**File: fi05160d - - Pharmacist – Philippa  
Duration: 0:52:19  
Date: 05/11/2019  
Typist: 839**

START AUDIO

Interviewer: To begin with, can you tell me a little bit about the work that you do as a pharmacist?

Respondent: I’m the [job title] here at [hospital name]. I do try my best to get up and review the patients and optimise their medicines and attend ward rounds. A lot of my work is policy-driven, so it’s doing all the background work to ensure that practice can be safe. It’s reviewing drug safety alerts and building in new practice that gets published so that we can update what we do.

Also, making sure that we’re as cost-effective as possible, a lot of it is linking in with procurement. In the current climate, it’s managing drug shortages on a daily basis, trying to think of a work around.

I also [job role details]. A lot of that is developing induction pathways, training pathways, and also trying to mentor them. I know, from being in that situation, you learn from doing. It’s taking a step back so that they can learn, but also being approachable and supportive so that they know that they can come to me with a question.

Interviewer: Yes, yes, gosh, so quite a broad role really. How long have you been a pharmacist for?

Respondent: [Number of years].

Interviewer: Can you tell me how you come across prescribing the morning after pill or drugs- I suppose, in this environment it’s more about drugs that induce abortion.

Respondent: In my role, here, I have nothing to do with it. My day-to-day job is the consequence of not going down that route. The only time I’ve ever had to deal with it was when I first qualified, working as a community pharmacist. You would’ve had requests, patients coming in over the counter and requesting it. Since my hospital practice, I’ve not had to deal with it. I know here does deal with it, but it’s not in my job role.

Interviewer: It’s not your job role, I understand. Thinking back to when you were working in the community in your junior… Sorry, was it your training did you say?

Respondent: No, I’d just qualified.

Interviewer: Oh, you’d just qualified and you were prescribing the morning after pill. Can you tell me a little bit about how you felt about that?

Respondent: Tick box exercise, especially in community pharmacy, they’re a customer and you give the customer what they need. My community experience was in [country name], which has a very religious background. There were pharmacies that just, point blank, refused to stock it. Your role, as the pharmacist, was to signpost them next door because [country name] likes to have one from each side of the fence right beside each other.

Interviewer: Oh right, okay.

Respondent: So you just go, “We don’t stock it, but they do.” You can refuse to sell it, but you have to be able to signpost so that the patient doesn’t suffer.

Interviewer: Okay. How did you feel about signposting?

Respondent: It just was a case of, wherever you were working on the day, you just did what you had to do. Whenever you’re locuming, you can’t really enforce your own opinions or beliefs. If the pharmacist who runs that shop decides to stock it, and offers that as a service, you can’t really, as the locum, turn that customer away. It is really- They’re more seen as customers, in community, than patients, especially when it’s an over the counter request. It’s not like a regular prescription that’s coming in. I didn’t really think much about it.

Interviewer: Yes, yes. So just, like you say, that tick box exercise?

Respondent: Yes, matter of fact. Inconvenience, because you’re just like, “Oh, it’s just a whole big checklist.” Also, because it does take quite a while, if you’re the only pharmacist, what is going on in the shop when you’re not there? There is a bit of anxiety about the supervision of others and what sales are going on that you’re not observing.

Interviewer: I see. So quite a lot of responsibility, really, you’ve got to have eyes in the back of your head, almost, in that role?

Respondent: Yes. That was a long time ago, seven years ago.

Interviewer: As you know, this project is about conscientious objection to abortion. What do you think constitutes conscientious objection to abortion?

Respondent: Because you have wonderfully explained it to me… I think it’s a bit jargony but it’s using your own thoughts and beliefs to make a decision.

Interviewer: Yes, thank you. If I was to say ‘conscientious objection’ to you, how do you think that sits in terms of your personal beliefs and also your professional beliefs?

