I: You’ve signed your consent form and you’re happy to go ahead?

Delia: Sure. No problem.

I: OK. First of all, can you tell me about your role professionally?

Delia: So, my role is I’m trained as a Consultant Gynaecologist and I’ve worked in gynaecological services for about 30 years in total and I’ve always been involved in abortion care from when I was a junior Gynaecologist trainee. I came to work here as a Consultant 15 years ago and part of the role that I came to….emm….was to develop the role in abortion care. So what I’ve done here is to set up a community based abortion consultation service. What we wanted to do was….when I came to [name of city], the model was that people went to see their GP and got referred by their GP to a hospital clinic, which was….depending on where you stayed, it was on 1 day a week at a fixed time. So what I tried to do here was to make the service much more open access. 14 years ago [I think] we opened to self referral clinic because we figured that women were smart enough to do a pregnancy test; realise they were pregnant and didn’t want to be, so they could phone up and they wouldn’t have to come via the GP. So what we’ve done is just gradually increase the amount we’re doing in the community service. So now we see about 4000 consultations a year through the service and the outcome from that results in about 3000 abortion appointments. So I lead the team; we have a variety of Drs and the backbone of the service is the nurses. We’ve tried to really develop the nurses’ role, so most of our nurses will do – lead an entire consultation, they’ll do the ultrasound for gestation and take the woman through the decision….if she wants to go for a termination, they’ll take consent and get everything all organised….they do absolutely everything that the law allows them to do. So really my job is to lead and hopefully continue to develop that service.

I: You’ve answered my next question really, which was your role particularly in advising women with regards to termination of pregnancy….

Delia: Yeah….I suppose in our clinic we work to the same model in terms of what we’ve tried to do is….the person who calls you in from the waiting room will be the person who sees you through the journey. So when you come in you’ll meet a Dr or a nurse and the consultation is kinda background medical stuff, but what’s your current situation, what your feelings about the pregnancy are….what you feel you want to do; I think they come to you as already they’ve made a decision – they want a termination and have more or less decided, in which case we talk through options and timescales etc. I wouldn’t say that people use this as a counselling appointment….I don’t think it is, it’s an options discussion really.

I: So you feel as if the women already know in their mind what they want….

Delia: I think most people know what they want to do and actually they’ve had the discussion about what they want with friends, partner, family….preferred person and I think most people are coming to us wanting to know how they go about it. Some people come in and they’ll say I’m not sure what to do, or they’re looking for some information or a bit of support about how to make a decision. So we’re kinda directed, the consultation depends on what the woman brings to it….it’ll go from there.

I: Is it very much like person centred then?

Delia: Yes. We’ve tried to keep it that part of our reason for developing the nurse role in abortion care etc is….some previous work in (city) [going back a number of years ago] showed that women got upset by having to repeatedly tell their story to different people along the way, so we’ve tried to….like….you phone up, make an appointment, come in and you see someone skilled up to meet your needs, so you don’t have to go to somebody else to get a scan, somebody else to get your consent form signed, this that or the other. Most people should hopefully be able to see 1 clinician who takes them through everything. It’s better for continuity. I know there’s different ways of running a service, like come in get a scan and go see someone else….to me that’s almost like a conveyor belt; maybe it’s more efficient….I don’t know, but I wouldn’t like to be on a conveyor belt myself.

I: Do you feel as a woman, you’ve brought your own personal views to your professional role?

Delia: Absolutely.

I: What, in your opinion, constitutes participation in the termination of a pregnancy?

Delia: By the clinician….I mean I suppose there’s all different ways that people can take part in the process….from the point of view of when women phone in here – they’ll phone the clerical staff who make an appointment; they’ll ask some questions, so they’re participating in the process to some extent. They get checked in at the front desk, they guy in the lab manages samples etc, so I suppose they participate, but by the definition of the law, they’re not doing the abortion. So, from my point of view, the person who legally does this is either the person doing the surgical procedure, or much more commonly, in this part of the country is medical abortion and technically the person who prescribes the drug is the person who’s done the abortion. So I suppose they’ve performed the abortion; everyone else might have participated in the process but they’ve not actually *done* the abortion.

I: Pharmacists who have dispensed the medication too?

Delia: Yeah, although I suppose pharmacies I don’t think, are dispensing abortion medication – not unless they had a license. They could be in a hospital or a clinic though – I guess you could have a pharmacy….I suppose I could say well let’s apply that Lloyd’s down the road as a place that dispenses Mifipristone….but to my knowledge, no pharmacies have that. I think the person who’s doing the abortion is the person doing the operation or the person prescribing the drugs.

