I: You’ve read you participant information sheet and signed your consent form, so are you happy to go ahead?

Dana: Yes, no problem.

I: OK. So, first of all, can you tell me about your role regarding advising women who are seeking advice on pregnancy termination?

Dana: Yep. So I work at the abortion services in [city]. My role as a doctor would be to speak to the women, have a consultation to find out how they’re feeling about being pregnant….to scan them to see how pregnant they are and to find out what they want to do with the pregnancy and if they opt for an abortion, then facilitating that for them in terms of prescribing medication and signing the certificate in line with the 1967 Abortion Act and I would follow up with information on contraception….a follow up plan and just checking for other things like gender based violence that might be going on….safeguarding things and making sure it’s the right thing for that person whether they need any extra counselling support – giving support and maybe get them back for any other appointments. Just in my day to day job with people who’ve had an abortion – just accessing health and I also perform surgical abortions as well. So I do that for people….maybe not so much with women themselves but I work lots with education on abortion care. At the minute in [University], abortion education was removed from the curriculum….

I: Really? When was that?

Dana: Well we only really discovered about 2 to 3 years ago so I’ve been working quite hard with the university making sure that goes in to the curriculm….so as of this year, they have mandatory education that goes in as of year 4 and 5 in obs and gyn block – so the university has given me 3 hours and with that I can go through the law on abortion and basically how that affects a health care professional….emmm….complications of abortion and worldwide as well. We look at Northern Ireland as well because there’s a lot of students from Northern Ireland who don’t understand the difference of all of the laws so we break that right up actually and then we do about an hour and a half role play so we discuss how we do unplanned pregnancy consultation and if you have a conscientious objection how you would manage that in a respectful way. A student gets to think about if they did have an objection how they would deal with that and also people who maybe don’t have objection but realise that some of their colleagues might….how they can manage that and support colleagues with that.

I: Yeah….OK….you think that’s really important?

Dana: Yeah. That’s taken me about a year of really solid hard work and it’s in the curriculum as of this year….

I: Fantastic

Dana: So there must be about 120 students now I’ve managed to get – it’s now compulsory in education and its examinable content.

I: Amazing.

Dana: So it has been really good and we’ve been able to present that work to Scottish abortion care providers and there’s now talk of it becoming mandatory in making a medical syllabus for the UK so that’s going to be part of the work that goes in to that.

I: That’s excellent.

Dana: So, yeah….I do lots on abortion.

I: Yeah and lots of hard work sorta behind the scenes….

Dana: Well yeah and thinking of who will provide abortion care to women in the future – we know numbers of doctors are going down that are participating in abortion….I think it’s really important that we support the next generation of doctors that actually want to be involved in abortion care.

I: Well you have actually answered my next question here….how do you feel about it personally? I think by how passionately you speak about it being introduced in to the curriculum again – am I right in saying you feel really strongly about having a strong education on the subject?

Dana: Yeah. I think that’s what the GMC would say….that’s what tomorrow’s doctors coming out say….all of the education in the syllabus and the curriculum are that doctors should be able to manage women who have had an abortion regardless of your conscience and they have to be able to manage the complications and I don’t think you can manage complications by not having an understanding of everything else that could go on for that person.

I: Is that because there are many reasons for terminations?

Dana: Yeah….it’s not just 1 reason and even regardless if you don’t feel comfortable with that fair enough….but you need to know the treatment process – the medical treatment; it’s a medical procedure at the end of the day and 1 of the most common medical procedures in gynaecology – so to come out of medical school with no education on it I think is appalling. That’s why it had to come back in and that’s why the RCM would say….

I: So am I right in saying that you think education is key here?

Dana: Oh yes, totally. Definitely. It is key and I think it’s really lacking in undergraduates particularly because we’ve looked at what [name of city]do what [city] do and [name of town]….they all do bits but it’s not that in depth. Now [city] has a lot and the other universities are starting looking at their undergraduate education. I don’t know how much goes in to nursing - how much nurses get exposure on and I think post-graduate education is just as bad really….that is my gut feeling. I’m being really honest here….

I: Ofcourse and that’s what I want….

