

Interviewer: … It’s almost like you hold your beliefs back because you think that won’t enter the consultation-

Doctor David: No, no.

Interviewer: … you have the patient to put forward.

Doctor David: Absolutely, yes. And I will be quite flexible, but I know what my limits are and what my lines are, and there for when we are faced with dilemmas where things don’t look good, but we don’t think that it reaches the point where I could actually sign on the form, then we will discuss with our colleagues.

If three or four of us can't agree, we will phone our colleagues in London and elsewhere, and if we can't get anybody to agree, then we have to say actually that nobody in the country is not willing to do it.

Interviewer: Yes. Have you ever had any circumstances where you’ve had to consult, not only your colleagues here, but maybe consult-

Doctor David: Yes, quite regularly a few times a year.

Interviewer: Oh perfect, so would you mind telling me just – obviously without divulging too many personal – but under what circumstances has that happened?

Doctor David: So, there was a baby with short-long bones, which is a skeletal problem, but it is compatible with life. Not the sort of usual adult life that you see out and about, so these individuals can be quite active functionally and live an independent, active life with a lot of support. And they are quite short.

Interviewer: Oh right, yes.

Doctor David: But it doesn’t stop them from doing pretty much anything, but just need support, and they have to learn to cope with their own difficulties as part of growing up.

A lot of that can be purely because of the world we live in; if you look odd, people make comments and you get stigmatised. It won’t affect a lot of people; it clearly doesn’t, and it will affect some people.

So, the nature of the condition meant that you couldn’t have picked it up until quite late, so they did make a diagnosis, but we just couldn’t agree to end the pregnancy, and we did ask colleagues around and nobody would agree to end that pregnancy.

Interviewer: Yes, yes, oh right, that makes sense.

Doctor David: So, you then have to support the family in those decisions, where we sit down with them and explain the law; what the laws allow us to do, what- the moral compass comes in and what are their options after the baby is born.

Interviewer: Yes, yes. So, you have to be very supportive.

Doctor David: Yes, yes. Because we can't forget that at the end of the day you still put the mother before the baby.

Interviewer: Yes, yes, that must be quite difficult, especially when you’re in that emotional situation and emotions start showing and coming through.

You know obviously for the purpose of our study as we were saying earlier on before the interview began, we’re looking at abortion right through from the morning after pill, right through to later terminations – would you consider the morning after pill to be a form of abortion?

Doctor David: No, because pregnancy has not even started. So, it depends on how far you stretch – abortion means when you are ending pregnancy after an implantation, and the morning after pill is taken at a time when fertilisation has probably not even happened. And actually, it may never happen, so it’s a precautionary thing.

Interviewer: Yes, sort of like the last defence of contraception as such.

Doctor David: Yes. But I would still see it as a contraceptive.

Interviewer: Yes. Would you see as part of the conscience clause, for example, pharmacists, they have to – if they refuse to provide the morning after pill – they’re meant to refer on to other services.

Doctor David: Yes, they shouldn’t deny women the right to take the morning after pill.

Interviewer: Yes, and would you see that as a conscientious objector as a doctor if somebody came to- a doctor who was a conscientious objector, do you think they should have to refer on?

Doctor David: Yes, they should because we are in a situation – it’s a very sort of similar argument – we get a lot of first time mums who just want to have a caesarean – but what I cannot see a good reason for, and there is nothing obviously, there is just-

Interviewer: Fear.

Doctor David: … they have either fear or just what they have read on social media, or what they have seen experienced with their family, friends, fear of childbirth and some \_\_\_[0:37:21] sometimes it’s just because they think that having a baby born naturally is going to affect their sexual and reproductive and neurological function.

And that is a perfectly reasonably fear to have, and no normal delivery is not always 100% safe; you can never guarantee that nothing ever will go wrong.

We have had – and I have seen in all my years of career, the most straightforward normal delivery and baby comes out fine, but then it really causes lifelong problems for the mother because of the complications during childbirth.

So, if I have conscientious objection to providing a first-time caesarean section when there is no valid benefit I see for the mother or baby, then I will have to refer the lady to one of my colleagues.

Interviewer: Oh, right.

Doctor David: And if they also refuse to do a caesarean, then we have to refer the lady somewhere else.

And I think if I refer to someone else, then I have sort of demonstrated my professional integrity, my empathy towards the woman and the fact that reasonable body of people who will actually know that I have said.

Interviewer: Yes, so it’s almost like you’ve had the opportunity to voice your objection, but you’re still caring and providing that duty of care to the patient in providing them with the opportunity to seek whatever it is they may want, whether it’s abortion somewhere else.

Doctor David: Yes.

