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Interviewer: Okay.

So, to begin with, can you tell me a little bit about the work you do as a health professional?

Respondent: Okay.

So, I am an [job role / title]. So, I’ve just finished ST4- in August, and I’ve just come out of- what we call, out of programme. So, sort of the clock has stopped on my clinical training, and I’ve come out to do two years of research.

I’m still doing the full-time on call. So, I still do my gynaecology on calls and my obstetric on calls as much as all of the other trainees back in the programme are, but the 9:00am to 5:00pm part of the job is purely research-based- which is great, which I’m really enjoying, but part of that involves me working in the fetal medicine unit.

So, Monday mornings, I’m involved in the fetal medicine MDT- that I’ve just been to this morning, and then we have a fetal medicine clinic on a Monday morning; and then, all day on Thursday is another clinical day. So, fetal medicine scanning on Thursday morning, and then pre-term labour clinic on Thursday afternoon.

And the rest of the time it’s generally research-based with the odd labour ward shift when they’re sort of really desperate. So, for example, this afternoon, I’m helping out on the labour ward.

So, that’s generally what my role involves.

Interviewer: It’s very varied, isn’t it?

Respondent: Yes, which is great.

Interviewer: Yes. Oh.

So, can you tell me, is abortion something that you come across often in your role?

Respondent: Yes. It’s a huge part of obstetrics and gynaecology.

I would say that it’s become a- it’s always played a huge part of the job, like from the beginning- from even being an SH0; but with my new role branching out into fetal medicine, it’s become a bigger component, I think, because we are unfortunately scanning babies with significant problems, and a lot of the management options offered to the woman, often that can involve ending the pregnancy.

Sometimes those pregnancies are early enough along- if we’ve picked something up very early where they can consider a medical termination. So, before the age of viability, but a lot more- and that’s what I was used to beforehand.

But, certainly, coming into this new role, we are seeing ladies later into pregnancy who are having a feticide as a method of termination to then go on to deliver, or have caesarean sections, or whatever the option is.

So, I would say it’s always been a very big role, but it’s become an even bigger role because of the context of learning to do feticides at a later gestation, and counselling these women about their options; so it’s become an even bigger part of my job, I would say at the moment.

Interviewer: What’s your feeling about that?

Respondent: I feel like it’s one of the most important things that I am learning to do.

So, I think… It’s really hard to articulate sometimes. But I think I feel very lucky that I have this opportunity to work within the team downstairs because the way that they support patients and handle these situations is done so well, and I’m learning that from them, so I feel very, very lucky that I’m getting that opportunity.

But I have to say, giving these women the opportunity to make what is the most difficult decision that they will probably ever make for the benefit of their unborn child. Like, it’s not for their benefit really. A lot of it is because they cannot bear to see their child go through that level of suffering really.

These women have come to us wanting a baby- wanting a healthy baby, and you see them go through that decision-making process; and then when they get to that point, it’s really, really humbling to watch a woman go through that, and to be able to support her through that process, which is probably one of-

So, I’m learning to do them at the moment, but I think it will probably be one of the most important bits of my job.

Interviewer: Yes. Oh, it’s unimaginable the pain that the women must go through, and torment really.

Respondent: Yes, and it’s such a-

I feel- like, it’s different to the early medical abortions- which, again, I completely agree with; it’s a slightly different context because it’s a very selfless decision that these women are making. Does that make sense?

Interviewer: Yes.

Respondent: Because for them maybe, it must… It probably is- maybe to have a baby with such terrible conditions, for that baby to then go on and die after suffering, and then they get a certain level of sympathy for that. The context of the support that they get must be very, very different.

Interviewer: Yes.

Respondent: So, I feel like it’s a very selfless and difficult decision that these women are making, and it’s incredibly important that we offer that to them.

Because we also get- and I think what makes it very, very clear to me of how important is, is we get women coming from Ireland to us where they don’t have that… I know things are changing recently, but they haven’t had that right, haven’t had that opportunity to do that. So, they come over to us from Ireland, so it’s really nice to be able to offer these women this level of care.

I think what really shocked me- and actually really upset me is, I was reviewing a case recently where the patient themselves had had to contact us via email, which seemed really odd.

Interviewer: Yes.

Respondent: Really, really odd, that it wasn’t just like one health professional referring to another health professional. This woman had had to email us herself and I was like, “Well, that’s really baffling.” And then you see what they have to pay.

Interviewer: Yes.

Respondent: And I just find that very difficult to get my head round, and the fact that we have to had a chip and pin card machine in reception.

Interviewer: Oh, gosh.

Respondent: Because I was very naive. I was like, “Oh, what’s this for? Is this for people to pay for their scan pictures?” And the girls were like, “No, no. This is for our ladies that come over from Ireland to pay for their treatment.”

Interviewer: Yes. Oh.

Respondent: And I just… I don’t know. For somebody that believes so much in what that is, you know, the importance of women being able to end their pregnancy for whatever reason that they might have, because it is their body; or, later on, they have the right to protect their child from terrible suffering. That should just be universal. That should be free, and it’s a little bit of a…

I feel very lucky that we work in a construct that we do in this country where this is something I can learn, I can offer, and I feel completely happy and privileged to do that; if that makes sense?

Interviewer: No, absolutely. Definitely. It does make sense.

So- as you know, this project is looking at conscientious objection.

What do you think conscientious objection to abortion is, or what constitutes it?

Respondent: So, my understanding of conscientious objection is due to religious reasons, a medical professional- so, within my context, a doctor, is able to not counsel a woman and not offer the services of abortion, and would therefore have to refer them on to a colleague that does not conscientiously object- is my understanding.

I think probably there is an element within the definition of, “It’s just a personal objection…” for whatever reason, which I really refuse to entertain the idea of.

So, say, if somebody has a religious belief, where in that religion’s teaching it is against abortion, that is in the context that they are able to object to that.

Interviewer: Have you encountered any colleagues who have conscientiously objected?

Respondent: Yes, which I am- and, unfortunately, within obstetrics and gynaecology.

Interviewer: Right, yes.

Respondent: And I have actually had this discussion with quite a lot of my colleagues, because I have quite a strong opinion on the matter, that I find it baffling, or confusing that you would enter into a specialty that requires that as a management option for so many things, and it is fine. You can be a doctor, and not agree if you have whatever personal religious beliefs, and that is absolutely fine.

There are lots of specialties where it will not really… You know, if you’re a surgeon.

Nowadays, even if you’re a GP- to some extent, you know, it would probably be easier, and maybe a little bit more appropriate. But I think within the realms of obstetrics and gynaecology, it is an enormous part of what we do. So, it’s really just turning your back on a huge proportion of what our specialty can offer.