Respondent: It’s a very delicate balance. We become healthcare professionals to put the patient at the forefront of why you do everything you do, they’re your priority. Your own beliefs don’t really factor in to the needs of the patient. You need to do what’s right for them. It’s their right to make that decision. I suppose the healthcare professionals that do object to it, wouldn’t put themselves in a job role where they would have to like… They probably, subconsciously, don’t apply for those jobs.

Interviewer: Yes, maybe, yes.

Respondent: Because they know that they would find it awkward.

Interviewer: Do you think it’s possible for somebody who… This is a terrible way to label people. I do it just, purely, for simplicity. I’m going to call someone who refuses to prescribe the morning after pill or refuses to prescribe or even dispense any, I can’t think of a better way to put this, medication that brings on abortion. I’d identify them as an objector. Do you think it’s possible to work, as an objector, in a pharmacy in this sort of environment?

Respondent: It depends how big your team is, and what mix of personalities and beliefs you have in that team. You may manage to find enough that could get the task done, in terms of supplying the [woman 00:07:45] that needs it or fulfilling that prescription to who needs it.

It’s also delicate because the drugs that they use to induce abortion can also be used to induce labour, so you can’t object solely from just seeing the drug. It’s knowing what it’s being used for. Sometimes it can have a benefit, you want the positive side-effects. Drugs have multiple indications. You can’t just have a blanket real of, “No, I don’t deal with that.”

Interviewer: Would you, working in the hospital in your role in the hospital… I appreciate you deal more with [job role]. Would you, in this type of pharmacy environment, have any indication on whether or not that medication that induces labour is for an abortion or not? Or are you just faced with a prescription?

Respondent: It’s clear cut because the dose is different and the preparation is different at the minute. I’m trying to procure it orally. Yes, it should be quite clear from looking at the dose and the route. It should be easy enough to work out if it was one way or the other.

With this trust, a lot of it is managed at a ward level. We’re just supplying the stock for that area. We don’t actually see the prescriptions. It’s very rare that a prescription would ever come via pharmacy. We’re just fulfilling the ward areas to have the stock for someone else to have to make that decision.

Interviewer: Yes, that conscious decision almost. I see, alright. In that case, would you feel that it is possible to work as an objector in a hospital environment?

Respondent: Yes, quite easily.

Interviewer: What impact would that have on other colleagues, for example?

Respondent: I know I’ve been on one ward where a nurse has refused. It was a really weird set-up of a ward, it was like trauma, orthopaedics, ENT, and then random abortions.

Interviewer: That is one heck of a mix. (Laughter)

Respondent: Yes. There was one nurse on the day. Then that just causes an inconvenience to the rest of the nursing staff because if they refuse to look after that one patient, it impacts the colleagues. They, then, have more patients to look after. I think it’s definitely one to factor in if you were the manager of that area, you’d maybe need to consider that if you were doing rotas. You couldn’t have a shift of all objectors. You’d try to factor that in. I don’t think anyone here even blinks or considers it.

Interviewer: Do you think it’s possible to work as a pharmacist who is an objector in the community, for example?

Respondent: Yes. My only community experience is [country name]. You could easily only agree to locum in the pharmacies that don’t sell it.

Interviewer: Okay, I see.

Respondent: You could make that choice.

Interviewer: What impact does that objection have on patients? I don’t know, what do you call them, service users or patients?

Respondent: It could be an inconvenience to them, if they turn up at a pharmacy and they can’t get it. You can’t not tell them where to obtain that service. If you do object, you have to signpost it, you can’t just point blank refuse.

Morning after pills are allowed in [country name] but abortion is still illegal. I have grown up with protests. Fundamentally, I’d say I am an objector. Part of that is religion, upbringing. I don’t really think about it much either.

Interviewer: Yes, yes, yes. I’m going to ask a sensitive question. Don’t answer if you don’t want to. Was your decision to move into [area of work] associated with your objector stance?