Dana: I suppose my speciality is community sexual and reproductive health, so it’s quite a new – well it’s not a new speciality as such, but for people in my job who qualified maybe about 10 – 15 years ago went through the obstetrics and gynaecology route….and they went and did their training in communities and moved in to the community and maybe about 7 or 8 years ago, there was new speciality formed called community sexual and reproductive health which was run quite similar to obs and gyn but abortion care comes in to my curriculum and it’s a lot more heavily weighted in my curriculum….it’s not compulsory and if I have an objection I don’t have to do it….but I think in the UK that’s why there’s been a big shift….in people in obs and gyn wanting to participate in abortion care – because *our* speciality is now about and also in obs and gyn there’s so much more stuff seen as exciting stuff in the curriculum….than spending time and wasting a clinic on running through abortion stuff as they would see an outpatient clinic as maybe not as exciting for them and we just know by the numbers of people coming to [name of clinic] from [city][uni]….there’s not really any teaching or training here. Again, I’ve been trying to get stuff in to the post-graduate system as well. I think people see conscientious objection as a bit of a get out clause ‘cause it takes out a whole host of stuff that you need to be able to do and retain competence in and if you tick conscientious objection, that gets you not having to do it.

I: OK….

Dana: I don’t think it’s like that for everybody, but for some people it can be a way out.

I: What in your opinion constitutes participation in abortion?

Dana: I could tell you it from the law and things….I think it’s quite difficult actually especially when I started looking through this for the undergraduates….what the GMC guidance says and what the Abortion Act allows you to opt out of – it’s quite wooly! Certainly if they don’t feel comfortable prescribing the medications then that’s 1 of the things. If they don’t feel comfortable with the actual surgical procedure then I suppose you could object to that. I find it very hard and this is my personal opinion….how anybody can refuse to see somebody who’s having unplanned pregnancy and be able to talk them through the process of continuing with having an abortion – maybe not doing anything with regards to the abortion….but being able to talk someone through the process and then showing them where they can go to get help. Whether people see that referral as something they object to – referring them on….but a lot of our services are self-referral now; but directing someone to a phone number – is that then procuring the abortion act? I find that really hard that you can just say I’m not having anything to do with abortions and I don’t want to speak about it. If that person wanted any other hospital procedure, you would need to talk them through those things – pros and cons….that’s personal, that’s *totally personal* and I think that people should be able to have an unplanned pregnancy consultation and discuss what their local services are in their area and if they don’t feel comfortable prescribing medication or doing the surgical abortion procedure, then that’s their right and that’s what the law would allow them to do which is fine and I need to respect that….but delaying an access in to a service that can help them – I don’t feel comfortable with that; but that’s personal.

I: I understand.

Dana: I don’t think the law is very clear on that.

I: Well I was going to come to that….and ask about what conscientious objection – what that term means to you?

Dana: I think it’s a term that’s changed for me as its not black and white but I used to think of it as black and white….I know there’s been guidance brought out in the faculty and I always say to the students it’s like you’ve got a big line and you’re not at 1 end of the line or the other….you can be somewhere along the line and I think that’s really important to speak to people about because I think there might be times in a person’s life where they just don’t feel that certain bits they’re comfortable with yet other bits….and….yeah, so I think it’s a very varying degree of your circumstances and I think you have to be very aware of your circumstances and then be vocal about that to whoever your line manager is….maybe say I’m happy to do a surgical abortion up to this point, but after that I don’t think I could do it because of X number of reasons….but making sure that person still gets access without….emmm….

I: Being able to signpost timely?

Dana: Yeah….get somebody else to help that person.

I: So are there a lot of different factors that need to be considered? Am I right?

Dana: Yeah….I definitely think so. I don’t think you object to it all or accept it all….I mean I know people who are at varying degrees of where they sit on things in terms of gestations and I get that. I get that different things happen in your life and you just mightn’t be able to do that at that point – so I suppose just making sure that you yourself are aware that that’s what’s going on for you and you can’t do it at that time for your own reasons. I suppose that’s why the law is there to help actually. I just don’t think it’s there for people to basically say I’m not helping you and you’ll need to book an appointment with somebody else and it’ll take you 6 months….

I: So do you think it should be made clearer then as far as the law goes within that clause of the 1967 Abortion Act?