I think my first experience of it was when I was a really junior doctor- I was an [job role / title] working in [name of city], and I was on a labour ward, and one of the senior midwifes said, “Would you mind prescribing this medication for the lady in our [name of room in department] Room?” I was like, “Yes, yes. Absolutely.” She was like, “Yes, because the registrar that’s on won’t do it because of religious beliefs.”

Interviewer: Oh, right.

Respondent: And that was my first ever sort of, “Oh, okay. This is a thing.”

Interviewer: This is a thing, yes.

Respondent: And I was like, “Yes, I…” I didn’t really think anything of it, but I was just like, “Yes, yes. Fine. Just show me how to prescribe it.” I got the protocol up. Prescribed it. It wasn’t an issue. But I remember thinking, “How does that work?”

Interviewer: Yes.

Respondent: What about if there were no doctors on call? It was just a bit… And I was like, “How does the registrar looking after the labour ward and all of these women able to opt out of looking after the lady in room 7?”

That was my very first experience of it. It was a very non-event- like, we were asked to prescribe stuff all the time, but it must have resonated with me in some way for me to actually remember that scenario.

Then I think moving on from there, every new job you go to, you are… not so- we haven’t been asked here, but every other unit, you are asked, “Who is happy…?” I think maybe because we don’t have doctor-led TOP services here, maybe. It might be.

But, certainly, at other hospitals I’ve worked at… I won’t mention them, but other hospitals that have termination services, we were asked beforehand- you know, “Who is happy? Who is not happy? Please send an email to us privately.” And I’ve always, obviously, said, “Yes.”

Interviewer: Yes.

Respondent: But sometimes it does get a little frustrating, in that you see people that maybe will cherry pick their opinion.

Interviewer: Okay.

Respondent: So, they’ll be like, “Oh, well. Of course, if the baby’s got an awful abnormality, I’m okay with it. But, oh, no; I don’t believe in…” what people coin as a “social abortion.”

Interviewer: A social abortion, yes.

Respondent: I’m like, “Well then, where on that spectrum of fetal abnormality do you draw it? Do you just draw the line with a terminal problem? Do you draw the line with something that’s going to cause pain?” It’s like, “Where do you draw that line?” And I think that sometimes is a little bit- And I have worked with people that will be like, “Oh, no, no. This one’s okay. But, Oh, no, no, no. That one’s not okay.” And I think, we can’t really do that.

I appreciate everybody’s right to their religious beliefs and their personal beliefs. I don’t believe that it’s appropriate to work in a specialty such as obs and gynae if you will not participate.

But, in that context, in previous units I’ve worked at- when, for example, everybody else is off on holiday (Laughter) that doesn’t conscientiously object, and it was kind of just left to me.

I was doing sort of three termination clinics a week, which- first of all, isn’t good for my training because I can’t be doing the- And, also, once you’ve done it a few times and you’re relatively senior, there’s not a huge amount additional to learn.

There can be challenging and interesting cases, but it’s not great for my training. And, also, like three a week. It emotionally starts to take its toll really, and it’s just... Sometimes they can be quite hard going consultations with all sorts of reasons, and all sorts of things that come up.

So, three a week, it was getting a little bit tough.

So, it was like, “Well, I know that there are other doctors in this unit that have the capabilities to do this clinic, but it’s falling to me to mop up all the work because they’re not happy to do it.”

Interviewer: I was going to ask, what impact would it have on colleagues if somebody does object, what impact that has?

Respondent: Yes. So, just in that-

So, from the point of view of sort of early- so we’re talking up to 12, plus 6 weeks, and the service that we offered there. Yes, if everybody was off then it would just potentially fall to one doctor that would do it. And, also, the time that it takes- because you require second signatures on documentation.

So, I would potentially do that clinic, and then whilst I’m seeing the next one, the nurses would have to try and walk around and find somebody that would do a second signature. And, again, if we’re thin on the ground of people to find, and those people that are in are… We had nobody to sign the document.

That didn’t happen very often. It was probably quite unusual that it happened to me in this unit, in which there was a small collection of quite a few people that- Well, not a small collection, quite a few people of the training registrars that were objectors; but it can have a knock-on effect for the workload for your colleagues, I think.

Interviewer: Yes. And, also, for you, in terms of- from what you’re saying, it sounds like a level of burn out really. If you’re the person doing that all the time.

Respondent: Oh, yes. Honestly. Yes, after that week- because, I… (Laughter) Because that had come quite close. I had burnt myself quite badly, so I couldn’t do any clinical work.

Interviewer: Oh, dear. Yes.

Respondent: But I could still do clinics, where I didn’t have to examine patients. So, I said, “Oh, well. I’ll do the TOP clinics because I can do that, and that’s fine.” We don’t normally have to examine the women, and that was okay. And then, quite soon after then, everybody else went off on holiday. (Laughter) I was like, “Oh, my golly.” (Laughter)

All I’m doing is these clinics, which- there is a certain level of emotional burn out that you get, because I take the consultations very seriously, and I really explore why they’re where they’re at, and really explore- trying to prevent it happening again.

Interviewer: Yes.

Respondent: Because what is worse is then doing a disservice to these women and not equipping them with effective contraception, or things like that to prevent it happening again, because that emotional burden on that woman for it to keep happening is absolutely huge.

Interviewer: Oh, gosh, yes.

Respondent: So, I don’t just say, “Yes…” as a formality. I talk to them quite in-depth (Laughter) about things, so it gets really, really exhausting. (Laughter)

Interviewer: Yes. You sound very invested in the patient when she comes to you.

Respondent: Well, I try. Sometimes I can get too invested maybe. (Laughter)

Interviewer: Yes. (Laughter)

Respondent: [Crosstalk 0:14:55] or… So, yes, from that point of view.

And, also, I think, from the woman’s point of view, they know that we need a second doctor’s signature because I would say to them, “Pop yourself in the waiting room. We just need to wait whilst we get a second doctor’s signature.” And if that’s taking a long time, she must be thinking, “Why is it taking-?”

Yes, she might think, “Oh, the doctor might just be busy.” But is she going, “I don’t know whether the doctors agree with it here,” and that is a judgement on that women that the health profession is doing, which is completely unacceptable. There is no judgement to be had, and if things are maybe taking a bit longer and that woman is having to wait longer when she’s probably got children at home, or things to get to, because there’s no one else to sign it, because nobody else agrees with it.

Interviewer: Yes, and it must be like- as a person anyway in a waiting room, I suppose you start thinking, “Oh, when is it going to happen?”

Respondent: Yes, exactly. “I’ve been told it was just going to be this amount of time. Why is it taking so long?”

And, often, these ladies have quite complex situations. Like, maybe they don’t drive themselves, they’ve taken time off work and they need to get back- and they’ve obviously not told them the reason; kids, all sorts of stuff going on.

Interviewer: Yes.

Respondent: So, yes. It can get a little bit frustrating at times, I would say.

