I: So, I’ve given you the participant information sheet and the main thing is really just to get a wee insight in to your role and your professional experiences and in a personal capacity….as well as – you know, both professional and personal opinions coming in to this as well. First of all, can you tell me about your role with regards to advising women who are seeking advice on pregnancy termination?

Daniel: I started working in the abortion service in 2016, so my role is to counsel and take the history from that when they come….like previous history of pregnancies, medical problems, allergies and then I go on to scan them – to see how many weeks pregnant they are and discuss with them their options as to whether they want to go for medical or surgical abortions.

I: OK.

Daniel: And then whichever they choose, we organise that. If it’s a medical abortion they go to the hospital and get done on the wards….if it’s a surgical abortion, they go to day surgery. So that’s where we stand. We get all the paperwork….consent, blood tests and then obviously a sexual health check.

I: Would you tend to see your patients through from start to finish then?

Daniel: Emmm….not the finish bit; so we see them for the consent/comms and make sure they’re fit for either of the procedures….if they’re not fit offer them something else. The medical procedure, from start to finish – from last year there is early medical abortion at home; EMAH as it is called. Maybe they might phone us to say that’s them passed and then we would see them back at clinic….they might come and get like coils fitted – that might be as you call from start to finish. But, if they go to the hospital for either medical or surgical termination, then we don’t see them as they would provide them with contraception….by the nurses at the hospital.

I: Right. OK. So, what in your opinion constitutes participation within the procedure of termination?

Daniel: Emmm….It’s right from beginning to the end. I think prescribing medicine is as important as carrying out the procedure….so I think once you’ve prescribed something that means you have agreed to go ahead and offer this person a termination – even just giving them oral tablets, or vaginal tablets….right from seeing them – from prescription right til they get to hospital.

I: OK. Can I ask what your views are – you know, thinking of the question ‘participation’ within the procedure….what are your views on that both personally and professionally? If you don’t mind me asking about both?

Daniel: Emmm….personally, we do see some really vulnerable women who feel that they are in this position just by sheer bad luck; maybe they were using contraception which didn’t work….or even….and it’s kind of very sad. Again, you do see some women who are using termination as a form of contraception which obviously is quite frustrating because you feel that you may not have provided enough information on contraception and that’s why they’re in this state. Or, they choose not to use contraception….then you can’t help much with that. Professionally, you just do the job for them to the best of your ability….with as little intervention from the hospital side; that’s why EMAH is getting more popular as clients don’t want much hospital attendance because they don’t….they have a perception they get judged – which is not the case. My problem is saying to them look you’ve been here 3 or 4 times in the last 2 years, would you like to consider some contraception….but I’m never judgemental in front of them.

I: Do you think that is of importance in your role – like helping people but without judgement?

Daniel: Yes. Yes.

I: Is that fundamental?

Daniel: I think if you give a hint of being judgemental then the whole consultation breaks down and once that’s the case, it’s difficult to engage the patient back with you and might lead them to go somewhere else….you know back to their GP if they didn’t have a good experience. No matter what your personal views are with regard to that particular consultation or patient- you must not be judgemental when consulting.

I: Can you tell me what you believe to have sort of shape and form your views?

Daniel: Just working in this clinic the past few years….emmm….initially I was never for termination….because of religious views – but now after working here, you feel that majority of the cases are as I said….you know just people who are in this state due to unfortunate circumstances….so that’s helped me to provide insight in to *my* practise and I’ve realised the best thing is to just treat everyone equally and not form any opinion. So that has changed I reckon by working with these clients….

I: Yeah. It’s such difficult times for people….so….did you have the same views prior to working here?

Daniel: I used to work in the hospital setting and the only time [to be honest] I was involved in women who were seeking termination is when they had any complications. So they were in day wards which is managed by the midwives and nurses and the only time we were called is if they were bleeding heavily. So, I kind of never had much to do with those sets of clients seeking termination. Just brief stories and most of that was complications requiring assistance. Over here in [name of clinic], you tend to get more of their social circumstances which was never the case before….so, yes we tend to be more kind of sympathetic and empathetic towards them.

I: More hands on within here [name of clinic]?

Daniel: Yes.

I: So, you’re seeing the patient as a whole….you think it’s different then?

Daniel: Yes….as I said we get more in to their social life and more in to their medical life. So that way, it’s good to get to know more about their circumstances in seeking termination. In hospital it was hands on just when things went wrong.

I: Would you say from personal experience, there is a difference from stepping in in an emergency situation compared to helping out when the person wants a termination for whatever other reason.

Daniel: Yes. I see that because in hospital setting, I think you are more of a clinician with a robotic mind who’s just going to the ward because of an emergency buzzer or someone has asked you to come and see someone who’s bleeding more than they should be….so you’re going there to treat this person and you never ask them about their social circumstances….what has been happening – you might just ask how much medication they had….it’s the intervention you may be doing….like IV drips and things like that; checking haemoglobin and things….so you are treating them more as a patient. But, here, I see them right from the start….sometimes they break down, they can be quite upset about termination. There was someone last week who said her partner has tried to kill himself at least 3 or 4 times because of a nervous breakdown – so she said even as much as he is delighted I’m pregnant, I cannot do this….for my sanity. It was quite….you know….getting involved in their social circumstances, you get to know what exactly they are going through rather than in the hospital setting where it….emmm….