Respondent: No. I know a lot of paediatric colleagues are against [area of work] because we are keeping the more premature alive. They’re against that because the quality of life that they, then, have as a consequence… Or the fact that, if we have a baby born at 22 weeks and it survives for 2 months but ultimately dies, have we prolonged their suffering? There are a lot of ethical debates in my field, as much as there is around the decision to have an abortion.

At the same time, I find it rewarding that we can make interventions that can prolong a life and help them to survive. It’s the parents, at the end of the day, whenever they get to bring a little one home. You get to see them come back in clinics and stuff, and start school. We do get a lot of past patients come to visit, you get to see what they look like. I think there is one ex-preterm that’s now a rugby player for the country.

My decision to go into [area of work] was more to do with opportunity at the time. You start your career, you have all these expectations of, “Yes, I’m going to become a specialist.” It doesn’t happen like that. It’s just, “There’s a gap, there’s a vacancy.”

Interviewer: I’ll plug it?

Respondent: I did most of my training in [city name]. When you were covering [speciality name], it was one of the responsibilities that you did [speciality name] as well as [speciality name]. It was just something that I enjoyed. It’s more to do with the multi-disciplinary team vibe and the critical care environment that I enjoy. My patients could be adults, it’s that environment where the pharmacist is actually a valued member of the team because they have to use us to make decisions. It’s a rewarding area to work in.

Interviewer: It does sound really, really, interesting. Like you say, different scenarios every day and-

Respondent: It can be challenging.

Interviewer: Yes, I can imagine. Sorry. You touched on, slightly- Obviously, you grew up in Northern Ireland. As you say, you experienced protests and you would self-identify as someone- I don’t know if that’s the right terminology.

Respondent: Yes.

Interviewer: As an objector, I was just wondering if you could tell me a little bit about what’s informed your views?

Respondent: Upbringing, mother, would be the strongest one. A Catholic upbringing, but also my mum was a religion teacher for 30 years. There is always… Like you would have people selling the Big Issue over here, back home there’ll be someone standing with a placard of horrible photos on street corners just trying to gain momentum for the whole, “Let’s keep abortion illegal in [country name].”

I know that there was one lady in [city name] that died because they refused to give her an abortion. I am very much of… There can be clinical need. The law does have to be lightened to some extent, and clauses put in to say when it is appropriate. You may find it difficult to find clinicians that would want to perform the procedure.

Interviewer: Yes. Is that specific to [country name], do you feel?

Respondent: Yes, I think it’s… Especially in the [country name]. I’d say they’re definitely trying to liberalise their views and legislation and that. It just needs to be something that… Because it’s been illegal for so long, all of your old clinicians have never had to consider it.

Interviewer: Yes, yes, that’s a good point actually, yes.

Respondent: If you were going to change the law, you have to then, “Do our clinicians have the skill? How do they train, how do they get the experience, how do the juniors learn?” Yes, upbringing is probably the definite…

Interviewer: Influencer?

Respondent: Yes, you don’t want to make your mummy cross.

Interviewer: Oh no, gosh. I’ve got one of those mums, definitely not. Did you have any particular views on abortion before entering the profession? Have they changed, at all, since you’ve come into… You know, as you’ve gained experience?

Respondent: No. I always try to think of this and then just put it across if it was me. I’ve just been brought up with, “If you get pregnant before you get married, the whole shame and disappointment that brings on the family.” That kind of perspective. I would be more of the… If I did get pregnant, I’d want to keep it. I probably will always just be an objector regardless of being a healthcare professional.

Interviewer: Again, this is sensitive. What’s that decision based on? Is it, for example, harking back to my days of going to school as a catholic, life becomes life at the point of conception?

Respondent: Kind of that. It’s also… I’d quite happily start a family. I’m now at the point where I can’t convince my husband to get on the same page. He wants stability, and to travel more, and is like, “No…” I’d, more, just take it as a blessing that it’s… Things happen for a reason. If I fell pregnant, I would keep it because things happen for a reason and it usually works out the right way. I’m quite pleasantly, naively, optimistic.