Interviewer: So- as you know, under conscientious objection, health professionals can object, and the law is quite woolly to be honest. There’s just a clause that gives health professionals the right to object.

Some health professional groups- if you like, they’ve gone a little bit further and said, “People must refer.”

What do you feel about the referral process? Do you see referral as part of the abortion process?

So, if somebody was an objector, do you feel that they should be able to refuse to refer on, as well?

Respondent: Oh, absolutely not. That would… (Laughter) I think somebody outside of the obs and gynae specialty.

So, for example, if you were a general surgeon, okay? And you have your religious, or personal beliefs. Okay; you’ve gone into a specialty where really you’re not expecting to come across it. It’s not a treatment option that you’re offering your patients.

And every now and then maybe somebody… I don’t know, you might see somebody in A&E who asks you as a doctor and, yes, they then- that situation, should be able to refer that person on. And they wouldn’t be proceeding with that treatment for the woman, so it wouldn’t be any judgement on the woman for them to say, “Oh, yes. That’s fine. I’ll just refer you on to this service. I’ll give you the information.”

Interviewer: Yes.

Respondent: I think- as a bare minimum, like that is you- and surely that must be covered by some clause by the GMC, that you cannot refuse care to a patient.

So, I would say if somebody opted out- somebody suggested that, “That is part of the abortion process. I do not have to refer a patient on.” I’m pretty certain that would be in breach of the GMC’s document. Is it good medical practice, or the good doctor? It’s on the GMC website, which we all have to adhere to. So, I’m pretty sure there would be a clause in that that all registered doctors are bound by.

Interviewer: Yes.

Respondent: So, I would challenge that ideology with saying, “Actually, you’re probably compromising the rules of being a doctor.”

And I don’t mind within other specialties that are not expecting to come across that, to then appropriately refer on, give them the appropriate information, or even just say, “Oh, just go to see your GP,” or, “Go on the Internet and Google BPAS,” or something like that. No, that is not taking part in the abortion process.

Interviewer: Yes.

Respondent: I can tell people- you know, I can- A man might ask me about a vasectomy, or his wife might ask me, and I’ll be like, “Okay. Yes, go to your GP. They’ll refer you on to a urologist.” That is not me participating in his vasectomy in any way, shape, or form. (Laughter) So, I would counter that argument with that really.

Interviewer: Yes.

Respondent: I have a huge issue with people within obstetrics and gynaecology saying, “I will need to refer you on to somebody else to do that.” Because even if nothing else is said, just that, that patient surely is going, “Why can’t this doctor do it because you’re sending me to another doctor that does the same job as you? Why can’t you do it?”

I would hope that the doctor in question doesn’t say, “I have a conscientious objection,” or, “I don’t agree with it. I need to refer you on to somebody else,” because you’re making a judgement on that woman. That could have a huge impact on what that woman chooses to do, and I just think that’s not what we’re here for. It’s nothing to do with our opinions.

Interviewer: Yes.

Respondent: So, I would hope that somebody would say, “Okay. Yes. That’s fine. Here are some information leaflets about it,” or, you know, point them in the direction of people that can give them information. “I will refer you on to somebody,” you know, that I suppose if you’re going to have to do it, and it has to stay part of our specialty, that people can object, that would be the best way of going about it.

Interviewer: Yes.

Respondent: And to know that it’s absolutely not…

Again, I would refer somebody to- I don’t do- I don’t know, open hysterectomies. “I’ll refer you on to somebody that can do an open hysterectomy because I can’t do them.”

Interviewer: Yes.

Respondent: I’m not in any way taking part in their hysterectomy. (Laughter)

Interviewer: So, it seems that you see… Maybe if I tell you about this case.

So, there was a case of two midwives- back in 2014.

Respondent: Okay.

Interviewer: I’m not too sure if you know them- or was aware of the case.

It was two midwives, up in Glasgow. They worked in a similar centre to [name of hospital], but they didn’t have any involvement in abortions. They were working on the labour ward, and then slowly abortions were introduced.

So, they were very senior midwives, and they invoked their right to conscientiously object. So, that’s their right. And it ended up in court- which quite often happens in these cases; and they developed a list of 13 points that they felt was participation in abortion.

Respondent: Okay.

Interviewer: So, things like signposting people on, providing support to family members, and the women supporting other midwives, other colleagues, who may be caring for women who may be undergoing an abortion- answering the buzzer, answering the telephone, things like that.

And they originally won, I believe, but that was then challenged, and it ended up in the Supreme Court.

Respondent: Okay.

Interviewer: And they lost, as the judge ruled that when the act was developed- if you like, back in ’67, that abortion was perceived as the hands-on activities only.

Respondent: Yes.

Interviewer: So, it sounds like you have that approach yourself, that you see abortion constituting- or participation in abortion, as constituting the hands-on activities only.

Respondent: So, I would say that speaking to a woman about her options of abortion is participating in abortion. Consenting her for that process is being involved with abortion. I would say prescribing medications, or doing the surgical procedure is abortion.

I would disagree with then delivering that woman because, actually, those people have not participated in- I suppose, the death of that child. They are then, in all intents and purposes, delivering a stillbirth.

Interviewer: Yes.

Respondent: Like, that baby had died in utero. So, we’re probably talking- you know, 24 weeks plus in the context of that case on delivery suite.

Interviewer: Yes.

Respondent: Because, at that point, if a feticide had been performed as a method of abortion and they are then to deliver on delivery suite, in all intents and purposes, that baby is dead in utero.

Interviewer: Yes.

Respondent: So, I would actually disagree, because I don’t think that care should differ in any way, shape, or form, than anybody coming in with a stillbirth baby.

Interviewer: Yes.

Respondent: But I would say, everything up until the point of the demise of that fetus, yes, is participation in abortion. From the point of talking to the woman about her options, to the point of the fetus being dead.

Interviewer: Yes.

Respondent: I would say, before that point- because some labour wards have differing thresholds for gestations that they have on labour wards.

So, here, I would say anything up to- I don’t know our exact cut-offs, but generally everything up to 20 weeks would go to gynaecology. Everything after 20 weeks, would come to obstetrics.

So, in those cases where the fetus isn’t dead yet, you are inducing labour, it will die during labour, or it’s never going to survive outside. It’s never going to be born alive. Yes, I would then say a midwife or doctor giving that medication to induce a labour that is therefore going to result in an unviable fetus being born, that- yes, is still an abortion process. But if it’s a baby that’s had a feticide, its heart has stopped, they have not been involved in that process.

I would say, anything from that point onwards is the management of a woman who has lost her baby in utero. And, to me, it is exactly the same.

Interviewer: Yes.

Respondent: So, that’s why I would have that different- But I could understand that they would be like, “I’m not going to give a woman medication to induce a labour for a baby that’s not already dead.” Absolutely.