Dana: Yeah. I’ve read it and read it and read it and maybe I’m just not reading it right or properly but it does say about the procedure and signing off the form and the medications but it doesn’t say anything about refusing to be able to see patients and have a consultation….is my understanding of it. That’s me looking at the nitty gritty because I was quite anxious probably about doing the teaching with the university students and being aware of all the people coming from different places and I was trying to be PC you know?

I: Yeah. I understand. So, have you experienced conscientious objection within your practice, like, emm….have you….

Dana: Well, yeah….so I’m Northern Irish which in Northern Ireland we don’t even have the Abortion Act because women can’t access abortions, so I suppose from a personal point of view, I’ve got a lot of colleagues back in Northern Ireland who wouldn’t do abortions even if they could because that’s just not in their comfort zone. That’s a whole other minefield of politics and religion and everything else.

I: Do you think morals are in that mix as well?

Dana: Yeah. Morals and people maybe not getting - never leaving the country to see what actually goes on in the real world and actually listening to women’s stories about what has actually happened to them. I think that’s so powerful. If some people could hear what goes on in the real world they actually might take a different stance on it but some people are just blind to it.

I: Do you think judgement comes in to it aswell? It’s just that it’s interesting to hear you say that *listening* to stories – every case is individual and there can be loads of different things….do you think not being exposed to these stories….do think this is forming judgement then?

Dana: Yeah. People living in their perfect world maybe don’t even realise that there’s a lot of bad stuff that can happen to people. I think religion, to be fair….probably a lot of colleagues back home [friends even]….it can be a religious thing for them. Again, absolutely fine….that’s maybe more of a personal thing and we didn’t have the Abortion Act. From that working perspective, yeah, I have worked with colleagues who have had conscientious objections – have I ever had any difficulties? Emmm….not so much. I think when I worked in the hospitals people knew quite quickly if you were or weren’t an abortion care provider. If you were then you were the 1 people would come to for the certificates and signatures and medications, or to go down and cover the clinics. There were colleagues who maybe weren’t and refused to go down to the clinics so you knew that.

I: Do you think that puts pressure on non-objectors?

Dana: Mmmm….definitely. From a training point of view too….definitely. You can have a whole module that’s just removed from the curriculum; whereas if you don’t [object], you are adding to your workload. You have to get your competencies and maintain that, surgical procedures, etc….so….yeah. When you become a Consultant though – the people who are conscientious objectors should take a bit of weight in other respects to free up clinicians who are willing to participate – to balance it out a bit.

I: I understand.

Dana: I know some people who would refuse to do Mifipristone, like signing in certain circumstances….but did that ever hinder the patient….probably not as they were able to find someone who would. In a busy hospital I can see more issues with that….

I: Yeah. Picking up on what you said about being quickly aware of peoples’ views and where they stand….were there meetings about that, or was it just a case of chat?

Dana: Well our faculty guidance say to be open about it….you don’t tell the world, but your supervisor should be aware….

I: And within your team

Dana: Yeah….although in a hospital setting….maybe about 7 or 8years ago, I think I probably did speak to my colleagues about it; but would I challenge them? Probably not. If you want to get training on it and learn, then you just get involved if that’s something you’re interested in.

I: What would you identify as limitations to CO?

Dana: Emmm….

I: Like, what would stop someone from conscientiously objecting?

Dana: I think it’s so important – I say this to the medical students….regardless of your view, sit and listen, see what happens, you’re not actively participating, but you’re listening to the structure….from an education point of view, it’s so important – just listening to some of the stuff that goes on for people. That’s 1 of the most powerful things that actually is listening to women’s stories….

I: And being open to listening?

Dana: Yeah. Not judging but just appreciating what can go on….that’s really important. People being aware of what the limitations of being a conscientious objector are and….well if somebody is bleeding to death you need to go – even as a result of abortion, you can’t say I’m not going to help because that was an abortion; you have to be very aware of limitations and certainly I’ve never worked with anybody where that situation has happened. I’ve heard of things like that happening, like people saying they’re not going to help – but that’s against the GMC regulations. I think that’s really important….people should be aware of what the limitations of being an objector are rather than what could sway people in to the way of [inaudible]….I think education and making people realise that it’s not just a clinic and it’s not just giving out medication and contraception….there’s so much of it that is an enjoyable part of the job. People always think it’s quite gloom and doom but actually it’s really enjoyable and I like it.