I: OK.

Delia: Currently both of those things have to be a medic.

I: Yeah. Can you tell me a bit more about your own views on that then?

Delia: Mhmm. It’s like for very historical reasons. When the Abortion Act came in to being, it was universally doctors….well doctors would do these procedures to keep it safe and it put a block on unskilled practitioners who were providing back street abortions. By taking it in to the medical domain, it kept it safe and it gave a route for doctors to legally provide abortions. But the rest of health care has moved on. I mean….I think it completely ridiculous really, but in my team of nurses….a number of whom are very experienced nurses, they will do the entire consultation with the woman….they’ll take her through her decision, but then that nurse at some point in the consultation has to then come….a lot of our patients are now going for the early abortion at home, so when they’re in their 1st consultation they want to go ahead to take their 1st tablet, but the nurse has done everything else and before she can give the woman the tablet, she has to come and get me or one of my colleagues to prescribe and sign the abortion drug. There has to be 2 signatures on the certificate, so I think that seems ridiculous….these are entirely independent practitioners who are making huge decisions with these women and taking consent….a number of the nurses who work with us are non-medical prescribers and they can prescribe all the other medicines in the world but they’re not allowed to prescribe that specific drug. Even although they’re experienced and in fact, to be honest with you, a number of them are much more experienced than some of the more junior doctors might have in the service….but because they’re doctors they’re allowed to sign the certificate and they’re allowed to prescribe the drugs.

I: Is it more about your title then?

Delia: Yeah. It’s about the title rather than actually looking at are these people skilled and competent to be able to do the procedure.

I: Do you think that impacts on time….you know on time frames?

Delia: It doesn’t for us because of the way I set the service up. When the clinic is running – it’s quite a big clinic that we run as you’ll see, but we always have 2 doctors available and the doctors again they’ll be taking their patient and be going through exactly the same consultation so they’ll need to get another colleague to get the 2nd signature for the certificate - the same as nurses, so it doesn’t impact on how quickly the woman can come to the clinic and how quickly she can start her treatment. For smaller services and smaller health boards, it may impact, if you’ve only got 1 doctor at a clinic….maybe a doctor and a nurse doing a clinic together….some of the reasons why some clinics haven’t opened up to self-referral is they want the woman to see her GP so she comes with 1 signature on her certificate and then the doctor at clinic is the 2nd signature, so for some areas it can delay and can be a block to timely access I suppose.

I: And depending on how many cases you have in a day, or a week….?

Delia: Yeah. We have a fairly big workforce at [name of clinic] and abortion care is one of our priority services and we try and run it so that the waiting time is never more than a week, so if it starts to go over that, I can make the decision to put on an extra clinic and pay staff. Like this weekend, we’ve got 5 staff working on Saturday to keep the waiting time down. Like holiday time and people are off on leave….when people are off on holiday there’s clinics on so the waiting time creeps up, so we can put on an extra clinic because we’re a big service. We can make those decisions and pull staff from less priority services to staff the abortion clinic.

I: Yeah, I understand. So, if I say conscientious objection to abortion, can you tell me what that means to you?

Delia: I think it’s a term that is misused and overused quite a lot. To me, what it says is somebody who does not wish to perform an abortion. I think and I suppose there are cases through law, people say that they don’t want to participate in any part of the abortion care pathway.

I: Yeah. Like what I was asking about earlier….what constitutes participation?

Delia: Yeah exactly. So I think you can participate in the care pathway without participating in performing an abortion.

I: So you think it would be more a direct thing then?

Delia: Mhmm. I think it should be. I mean my feelings would be very strong – if you’re not able to participate in the kind of support structures around abortion care, then an environment that provides abortion care isn’t an appropriate place for you to work in. I know that might not be necessarily a very popular view, but for example, if a woman phoned in here and said I want to make an appointment about getting an abortion and the person who took the call said I’m sorry I can’t help you with that, then I’m sorry, but that person is unable to a job working here. To me that would be blocking access and I don’t think the ethos of the Abortion Act, in the conscientious objection part of it, says that people say I’m not making you an appointment or I’m not checking somebody in for that clinic. But I know that views are obviously varied.

I: Is it fair to say that the clause within the 1967 Abortion Act….is that still a grey area? The conscientious objection part?