I do not enjoy, or feel particularly comfortable doing surgical terminations up to- I think I’ve probably done up to 11 weeks. It’s a difficult thing to do.

Interviewer: I can imagine, yes.

Respondent: And performing a feticide- like injecting potassium into a heart of a baby, is probably one of the most difficult things I’ve ever done.

Interviewer: Oh, yes.

Respondent: But it’s part of what we have to do, and it’s part of what… Okay, and they’re not doing that process. So, I would say, once the feticide has been performed, I would hope that they could just actually say, “I just need to care for a woman that’s lost her baby.”

Interviewer: You talked a little bit earlier on about it, but do you think people who are conscientious objectors, do you think they should maybe have a little bit of forethought about what their job involves?

Respondent: Yes.

So, it’s just changed, but as part of your obs and gynae training, we have like an electronic portfolio where you have to tick things off, and you have to show evidence that you’ve achieved stuff, and there’s a large section on abortion. And people can just tick conscientiously object to them all, and don’t even have to like…

Interviewer: Really?

Respondent: And I’m like, “Of the 11 modules of our specialty, that is an entire module.”

Interviewer: Yes.

Respondent: And people can just go, “Oh, no I can’t…” And if people- maybe they’re just like, “Oh, it’s actually easier if I just conscientiously object because I don’t need to complete that module.” That potentially could happen, which- you know, I don’t really like urogynae. I’d like to conscientiously- (Laughter) Do you know what I mean?

Interviewer: (Laughter) Yes.

Respondent: I don’t have any intention of doing that specialty, but it’s part and parcel of what the specialty involves.

So, I really feel that to work as a doctor in obs and gynae, I would really challenge the right to conscientiously object, because there are other specialties that you can do where you’re not making a judgement on the woman, you’re not leaving a huge burden on your colleagues, and you’re deciding just to cherry pick what bits of the specialty that you like.

Interviewer: Yes.

Respondent: I think with regards to midwifery, I feel that, actually, it’s not a massive part of midwifery, and some people can choose to specialise in that area.

Interviewer: Yes.

Respondent: So, certainly people that are within the fetal medicine unit, I don’t think- Well, you wouldn’t choose a job in fetal medicine.

Interviewer: No, you totally wouldn’t get an objector there.

Respondent: But, really, that would just not logistically work, and we rely so much on our specialist fetal medicine midwifes to support these women and to help counsel them.

And, also, I would probably say to a certain extent the delivery suite, because now it is part and parcel of the law in this country. It is part and parcel of our practice. It’s not a new thing. We’ve been doing this for years.

So, actually, if you’re a conscientious objector, you probably need to think within midwifery- which is clearly still an appropriate specialty to come into, but you probably shouldn’t think, “Maybe I want to specialist in fetal medicine. Maybe I don’t want to specialise on delivery suite as a shift leader or a manager,” really.

Interviewer: Yes.

Respondent: Of course, coming through on your rotations, that’s probably going to be manageable. It will be like, “Well, I don’t want to care for… I can’t care for this woman.”

Interviewer: Yes.

Respondent: I’ve had issues with it, but fine.

But I would say there are other specialties- you know, they could be in antenatal clinic, or they could be on the community, or they could be on the low-risk birthing suite. So, there are lots of other areas that they can easily go into.

Interviewer: Go into, yes.

Respondent: Yes. So, I think it shouldn’t be an absolute no to midwifery. Because, actually, it’s not something that people come across very much, and we need as many midwifes as possible.

Interviewer: Yes, we do. (Laughter)

Respondent: So, we don’t want to…

Interviewer: Put people off. (Laughter)

Respondent: We don’t want to detract people from coming into the specialty. But, I honestly feel that… you know, I don’t think people should do obs and gynae if they object.

Interviewer: Yes.

Respondent: Even if they just want to… I don’t know, be a gynaecologist. It doesn’t matter. It is still- as in they just want to do gynaecology that involves what we call benign gynae. So, dealing with ladies with heavy periods, and fibroids, and stuff. It’s always going to come up, so I don’t think you should just do another specialty.

Interviewer: Yes. No, that’s fair enough.

Respondent: I know it’s not a very popular opinion. (Laughter)

Interviewer: (Laughter) That’s interesting you say that because, in a way, I would have thought maybe the reverse, it would have been the norm to think along those lines if you worked in that speciality.

Respondent: Yes.

I have another colleague who’s now a consultant, and we think exactly the same on this matter. But, actually, I would say the majority probably don’t feel as passionately as we do. But, I don’t know. I’ve not spoken to people down in [name of department] very much, or other colleagues.

But, no. I have some good friends within the speciality that are conscientious objectors.

Interviewer: Oh, right. Yes. That’s interesting.

Respondent: Yes. So… Yes.

Interviewer: That is quite interesting.

So, from our perspective, we would label you, or class you, as a non-objector. What has helped inform your views?

Respondent: That’s a really good question.

I think it’s because of the reason I became an [name of job role / title].

Interviewer: Yes.

Respondent: The reasons I became an [name of job role / title] are exactly why I would never entertain the idea of being a conscientious objector, just because it is about...

I feel no woman should risk ill health, or death, as a result of reproducing, essentially. Like, that context is just unacceptable. Like, (Laughter) we, unfortunately, are the gender that has to be the one that reproduces.

Interviewer: Yes. (Laughter)

Respondent: And that sustains humanity. Like, this is something that has just been put upon women, and that therefore should be the safest experience of your life. Do you see what I mean?

Interviewer: Yes.

Respondent: Like, it doesn’t make any sense that it should be so dangerous, and I just don’t think any woman should suffer as a result of that. And with that comes the right for any woman who finds herself to be pregnant that does not want to be pregnant to be able to deal with that.

Interviewer: Yes, choose not to.

Respondent: And, of course, it goes from early abortion for social reasons to the very late ones that we do for medical reasons; and all of that is about keeping the woman safe.

I think, first of all, if you give health to the women in your population, you then make a stronger society, you increase their chances of accessing education, and the whole society will benefit from that. If you have a healthy educated female part of your population, the whole population of society will get better, and that starts-

Interviewer: Men might be scared to... (Laughter)

Respondent: Well, yes. Well, they should be. (Laughter) And we’ve seen that over time.

Interviewer: Yes, absolutely. Yes.

Respondent: That’s how things progress. And then the health of the children improves, and the education of the children improves. So, it all goes with that. And that just becomes part and parcel of why I did [name of speciality], and offering abortion is an absolute part of that.

So, when I was younger- you know, I was brought up Christian. I went to church. I have been christened. I would say now I probably am an atheist. So, I probably don’t have any… I have had a strong religious upbringing, I would say, but I’ve also been allowed to just find my own path and… So, I don’t have a strong religion that’s maybe interfering with that.

Interviewer: Yes.