Interviewer: And there was something else I was going to ask around the referral process and it’s gone out of my mind. Oh, that was it; would you see that as part of – if you were an objector and you had to refer on to a different doctor for an abortion, would you see that as part of the abortion process as a conscientious objector? Or can you see why a conscientious objector may see it as part of the process?

Doctor David: I think once they air their objection, then it shouldn’t matter what happens after that. Somebody else is entitled to facilitate, or even object again.

And they might actually choose to say, “Actually I don’t want to be the person who facilitates that,” and they may well choose not to actually, and the person seeking abortion may have to then go and find another person.

Interviewer: Yes. Do you think conscientious objectors as doctors, they should have the right to say, “No, I’m not going to refer you on; I object.”

Doctor David: I have not met any such person. I mean, that will be probably a very extreme sort of way.

Interviewer: I suppose they would, yes.

Doctor David: I think if they are themselves objectors, then they shouldn’t object to anybody else facilitating that.

Interviewer: Yes, yes. Well, thank you very much. We’re nearly at the end, it’s just the last question.

So, the conscientious objection clause is quite woolly; as I mentioned earlier, it’s been tested in law just back in 2014, and that case actually ended up in the Supreme Court. The midwives lost their case because the judge ruled that abortion is just a hands-on activity, so not those peripheral things such as answering the buzzer.

So, the clause is quite woolly, and we are finding that when conscientious objectors wish to invoke their right if it is challenged, those cases are ending up in court.

So, just out of interest, if the conscience clause was to be scrapped as it stands at the moment, what do you think should replace it, if anything?

So, do you think something was prescriptive around what conscientious objection is or isn’t, or just keep it as open.

Doctor David: So, I just need to think that again. So, you’re saying that if the- so there is no clause?

Interviewer: So, basically within the Abortion Act, it just says that healthcare professionals have the right to invoke the right to conscientiously object the \_\_\_[0:41:26] unless actually the life of the woman is in danger. So, it’s woolly; it’s open to interpretation.

Doctor David: So, if you scrap it, then what should replace it?

Interviewer: Yes, basically, yes. If anything.

[Break in conversation 0:41:38 – 0:41:53]

Doctor David: Why would you scrap it?

Interviewer: I suppose from our perspective- I suppose, maybe- I suppose the reasons why you might scrap it is if you were to replace it with more prescriptive, more stringent guidelines, or would you keep it open to interpretation to allow for those sorts of cases that you can't imagine or foresee might come up.

Doctor David: Yes, I think there needs to be room for flexibility, and I think that’s the reason why it’s there, because you can't be always, always black and then suddenly you are white. There is always shades of grey.

Interviewer: Yes, yes.

Doctor David: And because sometimes these can be life/death decisions, you need to have that freedom to allow.

And I think this is empowering clinicians; it’s not taking away- it’s not a disservice to women or babies that by putting this clause you are actually empowering somebody to use that to refuse the right to provide abortion.

Interviewer: Yes, that’s interesting, yes.

Doctor David: So they shouldn’t- women should not feel that the clause allows somebody to refuse an abortion, it should take into account – so there is like a contract, you know, you’ve got a person who is seeking treatment and somebody who is providing treatment; it can't just be seeking, seeking and providing.

Just many times the provider actually, by saying no, could be doing – by saying no – saying no sometimes is the right thing, it’s not a wrong thing because the reasons for seeking abortions are complex, and it maybe that the request for abortion was made without the individual thinking through and then has gone on and continued with pregnancy and thinking, “Oh God, what was I doing earlier, so I am relieved that the person didn’t do that for whatever reason.”

I mean, I’m talking about very rare situations, but it has happened where – and I actually know of cases I have seen in my practice where a person had planned to come to [name of abortion clinic], arranged for a termination, had the tablets, but then did not go on the day for the surgical procedure because they changed their mind, and they carried on with pregnancy.

And then I was asked to check the baby to make sure that the tablet hadn’t damaged the baby.

Interviewer: Oh, blooming heck. That’s an 11th hour decision, isn’t it?

Doctor David: Yes, yes.

Interviewer: That really is.

Doctor David: So, I don’t think saying no, if no is the right – if no is a reasonable option on the day between the two parties, then saying no, I think is acceptable.

Interviewer: Yes, I suppose like you said, there’s always going to be circumstances where maybe a woman hasn’t had all the correct information or, you know, maybe the baby is compatible with a healthy life and a fulfilling life, and maybe the lady hasn’t considered that situation.

Doctor David: Yes, we get that all the time.

Interviewer: Yes. Well, thank you so much; that’s the end of the interview. That’s all of my questions. Is there anything you want to add at all?

Doctor David: No, I’m fine thank you. Thank you for having me.

Interviewer: No, thank you.

END AUDIO

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