Delia: I don’t think it should be, but I think it is because of how people interpret it. I can see why it’s there and that when abortions became legal….I can understand if a hospital said right we’re going to provide abortions; gynaecology A, B and C….you will do abortions and if 1 of those people held personal beliefs, strong beliefs and they didn’t wish to perform an abortion – then I can see where conscientious objection comes from, but if that doctor from the same point of view said I’m not willing to see someone having anything to do with an abortion, or somebody else within the hospital said I’m not willing to register patients that are coming to the abortion clinic….to me that’s not part of that clause on conscientious objection.

I: OK….I understand what you’re saying and can I ask….have you ever had any experience of conscientious objection – with colleagues?

D: Mhmm….

I: Can you tell me about it if you don’t mind?

Delia: Sure. I suppose in various parts of my career and as a junior doctor there was….initially when I started in gynaecology, women coming to see about abortions….the clinics had like a couple of spaces at the end of clinic and women were just kind of added on there. Not a good way of doing things, but then a hospital I was working in….this was around the time – the same point in time that medical abortion became possible with Mifipristone getting licensed….in the hospital I was in, 1 of the consultants wanted to set up an abortion clinic, so that rather than the women getting slotted in, we had a specific clinic set up to do the abortion consultations. He then looked for someone to do the clinic with him, so I said I would be really interested; I had always been interested in women’s rights to choose etc and I thought it was a much better way to provide the service. So I used to do the clinic but when I was on holiday, not all my colleagues were willing to cover the clinic. They said no.

I: So they were vocal enough about it?

Delia: Yeah.

I: So did you find out through informal chats with colleagues or maybe through having staff meetings – did you find their views were well known?

Delia: Yeah I would say so. Most people – you were aware of who was willing and who wasn’t willing to do the clinic. Most people were but they wouldn’t necessarily hold their hand up and offer ‘cos there was this kinda element of a bit of distaste….like I don’t fancy doing that clinic. So I think there’s a lot of a crossover between things you don’t *fancy* doing and things you don’t do due to strongly held personal beliefs….I think conscientious objection can get used for distaste. Other points again….I’ve been aware of people who haven’t been involved in the abortion care service, which in some ways was more relevant when it was spread across gynaecological units but now abortion care – certainly with the bigger health boards – tend to come in to dedicated clinics and have, like in [city], a gynaecology ward where people having terminations would go there and nurses working that ward know that’s what they’re there for. Same as surgical termination lists….which is a minority of patients, but again, the staff working in theatre and the doctor doing the operation list that day know that’s what they’re doing. I suppose they have sorta bought in to it.

I: Do you think that conscientious objectors put a strain on non-objectors?

Delia: It can do. Certainly, perhaps more in acute settings….if the clinics need to be done and you have a number of staff unwilling to do those clinics then particularly when the normal staff [if you like] are off and you end up with needing cover for the clinic….you can cut the number of slots but adversely affect patient care because of staff views.

I: You’re touching on possible limitations? I was going to ask more here – what would you identify as limitations to conscientious objection?

Delia: I think, to me, it should only be the performance of the procedure. I think if you apply for a job and are coming to work in an area providing abortion care, then if you’re not able to provide anything to do with any of it….this isn’t the place for you to work. But, that’s not a very popular view. But that’s my view.

I: Sure and everyone has different views, coming from different backgrounds as well you know….what has helped you to shape your views?

Delia: Well I’ve always been….ever since I was a student and things, I’ve always approached things from a women’s point of view. At the end of the day….I think the law around the Abortion Act etc….I can see of the time as it came about, it was entirely appropriate and it was needed to try and keep women safe – to protect women and also to protect doctors from being put in jail for doing them….so I wouldn’t by any means dis the Abortion Act for coming into being, but I think now, for modern day purpose….my view would very much be it’s a woman’s view and her body and her fertility and pregnancy, whatever it is is entirely her own business, so I very much would support decriminalisation. I think it’s a nonsense that somebody comes in to a clinic and sort of for whatever her background might be….she might be a young student and unable to support her pregnancy or she might be a slightly older woman with 3 kids trying to get back to work and not have 2 pennies to rub together and cannot possibly afford to have another child….I fail to see why I should have the right to say yes you meet the criteria or no you don’t….so my view would always be it’s the woman’s right to choose could be grey. In that case they wouldn’t really need the conscientious objection where people are not willing to participate as the woman would make the decision. I think I would – well personally I would always interpret that within the Abortion Act, the woman makes the decision but I don’t know that people wouldn’t necessarily do that….so it – doesn’t *need* to be, but it *could* be.

I: Yeah. What do you think about like in present times – I know 1967 is a while ago now – so now what’s happening across the world, like in America….do you think that would filter down and affect us here?