Respondent: And I imagine that must be maybe difficult for some people, and I can’t really relate to that, because purely the reasons I became an [name of job role / title] are the reasons that I agree on abortion. They’re exactly the same thing.

Interviewer: Yes. So, you advocate for the women’s rights, really.

Respondent: Yes, and that’s… Yes.

Interviewer: That’s good. That’s what we need. (Laughter) Definitely.

Respondent: (Laughter) Yes.

Interviewer: So, did you have any particular views coming into the profession- you know, before you…?

So, I can only speak from my experience. So, for example, my background is [name of academic discipline]. I’ve never worked in nursing. I’ve never experienced an abortion personally.

Respondent: Yes.

Interviewer: So, I can imagine… I have that blinkered view of what I… You know, it’s a medical procedure, or what have you.

So, I’ve never seen it first-hand, and I don’t know whether if I did see something first-hand, whether that would jar me.

So, I’m just interested to know from your hands-on experiences, have your views changed, at all, or have they been strengthened? Are your experiences-?

Respondent: I would just say that they have been probably strengthened, because it’s one of these taboo subjects- which I still find a little bit… Sorry, I would probably relate that- but it’s probably a really odd analogy, to another slightly taboo subject, which is end of life care and death. And I feel like these are the two things that doctors just don’t really like to talk about.

Interviewer: Yes, and people don’t really. (Laughter)

Respondent: But, actually- and what I learnt as a junior doctor is, these things can still be done very well, even though maybe whatever anybody’s opinion in- the desired outcome isn’t maybe what they thought, or wanted, based on your own personal opinion with regards to abortion, but it can be done well. Okay?

So, with regards to early termination clinics that I’ve been involved in, when women say at the end, “Thank you so much for making this experience not as terrible as I thought it was going to be,” or, “Thank you for not judging me,” or, “Thank you for…” Just somebody at the end of that experience- which is a horrible thing for a woman to have to go through, for them to have as much of a positive experience out of that as possible. It can still be done really well.

Interviewer: Yes.

Respondent: And I think that has helped strengthen, actually, that it is very important and it should be worked on, that we try and offer the best experience.

Because it’s the same for anybody that comes to any clinic; you want to give them the best experience possible, and the abortion bit is sort of like, “Oh, we’ll step to one side,” or like, “Oh, only… It’s down to fetal medicine to deal with that horrible bit.”

Interviewer: What do you think makes people sort of shy-? You’re not the first to mention this, but there’s… I don’t know whether it’s shame, whether it’s uncomfortableness, whether it’s because it’s life- the life issue. That sounds like I’m dismissing it, and I’m not.

Respondent: No, no.

Interviewer: Because it’s very important.

Respondent: Yes.

Interviewer: But what do you think sort of makes people shy away from talking about it, in your realm?

Respondent: I think because there are certain words that people struggle to say, and it’s just about feeling comfortable yourself with something, because if you don’t feel 100% comfortable yourself with something- or understand how you feel about something, it’s very hard to talk to somebody else about it.

Interviewer: Yes.

Respondent: So, I think people within the profession need to figure out, you know, “Well, really… I do…” They all should be completely 100% okay with it. Feel completely confident in that. And, therefore, that allows you to speak with somebody.

Even if somebody was speaking to a patient and just had a momentary pause before they said the word “abortion”.

Interviewer: Yes. (Laughter)

Respondent: There’s a really subliminal message there, isn’t there? And there are other things. Like, you know, half of my friends that are also doctors, but not gynaecologists, can’t say the word “vagina”. Literally, they’ll stop, and then they’ll say the word. I’m like, “It’s okay. It’s an anatomical body part.” It’s like, “It’s my job.”

Interviewer: (Laughter) Yes.

Respondent: But there are certain things, and I have to say…

Something I really struggled with was seeing in antenatal clinic obese women, because they would have to come to clinic to have a conversation about the risk of obesity in pregnancy.

Interviewer: Oh, yes. Yes.

Respondent: And that was just… I found it so difficult, because I was like, “Okay. What’s the best way of going about this?” And you would see people stumbling over their words, and you would be like, “Oh, try and mumble about raised BMI, or mumbling about being a little bit overweight, or mumbling about…” Again, I just needed to understand what I was going to say.

I asked a few of my friends that were overweight, or obese, “How would you want me to talk to you about it?” And then once I had understood that, I was just much more confident with it.

So, I think it’s because maybe some doctors or health professionals don’t quite know how they feel about it, or don’t know enough about it, or they’ve not had enough experience of it.

Interviewer: Yes.

Respondent: So they don’t quite know what to do, or what to say, and they just fumble over words, and they just look very, very awkward about it.

Interviewer: And skirt around it.

Respondent: I think it’s probably either not knowing how they feel themselves about it, or not really had enough experience, or exposure to it.

Interviewer: Yes.

Respondent: Which is why we maybe shouldn’t be sweeping it under the carpet as an option in our specialties.

Interviewer: Yes. I was going to say- Yes, maybe that-

Respondent: And even if you do conscientiously object, you still need to understand it all.

Interviewer: Yes, yes.

Respondent: You need to have a working understanding of it all. Yes.

So, I don’t expect you to stand in theatre and watch a termination, but you should know what the process involves because you will still see women that come in with complications.

So, do these doctors then not see women that come in with complications of abortion?

Interviewer: Yes, that’s it.

Respondent: That’s like… That’s impossible.

Interviewer: We’re short enough- aren’t we, on doctors, let alone people opting out? (Laughter)

Respondent: Yes. Yes, because these women have complications. So, you have to have an understanding of the process to then understand what complications are possible, and then how to manage it.

Interviewer: Yes.

Respondent: And if people are saying, “Oh, well. Referring them on is part of the abortion process.” Well then, looking after a woman that comes in with an infection afterwards is part of the abortion process.

Interviewer: Yes. Yes.

Respondent: And that certainly would go against anything that the GMC issues as guidelines on being a doctor.

So, I think it’s just maybe lack of exposure, and lack of understanding and confidence in how you feel about something.

Interviewer: Yes, that’s an interesting point.

So, do you think there are any limitations you would put on abortion? So, you’re very experienced, you’ve experienced social- well, as people class them “social abortions”, and then abortions later on in gestation due to fetal abnormalities.

I’m wondering, is there any limitation you would put on performing an abortion- so, a woman who comes in for her 102nd abortion, or anything like that?

Respondent: I would- as a blanket rule, say, “No,” because what I would- My own personal opinions on what I would personally do myself have got nothing to do with what I would offer her. So, no.

But I have seen women in clinic that are coming in for their fifth abortion, and I have just had to say to them, “We need a very serious chat about contraception here.” Because when you just see contraception failure, after contraception failure, after contraception failure. There are good effective methods.

So, there are times where- I haven’t said, “I will (Laughter) refuse to sign this paperwork until you come up with a better plan,” but there have been discussions along those lines. So, you know, “This is not a form of contraception. Okay? And we have options. So, you know, we’ve had very long in-depth chats about.”