I: You see it as helping people?

Dana: Yeah. Probably….and this is personal….I suspect that a lot of people who don’t want to do it are more interested in the surgical things and that gets them….but just listening and being involved is really exciting and also just other stuff like initiatives and things like that is a specialty. Some people think it’s quite a depressing specialty but it’s actually exciting….well *I* find it exciting.

I: OK. Yeah. Can I ask what do you think has helped you to form or shape the views that you have?

Dana: Probably I put a lot down to being Northern Irish and being a woman who has….pays the same taxes in the different countries and yet don’t have the same rights as somebody in Scotland, so I grew up in Northern Ireland….I didn’t have the right to an abortion; I couldn’t access it. Whereas someone of my age, exact same circumstances up in Scotland and part of the UK had access to it! That really pissed me off….like *why* is that….it shouldn’t be and Northern Ireland has spent all of its years trying to be part of the UK….fighting for it and yet we….that’s 1 of the things I find difficult to….I find it really hard. It’s such a taboo subject in Northern Ireland and that interested me – because no one spoke about it and at university I thought I’m going to get interested here and I found out it was really important, so….that’s a massive part.

I: OK. This is quite a personal question which I hope you don’t mind me asking/

Dana: No

I: Do you think that’s 1 of the reasons why you moved here [to Scotland]?

Dana: Yeah. Well to be honest, I didn’t get the grades for medical school in Belfast but would I have wanted to? NO! I wanted to get out of the country as it was very narrow minded, so it was good to get out of the country and move to Scotland. Still quite close by….definitely I’ve learned a lot more about the world. My colleagues back in Northern Ireland who’ve never got out of the country are like….well just the exposure to other cultures….Northern Ireland is too religious, it’s not….you get the odd like Chinese person….it’s very 1 way or the other. Whereas when I went to university I discovered this whole new world….different cultures, languages, interests….

I: Very diverse….

Dana: In all the different cultures there’s lots of other stuff that goes on and it’s really quite difficult….you know learning about trafficking and lots of other stuff that in Northern Ireland you think it doesn’t go on….but it definitely goes on.

I: So that brings me then to asking if you had the same views prior to becoming a consultant? Have your views always been the same? Or do you think they’ve possibly become stronger?

Dana: They’ve got stronger. So, I had a baby 2 years ago and….this is around the time we were talking of CO and where you lay on the line and in my head I thought would I feel as strongly for abortion care while having a baby….and I felt stronger I think because you realise how much hard work it is and people in early pregnancy….feeling really sick – how awful that is for that person when you don’t want to be pregnant….I think it probably pushed me to be more – and all the education stuff I’ve got going. I thought it might have swung me the other way but that was just me thinking maybe what should happen….

I: It’s very personal

Dana: Even when I was heavily pregnany I was still more than happy to….personally I didn’t have any problems in getting pregnant – I didn’t have to have IVF or anything and I wonder if that happened or if I’d miscarried or something like that would change views….would personal circumstances like that have changed it….I don’t know. Certainly my views have got stronger and I think it’s rubbed off on my family back home who had quite narrow minded views….I’m thinking actually this is really important.

I: So even with your parents?

Dana: Yeah because I want to make sure they’re aware that’s what I was doing….we do a lot of work – research where your name gets put up….plus with abortion, the more people who make it look like it’s something *bad* the more it’s stigmatised and this could be your potential friends….so I’m open about it all.

I: You’ve answered everything and it’s your story. I really appreciate you taking the time to tell me. Is there anything else you think we haven’t covered?

Dana: I think it would be very interesting to see what patients’ opinions are. Finding out what the public think….you know, are they aware that doctors can have this CO….and how do they feel about that? Do they feel we should be allowed to or not?

I: Again, then, educating the public as a whole?

Dana: Yeah….also more to protect the public because if they have a clinician who’s being obstructive – then letting them know that the law doesn’t let that happen….so that’s more just about the public because there’s no other area in medicine where you can have CO. I say that to the medical students as well….it’s very hard doing it in a balanced way….

I: It’s the same for researchers – balance is important. But you mentioning about raising public awareness….that’s really interesting. So, is there anything else you can add?

Dana: No I’ve just gone on….

I: No, you’ve been really insightful, so thankyou.

Dana: No problem.