Interviewer: Yes, no, there is nothing wrong with that. I’ve winged it for [number of years], it sounds like a good way to be. What do you think are the limitations to participation in abortion or prescribing medications that induce abortion or the morning after pill?

Respondent: Availability.

Interviewer: Maybe if we use a bit of an example, actually. I don’t know whether you’re familiar with a case of two midwives, back in 2014, who took their case to court. They were objectors, practicing Catholics. They worked on a maternity ward, a delivery ward, that didn’t perform abortions. Then as, obviously, changes are made to procedures, abortions were introduced. They felt they didn’t want to participate. They were practicing Catholics. They took their case to court. They originally won, then they were taken to the Supreme Court and that was overturned, the decision.

They created a list of 13 points of action, I suppose, that they considered to be participation in abortion. That was things like answering the telephone to patients, booking them in, administering- I don’t know whether medication was on there, but certainly supporting other midwives who were supporting the women who were undergoing abortion, answering emergency buzzers, that type of thing.

They lost at the Supreme Court because the judge ruled that when the Abortion Act was envisaged it was envisaged the conscious clause should only apply to hands-on activities.

Thinking about that, what would you identify as being the limitations to participation in abortion? Would you, maybe, see it as that broad perspective of all those different elements?

Respondent: No, that list is… If anyone had looked at that objectively, we’d have told them that’s stupid. As long as you’re not the person actually administering the dose, or having to do the procedure, to me they’re the limitations of how you can object. A patient has every right to phone up and enquire about when her appointment is. You’re not facilitating it because you’re not the one doing it.

Interviewer: Yes. So you would take the perspective that it’s a hands-on activity?

Respondent: Yes.

Interviewer: Can I just ask, do you see signposting as participation in abortion?

Respondent: No.

Interviewer: No? It’s thinking, again, of that sort of-

Respondent: Back to, the patient has their own right to make their own decisions. They may or may not go ahead with it, you don’t know that at the time of signposting, they’ve still got time to deliberate. You can’t stop them.

Interviewer: Yes, yes, I see. Thank you. Are there any limits, that you would impose on anyone else, to participation in abortion? For example… This is a bit of a crass example. A woman who was on her 15th abortion or coming to you for the morning after pill for the 20th time, would you impose any limitations, for example, on an individual in that instance?

Respondent: No, you’d probably just want to counsel her and give her advice about how to have safe sex. We see it quite a lot with babies. It’s unfortunate that there are ones that have to do IVF and struggle to have one child and yet there are ones who are lower economic, safeguarding concerns to the hilt, and yet they’re on their 10th child. None of those children are in their care. Sometimes it’s quite hard to see that disparity.

Interviewer: Yes. It’s quite a jarring contrast, isn't it, really?

Respondent: The patient has a right, but probably if they’re having that many a consultant needs to have a discussion about how could they make a permanent solution to stop her ever getting pregnant. I don’t think you can consciously object to a woman making that choice, to have a hysterectomy, because there is no life involved. It’s just a woman deciding three children is enough or it could be health reasons as to why they have a hysterectomy. I think you’d be doing the patient a disservice if you didn’t try to escalate it. Are there safeguarding concerns with the patient, if there at that point?

Interviewer: Thank you for that. I’ve asked have you ever refused, or considered refusing? Then you spoke about your experiences in [country name]. I was just wondering, do you know of any other colleagues who might have objected to providing any sorts of medications or the morning after pill?

Respondent: Not off the top of my head.

Interviewer: No experience of that? Do you think it’s spoken about at all?

Respondent: No, but I think part of it’s due to- A lot of it is given out through the family health clinics.

Interviewer: Yes, yes. So it’s quite accessible, isn't it, really?