Interviewer: Yes.

Respondent: At times, yes, I’ve had to go, “Okay. Well, this isn’t what I would be…” I would recommend a Mirena, or something like that, that’s going to be much more effective, and I would say…. I can think of one patient, of all of those. You know, I frequently would be seeing women in clinic who have had several previous terminations.

Interviewer: Yes, several times.

Respondent: Or, that would lie, and then I would look at their notes and be like, “You’ve actually had four.” (Laughter) But I would never refuse. No.

Interviewer: No.

Respondent: No.

Interviewer: That’s fair enough. So, there are no limitations you would put on that.

Respondent: No.

Interviewer: How about- this is quite challenging. Sorry. Sex of the baby. Have you encountered that, where people have- you know?

Respondent: Well, that’s illegal.

Interviewer: Oh, is it?

Respondent: I’m sure.

Interviewer: I didn’t even know. (Laughter)

Respondent: So, from social abortion, sort of- I would say from a fetal medicine point of view, I suppose it comes a little bit challenging as there is sort of…

I don’t think there’s any law as to what… No, there isn’t any law, I don’t think, as to what is defined as appropriate, and what isn’t, when it comes to a fetal abnormality; if that makes sense?

Interviewer: Yes.

Respondent: But I think the clauses- certainly to do with significant long-term suffering to the baby, or a significant physical problem. So, for example, in a baby had a cleft lip and that was all, we would be going, “Absolutely, no. That is not a reason, under that clause.”

Interviewer: Yes.

Respondent: But that is still open for interpretation, isn’t it? And I think that’s something I’m getting into in fetal medicine. I can see that it’s something that maybe is a little bit challenging, because the more we can scan, the more that we can pick up.

We’re going to be picking up more stuff, and I wonder whether there needs to be some kind of formal description of what is, and is not, appropriate because things can become murky.

I think from a sex point of view, that’s- to my knowledge, certainly illegal in the UK. I think babies cannot be picked based on gender, unless there is a genetic abnormality that is specific to male or female.

Interviewer: Yes, I get you. Yes.

Respondent: And then, when they have pre-genetic- So, what happens, they go to London. They have IVF. The embryos are screened, and in a scenario where- for example, I think it’s haemophilia, then the male embryo would not be-

Interviewer: Implanted. Yes.

Respondent: Implanted. It would be a female. So, only in that context, I think, is it possible. And, obviously, that’s embryo selection.

Interviewer: Yes.

Respondent: Otherwise, it would just fall under, “A woman that has had a pregnancy. It is a boy. It has a problem that affects males.” But we’re doing it because of the problem, not because it’s a male fetus, so to speak.

Interviewer: I understand. Yes.

Respondent: Even in multiple pregnancies. So, where you’ve got four, five- even triplets, or beyond, and you’re talking about selective reduction.

Interviewer: Yes.

Respondent: So, reducing the number of pregnancies to increase the chance of a successful outcome, you would never be selecting based on gender. That would just not- You wouldn’t-

Interviewer: Enter the conversation.

Respondent: Yes. You wouldn’t go, “What do you want?”

Interviewer: (Laughter) Yes.

Respondent: That just would be completely unacceptable.

Yes. So, I suppose if that wasn’t a law… Yes. No. (Laughter)

Interviewer: Yes. No, that’s fine. (Laughter)

Respondent: Absolutely not. (Laughter)

Interviewer: Have you ever experienced a woman who’s been refused care before- abortion care?

Respondent: I must have done. I’m trying to think.

Well, I suppose these women that come over from Ireland.

Interviewer: Yes, of course. Yes.

Respondent: Yes, that sort of have to email themselves. It’s very odd. Yes.

But I’ve never really had that conversation where I’ve explored that previous experience that she’s had.

Interviewer: Yes.

Respondent: We’ve always just sort of- To start off with, “Here you are,” with accepting people. “We’ll do whatever you need us to do- that’s right for you.”

Interviewer: That’s fair enough.

Respondent: Because I’ve never had that experience where I’ve explored that experience of the woman being refused care previously. Yes, that’s about…

Interviewer: Do you think health professionals and colleagues of yours, they should have the right to conscientiously object?

Respondent: I would say not within the specialty of obstetrics and gynaecology.

Interviewer: That’s fair enough. Yes. No, you’ve spoken about that before.

Respondent: Personally, yes.

But I feel that that ruling shouldn’t be to all doctors. I feel like you should actually be able to come into the medical specialty and be able to conscientiously object to abortion. But I’m sure there are probably other things that come under that remit, but I can’t think of anything off the top of my head. But I just don’t think it’s cohesive with really being able to commit yourself completely to what obs and gynae requires.

Interviewer: So, do you think it’s impossible for somebody who does object to working in obs and gynae?

Respondent: I don’t think it’s impossible, but I don’t think it’s appropriate; if that makes sense?

Interviewer: Yes. Yes. No, that does make sense.

Respondent: No, it absolutely is possible. And I suppose you’re just going through your career hoping that that situation doesn’t come up, or you don’t mind that that situation comes up because you think it’s okay to go, “No,” which I don’t. I purposely always try and ensure-

I would hope that, actually, the patient goes away from seeing me not understanding anything about my own personal belief systems.

Interviewer: Yes.

Respondent: I would hope, because I think that’s got nothing to do with it. Like, you leave whatever you’ve got at the door.

Interviewer: Yes.

Respondent: So, I don’t think it’s impossible, but I just don’t think it’s particularly appropriate.

Interviewer: Yes. No, that’s fair enough.

Do you think objectors should declare their objection prior to working in this sort of arena- obs and gynae?

Respondent: I would like to think that they should do, because it’s about your ability to fulfil your obligations as a doctor, and I feel like it maybe should be part of the screening process for... But, again- similar to midwives, we need people to do obs and gynae.

Interviewer: Yes.

Respondent: So, I’m sure the college wouldn’t- And, also, there would be a massive backlash from the college, because it would be in the context of what religious discrimination- and, you know, all of this, which is not something that the college would want to even entertain the idea of, I’m sure. But I think I would be interested.

If I was interviewing a panel of junior doctors that wanted to come into obstetrics and gynaecology, and it was between two candidates, and one of them objected, and they were identical.

Interviewer: Yes.

Respondent: Identical in every way, and I had one job. I would want to know the difference, because if one of them didn’t, then she is going to be able- if he or she wasn’t a conscientious objector, she is going to be able to offer the NHS more than the person that does object, and offer a more holistic care to any woman that’s in front of her.

Interviewer: Yes.

Respondent: So, I think it- It would be very controversial, and I don’t think it would ever happen, but I believe that it is a factor. Because it’s like, are you employing somebody that can do the whole job, or are you employing somebody that can only do a bit of the job?