I: So here, it kind of opens that vision up? You think you get to see more aspects of that person’s life?

Daniel: Yeah.

I: If I said the term conscientious objection….what would that mean to you?

Daniel: I think it’s more to do with mostly religious views which obviously some of my colleagues have….but I see this more as a service we provide and I see it as a way of helping them because an unwanted pregnancy might affect them – emotionally and financially; so we are helping them.

I: Have you ever experienced CO first hand? With other colleagues or even yourself at any point in your career….have you ever had direct experience of CO?

Daniel: Not….me as a patient….or….?

I: Like, say if you’re treating someone in the hospital setting, was there ever a time you objected to taking part in the procedure at all?

Daniel: I haven’t, but I know of colleagues who used to and that is why I used to be called to….like sign certificate….

I: How did that make you feel? As it were, like having to step in and take responsibility for a case because somebody objected to treating that patient?

Daniel: It was fine as long as that work was done….if not by them, as long as I was completing it – I don’t mind it; I still don’t mind it. I was doing vasectomies and someone came down to say there was no doctors to sign it – that’s only going to delay things….especially now with EMAH….it’s better they get sorted and go home today rather than wait and makes things….like they can’t get tablets til all the paperwork is done and signed….

I: Yeah….what would you identify then as limitations to CO?

Daniel: [Pause]….I don’t get that question….

I: OK….it’s maybe….I think if you haven’t conscientiously objected, it might be difficult to put that in to perspective, but if somebody on your team did conscientiously object….what do you think might affect that? Like what might impact on their decision….does that make sense?

Daniel: I think most of the time it’s religious….reasons why people raise that. I haven’t come across any person who just refuses to get involved because of the fact it’s going to impact on their conscience….what I have seen, most of it is down to religious views….and that is all I have seen….I haven’t seen anyone say no I don’t want to do it because I don’t believe in termination….I haven’t come across that. I have seen colleagues who’ve said I don’t want to get involved purely because they want to escape from doing the job, but that was just in the hospital setting, not here.

I: Right. OK. How did that make you feel?

Daniel: Well the thing is, I can’t challenge that because they are my colleagues….you just keep quiet. The thing is it’s their views. Some people have told me it’s their religious beliefs and you can’t challenge that because you’re going to….you’re not going to get anywhere with that….you know it’s not their religious beliefs because you know happens in that religion but you can’t challenge because everyone is different.

I: Have you ever had staff meetings, or maybe within reflective practise, have you had the conversation as a team about CO? Has that ever been an issue raised?

Daniel: No….no.

I: You don’t feel it’s spoken of very much?

Daniel: No….

I: No? OK. Do you think it would make a difference if the subject did come up within meetings, or in particular within reflective practise? If there was a case that maybe stood out….to use as an example in a staff meeting to speak of the subject? Would it make a difference to highlight….?

Daniel: It can if the outcome of that was not good for the patient or for the service….that maybe the reason why it would be raised in reflective practise….best thing would be to learn from that experience and to step in if someone else has raised a CO to signing or prescribing and we could look for alternative ways for us to help out the patient.

I: Yeah. Is there anything else, looking at the subject as a whole, that you think I haven’t covered? Anything you might like to add?

Daniel: Eh….not much, no….as I said the only time you feel frustrated is when people use termination as a form of contraception and to be honest, it does happen quite a lot and it’s on the rise amongst folks….but again, I don’t know how best we can manage that….deal with that.

I: Do you think that as a society with various different backgrounds and cultures….there’s huge….we are very diverse now, so do you think that education plays an important part?

Daniel: Oh yes, definitely. It starts right from grass roots….growing up, in schools and that is very important to teach this to younger kids….

I: From an early age?

Daniel: Yes, yes. I can understand where accidents can happen but to use that just as a form of contraception, you know it is morally not right. I have seen a lot of people who have come back….not in the near future who have maybe by 5 or 10 years down the line that maybe have had that in the past….That’s what I say to clients, it might be fine now….but it’s going to impact on or can have an impact on your psychological health in the future.

I: Do you think that counselling is important….or the option of counselling?

Daniel: Yes, we do have a form to refer to the counsellor and there are people who actually ask for counselling….we have sent some of the really bad ones who just can’t get to terms with it….we send them right up to the counsellor [on the 2nd floor here].

I: OK, yeah….I really appreciate your honest answers. Looking at the 2 main questions of this study that we hope to answer….what do HCP’s understand as constituting participation in abortion and also which elements of the abortion process should HCP’s be permitted to withdraw from on grounds of conscience?

Daniel: With regards to the 2nd question, which elements could permit to withdraw on grounds of conscience, it can be anything because if you’re prescribing [medications] and physically not administering it….you have still participated in it and if you are involved in giving medicines or doing surgery you can withdraw from all of them….seeing them initially and scanning them….probably with scanning and finding how many weeks they are….then that leads to them making a decision on what they want, so….eh….yeah I feel prescribing and administering are the main part in it.

I: Sure….OK….that brings us to a close then if you don’t wish to add anything else?

Daniel: No….

I: Thank you so much for taking the time to speak with me.

Daniel: No worries.