Respondent: It’s accessible, but it also takes it out of the majority of hospital work. As hospital pharmacies, you don’t get exposure to it. In community, you’re very much the lone pharmacist in the majority of shops. You may think about it, but the next time you see a colleague to have a discussion it’s out of your head. You don’t really have a peer to have that discussion at the time.

Interviewer: Have you been, ever… When you’ve applied for a job, for example, have you ever been asked what your position is at all?

Respondent: No. I have been asked what my political views were, whether I’m [political party names], or refuse to declare, but never-

Interviewer: Alright. I only ask that, sorry, because speaking to some midwives and nurses who have gone for jobs, they’ve been asked for different positions.

Respondent: A midwife, that makes sense that they’d get asked that question because they will come into a situation with that. Whereas, as pharmacists, we try our best to be patient-facing but the majority of our work is away from the patients. You could easily sidestep… I’d probably say a lot of our staff that do the ward top-ups aren’t pharmacy trained, they’re just band two technicians. They don’t know what half the drugs do, they just know it’s on a list and it needs to be-

Interviewer: At point A or B?

Respondent: They just supply it, maybe naively, they don’t actually know what it’s for. Maybe we use that to our advantage.

Interviewer: Yes, yes.

Respondent: I probably wouldn’t apply for a job where that would be the sole patient that you’d have to look after.

Interviewer: Yes, \_\_\_[00:28:13].

Respondent: I’d make that conscious decision to go, “No, that’s not for me.”

Interviewer: Again, this could be perceived as quite a sensitive question. I’m trying to think of an easier way to put it. As an objector, do you think… Say, for example, I was an objector, do you think I should put some forethought into the type of job that I would be engaging in? So working in an environment such as the women’s hospital where you may dispense medication or write up medication that might induce an abortion? Do you think I should be thinking about that before I enter the profession?

Respondent: I’d probably say, on a subconscious level, we do consciously object by not applying for jobs that will put you in that situation. It’s harder if you’re a medic or a nurse, because you may have to rotate into that area and not have a choice over it. You could raise your concerns with the supervisor. They may put you in a different rotation.

We make, I can’t think of the word, compensations for other religious beliefs. I think, sometimes, Catholic beliefs are maybe a bit downplayed in society. Thinking back to the likes of Eid, workplaces are very accommodating to ensure those faiths get to celebrate their celebration. Rotas are adjusted and they’re given the time off. Christians are kind of like, because they’re mainstream, not treated as-

Interviewer: Yes. If you don’t want to work a Sunday, you have to work a Sunday type thing.

Respondent: Yes. The Sunday rule, technically you can do it. You could have every holy day off as a holy day of obligation, but we generally don’t.

Interviewer: No, no, that’s true, yes.

Respondent: It is there that you could do it, but…

Interviewer: I see, yes, yes. What do you think that is? Just because you may be Catholic or Christian or-

Respondent: Fear of discrimination. If you were discriminating against the other minority faith, they don’t want that backlash. Whereas, if Christianity is more mainstream…

Interviewer: I suppose, from an objective perspective… I don’t mean the object- I mean if I was an objector, my reasons are as valid as somebody who may be Muslim. My reasons are as valid as someone who may be Jewish. My reasons are just as valid, as a Catholic, as the next Catholic. Surely that’s important?

Respondent: It should be. Somehow society has just got to a point where, maybe, we just don’t pay enough attention. At the end of the day, you’ve got rotas to fill. If you started to make compensations for everyone’s little quirks or beliefs, you would never have your workforce in work.

Interviewer: (Laughter) Yes, that’s a point.

Respondent: You do get… I would consider myself not the greatest of Catholics living in [country name]. I would feel a hypocrite if I was to start taking the holy days off. Maybe it’s a bit of… If we’re brought up with it as a child, it’s just part of your upbringing, it’s not a conscious choice to choose a religion. You might have more passion and want to be a really strong Christian. I’m thinking more about the born again, Reformed-

Interviewer: Evangelical?