Interviewer: Yes.

Respondent: And that is essentially what it is. So, I do think it should be included. (Laughter)

Interviewer: Yes. (Laughter) Oh, God. (Laughter) [Crosstalk 0:47:27].

And you’re not alone in that opinion.

Respondent: Really?

Interviewer: No.

Respondent: Okay.

Interviewer: No, you’re not alone, at all.

Have you ever been asked your position on conscientious objection?

Respondent: Yes.

So- like I said before, I worked at a previous hospital. You would get an email to say-

Interviewer: Oh, of course, yes. Sorry.

Respondent: Yes.

More from a very supportive role- and, also, probably because I’m a female but… (Laughter) Bless them.

So, in our fetal medicine unit downstairs, just before the first feticide that I was involved in and learning to do, one of my supervisors was like, “Are you okay with this?” And I’m like, “I’m absolutely fine.” And then afterwards, everyone was like, “Are you okay?” I’m like, “I’m fine, guys.” But that’s more of just being supportive about it.

Interviewer: Yes. Yes, it’s being caring. (Laughter)

Respondent: And as much as I would literally have been like, “If I wasn’t okay, guys, you should have booted me out of the door and ask me, ‘Why am I training to be a [name of speciality] specialist?’.” (Laughter)

Interviewer: I’m Okay. I’ve got my big girl pants on today. (Laughter)

Respondent: Yes, exactly.

But it was more, I think, just a quick, “You are okay with this?” I was like, “Of course I’m okay with this.” And more of a supportive thing, which was…

Interviewer: It was quite kind really.

Respondent: I know. It was. It was lovely. It was very, very sweet. But I’m just very matter of fact about things. (Laughter) But, of course, I am. So, yes, I have…

I’m sure if people don’t know me and they come for a second signature, it’s like, “Oh, you are okay with this, aren’t you?” “Of course, I am.”

Interviewer: Yes.

Respondent: So, yes. I would probably say- I’ve quite often sort of been asked throughout-

Interviewer: Yes, directly, and indirectly, in many ways, as well.

Respondent: Yes.

Interviewer: I’ve asked you that- what elements of the process should you be allowed to refrain from. But, you know, you were quite clear before.

So, there are some places where health professionals can’t be a conscientious objector, such as- I think Sweden and Iceland places-

Respondent: Oh, interesting. Okay.

Interviewer: Yes, yes.

And then there are some places like Italy where whole institutions will invoke their right to conscientiously object. I suppose there’s a religious element maybe to that. And I was just wondering what your views are on that? Would you think we, in the UK, should maybe go to either extreme, or-?

Respondent: I think we should. I would like us to say, “You cannot conscientiously object if you work in the health service in this country,” and I feel like that would be incredible, and I would be very proud to work in a health service that says that. And something such as the NHS really probably should be a leader on that because it is free healthcare at the point of access.

Interviewer: Yes.

Respondent: Well, no. It’s free healthcare. Full stop. Not at the point of access. I’ve worked in [name of country], so…

Interviewer: Oh, yes. (Laughter)

Respondent: So, it’s free healthcare to all based on need and priority, and that’s why it’s so great to... You know, why I became a doctor was because of the NHS. Like, I wouldn’t have become a doctor if we had a private healthcare system in this country.

Interviewer: No.

Respondent: And, as part of that, we should be making a statement such as that. Like, any care that anybody needs will be offered to you, you know. So, I’m actually quite interested-

Iceland and who else?

Interviewer: Iceland and Sweden.

Respondent: Sweden. Okay.

Interviewer: So, I believe- I’ve been told through this process. I didn’t know this before.

Respondent: That’s really good.

Interviewer: But I believe that in Iceland, there’s 100% abortion rate for babies with Down’s syndrome.

Respondent: Okay.

Interviewer: So, I suppose the fact that at some point there will be a point where maybe people with Down’s syndrome don’t exist in Iceland.

Respondent: Yes. Yes.

I think people will infer, that will be like, “Well, nobody can object to abortion.” That’s actually nothing to do with people saying yes or no to abortion. That’s probably more to do with whatever the social education and understanding is regarding Down’s syndrome. Does that make sense?

Interviewer: Yes.

Respondent: So, I think that wouldn’t- If everybody did abortions in this country, we wouldn’t all of a sudden have that because of the- I would say, the medical understanding, education, societal make up in this country. We wouldn’t all of a sudden go, “Oh, all the doctors will do abortions. Let’s all have an abortion.” Like, it doesn’t sort of… It definitely wouldn’t- but people would probably use that argument, wouldn’t they?

Interviewer: Yes. Yes.

Respondent: But I would like to see that happen.

Interviewer: Yes.

Respondent: I think it would never happen, in all honesty. We’ve got bigger fish to fry, (Laughter) to be honest. But I would like to see that stance within obstetrics and gynaecology, and I really don’t see why that can’t happen. I just don’t understand why that couldn’t happen.

Interviewer: No.

You said you don’t see it happening. What do you think the barriers to that happening would be?

Respondent: Probably political correctness.

Interviewer: Okay.

Respondent: And the bill would be accused of being discriminatory, despite conscientious objection being discriminatory towards the patients.

Interviewer: Yes.

Respondent: And we’ve probably got a service that works okay as it is. So, there wouldn’t be… And there are private companies that fill that gap.

Interviewer: Yes.

Respondent: You’ve got private out- you know, Marie Stopes, BPAS.

Interviewer: Yes.

Respondent: So, there’s no incentive for a government- because it would have to be a government legislation. It couldn’t be- I don’t think it could be some- The college could only make a recommendation, but I don’t think they could particularly enforce it.

Interviewer: No, they couldn’t.

Respondent: I think it would probably have to be legislation, and I just don’t- Like, the government are not going to be interested in annoying the group of people for a legislation that they don’t need because there are private companies that are doing probably the majority of the work anyway.

Interviewer: Yes.

Respondent: So, I think there’s probably- They will have no interest in it.

Interviewer: So, the current guidelines are very woolly- as I said. If they were scrapped around conscientious objection, what do you think should maybe replace that clause, if anything?

Respondent: I think I would like the college to make a recommendation or a statement on it that basically says, “In order to offer complete non-judgemental holistic care to all women in the UK, discussion of abortion and performing of abortions is part and parcel of a career in obstetrics and gynaecology.” And they would just recommend any candidates considering applying to obs and gynae, considers that in detail.

They won’t be able to say, “You can’t apply.” I would like for it to be on the application process.

Interviewer: Yes.

Respondent: So, they wouldn’t be able to discriminate against it because it wouldn’t be legislation, but I think they should ask it.

Interviewer: Yes.

Respondent: And I think as part of the training portfolio, that you shouldn’t be able to conscientiously object to the whole thing. You can conscientiously object so you don’t have to be signed off for performing the procedure. But, actually, the performing of the surgical procedure is the same as management of miscarriage. So, actually, the technique.