Delia: Yes. There’s every risk of that happening and it is very very concerning. The 40 days for life protest that took place in [city] over the lent period and other sorta protests that have taken place at other points in time – I think that whole 40 days movements – that’s come from America as it’s fairly new here. There’s been sorta smaller pro-life presence in [city] for a while, but that enormous vigil outside the [name of hospital], that’s new and has been gradually building over the past 2 or 3 years. That American organisation, funded by far right fundamentalist Christians – so I think it is already having an impact here. I know personally I’ve spoken to a number of patients who have went to hospital for a termination; or those in the middle of a miscarriage during that period in time and they were *very* upset by the presence. The staff as well. 1 or 2 friends working there say I don’t need this coming in to my work and even although it was presented as peaceful prayer – as a peaceful vigil – but actually having that volume of people at a hospital gate sorta chanting prayers can be intimidating to a number of people. That has come from America and you only have to look at 1 of the potential Prime Minister candidates for later today….he said he thinks that 12 weeks is the right upper limit and he said that for a long time….even back like 8/9 years ago he was quite vocal. All that’s going on in America just now gives it credence – like a justifiable thing to do. Again, some of the political views from Northern Ireland who are now propping up the UK government – how do we move forward from that….so it is threatening to some extent to the UK…whether or not it could actually result in changes to services I don’t know, but it could certainly intimidate women….when you get those protests.

I: Do you think it might help HCPs to have more of a stance with conscientious objection?

Delia: I think that people can go either way with it. When I see things like that it makes me more determined than ever to fight for people’s services and to try and get a way to stop getting people doing those protests at hospital entrances but yeah I suppose people can go either way. People can get intimidated by it and it can be quite threatening….I suppose if you might get unsettled by it and feel that you personally are at risk….it can certainly be upsetting for staff. A number of years ago when there was quite a bit of what was called the pro-life alliance that stood for the 1st Scottish Parliament I think it would be….late 90s….there was quite a lot of activity at that time outside various clinics and there was some stuff that got sheer out of hand like naming staff etc….that can be really intimidating and that’s when people can feel that personal threat. I think – those sort of things, like becoming threatening to people, perhaps staff won’t want to get involved ‘cos they feel a bit scared about that.

I: You know how you said, your views as student you were very much like, and are still are very much about pro-choice – were you like that prior to becoming a student? Looking back – when you were growing up?

Delia: I think probably – yeah….

I: Thinking of pre-understandings….

Delia: Yeah, yeah. I think I grew up with a belief, personally for myself that I would go on and have an education and a job and that a pregnancy at an early stage in my life wouldn’t necessarily be something I was going to do….so I suppose I would have. If someone said to me what would you do at age 14 or 15 if I had got pregnant….I suppose I would have had an abortion. It should be a possibility that that would be a choice for me.

I: Do you think your views or belief system has shaped who you are now?

Delia: Yeah. I suppose all through my career there’s always different choices you can make and there’s different areas you can go in to and I always knew I wanted to do gynaecology as I knew I wanted to do women’s health. There’s different career paths you can take and I could’ve gone down a path where I was a big gynaecology surgeon doing massive operations….but I suppose that wasn’t what I was particularly interested in. I ended up in this field because I think you can actually do small things to improve life for a lot more people. You could do something massive for a small number of people but I can do small changes that make a lot of difference for a lot more people.

I: That makes sense. You’ve answered everything I have asked and this has been really insightful….I’m really grateful to you.

Delia: No problem.

I: Before we finish up then, is there anything else you want to add?

Delia: I suppose I just get very frustrated with conscientious objection….not that – I don’t think – emmm….I mean I know people who are pro-choice and more when I was in the hospital setting I suppose….but I get quite frustrated when you get like knowing a woman has to come get an abortion but we better check who’s on the rota – to check we can bring her in then. To me, I think that is disgusting that somebody could be treated poorly because of who’s on duty that day. Again, it doesn’t often apply to our setting but more in maternity side of things where people are having an abortion because of foetal abnormality, emmm….and people not being willing to take care of them….I would personally feel very angry at that. You don’t opt to go in to obstetrics and maternity care to only work with people when things are going well and that person is in such an awful situation….it totally stigmatises people to say I’m not willing to care for that person. Though, on the other hand, would you want them to care for you if they don’t support your decision, but….I mean my personal view, if I was in charge of who gets jobs and who comes and trains as obstetricians and gynaecologists these days – I think they should be allowed to say if you are a conscientious objector then this is not the career for you. But we’re not allowed to say that. That’s what I would do, but I can’t….

I: Well…thanks so much. Your experiences, your views and opinions have really come across and that’s great.

Delia: No problem….no problem.