Respondent: Evangelical Christians, where they decide as an adult to pursue the faith and then it’s that or nothing. It’s very much their… Every day, everything is… That kind of mentality.

Interviewer: Do you think it’s possible- Sorry, I might have asked this. I think I did. Is it possible to work as an objector as a pharmacist? Do you think you should be able to work, as an object, as a pharmacist?

Respondent: Yes. I’ve managed to get [number of years] down the line and I still don’t… It doesn’t really enter into my conscious thoughts.

Interviewer: Yes. Do you think anybody else, who would be an objector working in a community pharmacy- Do you think it’s possible to work there, and for the operations and systems to flow quite easily?

Respondent: Yes. It depends if they’re the only pharmacist in community. If there were two of you on, one of you could be an objector and it doesn’t have to be… Or it’s a case of signposting.

Interviewer: I was just about to say, how would it work if there was only one? But signposting. Okay. Sorry, I’m just… Sorry, did I ask this? Do you have to declare if you’re an objector? Sorry, I have haven’t I? Did I? No, because I mentioned midwives have to declare. Have you ever had to declare?

Respondent: No, I’ve never seen it on an application form.

Interviewer: Yes, okay. What elements of the process do you think pharmacists should be allowed to refrain from participating in?

Respondent: It’s up to that individual. I don’t think, as management, we can enforce that from on high.

Interviewer: From our perspective, we’re trying to gain some clarity on what is considered to be participation. Do you feel that people should be able to refuse to participate in… You know, thinking of those 13 points that those midwives raised. Do you think people should be able to refuse to participate in them, or just the hands-on activities as such?

Respondent: I think, with the likes of this trust and pharmacy, a service is provided to our patients. That service can only be provided if they have drugs available. We, as pharmacy, facilitate that to happen but, at the end of the day, we’re just supplying stock. I can’t think of anything else controversial, but there are other things that are controversial out there. It’s just a case- We’re not the ones that are giving the doses. To me, it’s more black and white. It’s a service that’s being provided, we’re just a supply function.

Interviewer: Yes, yes. So it’s not your decision what happens once the medication is out on the ward?

Respondent: Yes. We don’t meet the individual patients, we don’t know the backstories, we don’t know if it was actually a medical emergency. If health was at risk, we’d… We can’t make that decision from down here. In those circumstances, you don’t want to be the one that’s denied that access to something that could save a life.

Interviewer: I’m sure you’re aware, some countries don’t allow healthcare practitioners to conscientiously object. Like Iceland and Sweden. Then there are whole institutions, such as in Italy, where they’ll invoke their right to conscientiously object. So they won’t offer abortion services. I was just thinking what your thoughts are on that, do you think there should be blanket rules? I suppose they’re two extremes of different blanket rules.

Interviewer: No. I’ve been brought up in a country where it is illegal and it can’t be provided in the whole country. Here is a good example, we get patients from [country name] that fly over and then fly home again. I don’t think it’s as black and white as on-high declaring that you have to think one way or the other. I think, whenever it comes to healthcare, it is all about the patient’s choice. It should be about the professional’s choice to make a decision.

Interviewer: Whose rights do you think, or whose choices, come first, the patient’s or the healthcare professional’s?

Respondent: The patient’s. If you object, you have to find someone to stand in for you so that the patient still gets what service they want.

Interviewer: It sounds like you’re saying you can remove yourself from the situation, almost, but you’ve got to make sure that person is catered for?

Respondent: As long as they’re still seen to, you’ve done your part in putting that patient’s needs first but you’ve not compromised your beliefs.

Interviewer: Yes, thank you. Oh, we’ve past that one. I’ve just asked that question, thank you. Do you think there is a potential conflict of interests, for someone who is a healthcare practitioner who is an objector, where they have to put the patient first?