Interviewer: Is the same.

Respondent: It’s not an additional- Like, you don’t have to do a separate thing- only if you do advanced abortion care which is beyond 12 weeks, which one of my colleagues has done, do you have to learn additional procedures.

Interviewer: Yes.

Respondent: But, actually, we learn the same thing. So, most of us learn how to do it on miscarriage. It’s the same thing for an abortion. So, actually, there’s no additional technique that anybody has to learn, and I still feel that they can say that they do conscientiously- they have the right to conscientiously object.

So, when we review the portfolio, we can see that they’re not participating in it, but they still need to show evidence that they understand the theory behind it.

Interviewer: Yes. I suppose that’s important from a patient perspective.

Respondent: Yes.

Interviewer: Because if that person’s the only doctor available, and there’s a woman in desperate need and that life might be in danger, then I suppose you want a doctor to know what they’re doing, don’t you? (Laughter)

Respondent: Exactly. Exactly.

So, I feel like that needs to be- I haven’t actually seen what the new portfolio section is on abortion care, because it literally only came out- It came out in October, I think.

Interviewer: Yes, it’s very new.

Respondent: But I would like the college to be stronger on it, because they’re very much about complete holistic care of the woman and being able to optimise every element of her health, and I can’t opt out of urogynae. (Laughter) So…

Interviewer: (Laughter) Damn it. (Laughter)

Respondent: Yes. (Laughter)

Interviewer: So, you mentioned this before, and you talked about your personal feelings, and it’s almost like you have a professional head, and a personal head.

Respondent: Absolutely. I even have two names.

Interviewer: And you keep the two sort of separate things. (Laughter)

Respondent: At work, I’m Dr [name of doctor]; and at home, I’m… I’ve taken by husband’s name. So, I do have these two very split… (Laughter)

Interviewer: Oh, yes. But that’s a good way to have that differentiation, isn’t it? Yes. (Laughter)

Respondent: Absolutely. I get in the car, and then I’m back to being Dr [name of doctor].

Interviewer: So, do you think that the rights of the patient override the rights of the healthcare professional?

Respondent: Yes.

Interviewer: Yes.

Respondent: No, absolutely. I just think… I can’t really relate to bringing my personal opinion into the consultation, because even in something that’s- I don’t know, really mundane. Right. Let’s think of something really like… I don’t know. Should I take a painkiller, or not? I don’t know. And when patients come back and say, “What would you do, doctor?”

Interviewer: Yes.

Respondent: I feel very uncomfortable with that. And, often, I get away with not saying what I would do. Most of the time, because I say, “Okay. It’s not about me. Let’s go through all of the options again. Okay? This is the benefit and negative- you know, pros and cons of each of these options. Whatever is right for you is right for you. I will support you no matter what decision you make.”

It doesn’t happen very often, but sometimes it does happen where they say, “What would you do?”

Interviewer: Yes.

Respondent: And most of the time I have got away with not saying what I would do because, actually, that shouldn’t matter really, because I’m like, “I’m a completely different person to you. I have completely different circumstances. I actually maybe don’t know what I would do myself when I’m in your position.”

Interviewer: Yes. Yes, that’s true.

Respondent: Like, “I am not currently- say, 16 weeks’ pregnant. You are.” And I would probably say I can count on one hand in nine years the patients that have really said, “No. What would you do?” And I have had to say what I would do.

Interviewer: Yes. Oh, really?

Respondent: But that happens so infrequently.

It would be very interesting, you know, to actually watch other people’s consultations and see what happens because it’s just… Maybe it’s just the way that I am, I don’t know. But, I have never really brought my own personal opinion. I obviously have my medical opinion, but not my own personal opinion into anything.

Interviewer: No. And that’s beneficial to the patient really because- like you said, especially around abortion care, there is stigma around abortion. It’s a very divisive sort of topic and, you know, rightly so. It is about life.

So, I suppose if you’ve got somebody- you know, a doctor, who is there saying, “This is all about you,” that’s quite nice really. It’s what you want as a patient.

Respondent: Yes. And it actually makes me feel uncomfortable. I feel like, “Oh, God. I really don’t want to risk projecting what I think, that’s going to completely influence this person’s life.”

So, that’s why I have such difficulty understanding how somebody else can project their personal opinion onto anyone.

Interviewer: That’s really interesting.

I think I’ve asked everything that I needed to ask, to be honest with you- while I scoot through this.

Respondent: Yes.

Interviewer: I was just wondering, is there anything else that you want to add, or ask?

Respondent: I don’t think so. I’ve probably wittered on enough really.

Interviewer: (Laughter) No, not at all. It’s all good.

Respondent: I’m like a wind-up toy. Once you get me going on something like this, I’m like…

Interviewer: No, it was really, really good. It is. It’s really good, and it helps us.

Oh, just one last thing.

Respondent: Yes.

Interviewer: Have you ever spoken to your colleagues? You mentioned you’ve got some friends who are conscientious objectors. Prior to this, did you ever speak to them about it, or anything?

Respondent: I have actually, and they quite clearly know how I feel, but I haven’t sort of discussed it in-depth. Like, we haven’t had a little debate about it.

Interviewer: Yes. You don’t want to fall out over it. They’re your friends. (Laughter)

Respondent: Yes. No, exactly. And it’s about… You know, it certainly hasn’t been in a confrontational way, or just… I mean, it hasn’t been recurrent conversations, but certainly there has been a few moments of people saying, “Oh, well. I object for X, Y and Z reasons,” and I was like, “Well, I obviously don’t. I don’t think that’s appropriate in a specialty like this because I don’t think you can completely care for a woman without influencing her decision-making, which I think is unfair,” and we’ve never come into arguments about it.

If I had hidden how I felt about it, I then wouldn’t feel like I was being truthful; if that makes sense?

Interviewer: Yes. Yes.

Respondent: Like, “Oh, yes, yes. That’s fine. Yes.” Because I don’t think it’s fine. But they know me very well, and they know how honest and upfront I always am.

So, it’s never caused an argument. We’ve never had a heated debate about it, but I would pretty much be sure that all of them would- if you asked them, “What does [name of doctor] think about this?” They would say, “She doesn’t think conscientious objection is appropriate.” I would hope.

Interviewer: Yes. Yes.

Respondent: Yes. But, no- nothing more sort of detailed than…

Interviewer: A general…

Respondent: Yes. A general comment on a situation.

Interviewer: Yes. (Laughter) That’s fair enough.

Is there anything else you want to add?

Respondent: No, I think I’ve said more than enough, frankly. (Laughter)

Interviewer: Okay. I’ll stop this then. No, that’s absolutely brilliant. Thank you.

Respondent: Was that okay?

Interviewer: No, that’s absolutely fantastic.

END AUDIO

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