Respondent: It depends on the size of their team. If they’re a lone worker, they will probably have to compromise their beliefs for the good of the patient. If there are enough of them, and that person can remove themselves from that situation, that would be the idea. Sometimes you will be put in a situation where you just have to get on with it.

Interviewer: Yes, yes. It must be difficult, though, to calm that sort of mental battle that you might have with yourself.

Respondent: My head is kind of thinking about, if that person did have to do that, what conflict and dilemma they would have for weeks to come. Would it play on their mind? Would it be like PTSD? Because it is something that they’re so against, would it impact them mentally as a consequence? Potentially.

Interviewer: So it could affect their wellbeing?

Respondent: Which is not what you, as an employer, want for your staff. I think, for the likes of midwives, it’s good that they ask the question so that you, as management, can try to mitigate for that when you are doing staffing and rotas.

Interviewer: Do you think everyone should be asked, all healthcare practitioners should be asked?

Respondent: No, because it’s not going to be applicable to all things.

Interviewer: Yes. It is very much… This is a specialist hospital that deals with women’s health. It could be that everyone gets asked if they’re going to work here, potentially. I’ve come from [hospital name], which was a massive hospital. You could’ve been covering services that no impact on this topic at all, and could easily get through your healthcare career never being asked the question in your practice because it’s just not relevant if your patient cohort are males with renal disease or cardiac defects. You could easily get through your career.

Interviewer: Do you think people shy away from asking about it, or do you just think it’s not on people’s radar?

Respondent: It’s not on people’s radar because they’re not dealing with it. Maybe it’s not talked about a lot so… I don’t recall ever having many teaching sessions on it as an undergrad.

Interviewer: I was just about to say, did you get any training on it?

Respondent: I can’t recall anything.

Interviewer: Do you think, maybe, people should be given training on it?

Respondent: I think it makes for a good ethical dilemma discussion. Especially as an undergrad, before you qualify, to have that discussion. It could be because I went to [University name], which was in [city name], which was in a country where it’s illegal.

Interviewer: (Laughter)

Respondent: In hindsight, but…

Interviewer: But no, it’s interesting you say that. Talking to different people who’ve done their pharmacy training in all different places around the world, even, it doesn’t seem to be coming through that there is much training, if any, on it.

Respondent: No, I don’t think we had any. I just knew that, once qualified, certain shops didn’t have it. That was more just a matter of fact of, “Oh, I’m working in a shop that doesn’t do it.” Or, “Oh, I am.” You’re just like, “Oh, where is the paperwork kept?”

Interviewer: When you were a locum in those shops that did, would you still prescribe the morning after pill in those instances?

Respondent: It wasn’t a prescription.

Interviewer: Oh, sorry. Would you dispense, sorry?

Respondent: Yes, but it’s more that you sold it to them. It’s really expensive.

Interviewer: Like a transaction type thing?

Respondent: When you’re in studentville, it’s more… I don’t know. I think there is a difference between the morning after pill and abortion. The morning after pill is generally just conscientious people panicking about something that might never happen.

Interviewer: I suppose it’s like Russian roulette, it either does or doesn’t but you’re never going to quite know.

Respondent: Yes. Whereas abortion is a conscious to make when you know you’re pregnant.

Interviewer: Do you see the morning after pill as abortion?

Respondent: No.

Interviewer: Can you tell me a little bit about your thinking behind that? I’m sorry, it’s really… I’m challenging you.

Respondent: It’s too early on, I suppose. Nothing will have happened or developed that… It’s probably someone who… People who would want the morning after pill, in my head, are potentially young professionals, conscientious, studying. They have goals that having to have a child might hinder. Whereas the people who…

I don’t know what the statistics would even be, the ones who go for abortion, did they take a morning after pill or did they seek it? That’s, potentially, a good area to divulge in terms of statistics. I think it’s worse to sit on it and ponder, like the ones that wait right up until the 11th or 12th week to then have the abortion, that’s cruel.

Interviewer: I think the statistics, in terms of abortion, I think one in four women will have undergone an abortion at some point in their lives. I think that’s the statistic. I’m not sure, though, whether that includes the morning after pill, I don’t think it does.

Respondent: Yes. I don’t know why my head says, “No, the morning after pill isn’t abortion.” To me, abortion is… You know you’re pregnant, and you’ve made a conscious decision to terminate it.

Interviewer: Like you say, it’s knowing isn't it? It’s that decision to do that?

Respondent: Yes.

Interviewer: As I say, we’re looking, hopefully, to use some of this information to inform some sort of guidance or at least provoke some debate around it to get some clarity. If the conscientious objection clause was completely scrapped, what do you think should maybe replace it, if anything, really?

Respondent: Something less jargony, that just explains in more black and white what you can refuse as a healthcare professional and what you can’t. So not just a blanket, “You can make a decision not to do it.” I think, probably down to that case that got thrown out by the Supreme Court, what points were acceptable and what points weren’t? So more black and white in terms of the hands-on procedure and administering the doses are where you can object. All other interactions and facilitation, you can’t object as a healthcare professional because you’ve got a duty of obligation and a code of ethics, as a professional, to put the patient first.

Interviewer: Yes. Is there a code of conduct, with regards to the morning after pill and abortion medication, that you have to adhere to? Or even around conscientious objection?

Respondent: Not in pharmacy. We do have a code of ethics, but nothing to do with… You can put the patient first but, in certain circumstances, your beliefs can outweigh the patient’s needs.

Interviewer: So that’s not allowed?

Respondent: I think it’s more, again, that it’s not on their radar. It’s not there because they… The code of ethics is very much you put the patient first, confidentiality, you…

Interviewer: It sounds quite generic, almost, like a generic situation.

Respondent: They’re very generic. I think it’s because a pharmacy society can’t dictate to an entire profession whenever a very small minority would be put in a situation…

Interviewer: Yes, yes. I suppose there are always going to be… You can cater for every situation- Well you can’t cater to every eventuality, really, can you? It’s like asking to find out every human interaction ever.

I think I’ve asked everything that I need to ask. While I’m just quickly scanning over these, is there anything that you want to ask me or anything that you want to add?

Respondent: No, I’m okay.

Interviewer: Yes, okay. I think I’ve asked everything. I’m just going to have a quick scan over.

[Break in conversation 00:49:30 - 00:49:47]

Is there a referral system in the hospital, that you know of, if somebody was to object? Say if I came to work in the pharmacy and said, “You know what, I know what those medications do. I don’t want any part in it.” Is there any kind of system in place so that you know how to deal with me, as such?

Respondent: As a [job title], if it was one of my juniors, I’d want them to come to me. It’s just giving your staff that point of reference of who they can escalate prescriptions to. As it stands, we don’t see the prescriptions. It’s very hard to answer that question because we don’t really see the patient side of it.

Interviewer: If a colleague was to say, “I’m not going to even touch those medications.” Would you still want them to just come to you and say, “Look, I’m not very comfortable with doing X, Y, and Z because…”

Respondent: Yes. You can mitigate for that. It’s as simple as, you don’t give gelatin to certain patients. You make compensations, you alter what you do.

Interviewer: I suppose it’s just being personable towards people, really, and considerate.

Respondent: Yes, you can’t… You have to individualise, you can’t just have a blanket rule of, “No, you have to do it.” You can’t just dismiss people’s beliefs and think that it’s okay. That’s where you lead to discrimination lawsuits and trouble like that.

Interviewer: Yes. (Laughter)

Respondent: I’d like to think that the workplace is an understanding environment and there would be someone else that could do that role if someone had strong beliefs like that.

Interviewer: Thank you very much. That’s everything that I needed to ask, we’ve gone through. Thank you very much for being so open. I’ll just stop these if that’s okay. Thank you very much.

END AUDIO

[www.uktranscription.com](http://www.uktranscription.com)