**Damien: 23/7/2019**

I: So, you have read over the participant information sheet and you are happy to go ahead?

Damien: Yep, sure.

I: OK. Keeping the subject matter in mind then, can you tell me a bit about your role with regards to working with women who are seeking pregnancy termination?

Damien: Well, I am a Consultant Anaesthetist and Intensivist and in the anaesthetic role we cover surgery, so like gynaecological lists. Now, eh certain hospitals work from lists – like the hospital I’m in at the moment tends to slot the ad-hoc things on at the end of the day or weekend lists. So there are occasions where, eh….sometimes they might not appear until the day of surgery on the list….you know like any ad-hoc things….eh some additions to your list are terminations of pregnancy.

I: Right, OK. OK. So is it right then to say that sometimes you could go in and you might not know what you’re going in to that day?

D: Well normally you would have an idea in advance – you’ll usually know you’re covering a gynaecology list but you might not necessarily know everything that’s on the list and things can get added on the list at relatively short notice.

I: OK, right I understand. So if I say to you the term conscientious objection, can you tell me what that means to you from your point of view?

D: From my point of view CO means that although the service is available, you may have a personal objection to taking part in that for moral reasons.

I: OK. Can you expand a wee bit more on that? Like what would the moral reasons be; if you can have a wee think about that?

D: So, the moral reasons would be that there is something involved within that particular case – if I find that my action in it would cause me to do something that wasn’t morally acceptable to me. It would be a personal decision based on my own morals which can be brought about by my own philosophical stance; can be religion too. It would be a sort of recognition that this is for something to be a moral matter I would feel the need to think about it in terms of CO….I feel I recognise that there is a service there to be provided, but by participating in that, that would cause me a moral sort of eh question that might make me believe that I wasn’t doing the right thing potentially.

I: OK. Yeah, I understand. Is CO something you’ve experienced? Let’s put it in terms of pregnancy termination….let’s say there is a case where you’re working with a woman who is terminating a pregnancy….have you ever had direct experience of that? Have you ever conscientiously objected to that procedure?

D: Yes.

I: OK. Have you also come across it with other colleagues as-well?

D: Yes. Within our department, I work with people who will not perform abortions and those that will perform abortions. What normally happens is if there is an abortion that comes on the list, the person will do the list up to the point of the abortion and then will swap with another anaesthetist.

I: Right, OK.

D: It is a fairly standard procedure from the anaesthetist point of view, you know it doesn’t really require any sort of specialist input….you know like specialist knowledge or anything, its basic generic skills.

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

D: For me it would be direct involvement within the procedure itself – you know direct provision of anaesthesia for that specific procedure. It would not preclude me then if I was asked to see a lady after that….for post-operative pain or anything like that. For me, it would be specific to the procedure itself. From my point of view, after its done – from a moral point of view, if the woman was represented like for further anaesthetic advice or….I would say OK. Things have been done, so we just move on, it’s the actual procedure itself….

I: OK. I see what you mean….so basically any after care or any care sorta leading up to as-well?

D: Well, as I’m not actually anaesthetising her, so the care leading up to, I wouldn’t be involved. We would leave that to the anaesthetist that was actually going to do the procedure. In the same way if a surgeon was consenting somebody for a surgical procedure – not necessarily an abortion, but a surgical procedure, we would expect that the person doing it would be doing all the pre-operative work too….

I: Yeah, I understand. So, what do you think would be possible, or what would you identify as limitations to CO?

D: I think it would be very difficult to justify CO where there was a life at stake – like if it was an emergency and the life of a woman was actually at stake….from that point of view. I think it is a very grey area when it comes to more ancillary roles, so if you’re not involved in the procedure directly….you know like the pre-care, after-care, I think that is quite a difficult and grey area. It’s a strange parody. I remember thinking about it with the midwives at the [name of hospital] – the [name of place] case because there was part of me that thought I couldn’t really see their point as they seemed removed from the bits….

I: The actual procedure?

D: Yeah….but, I hesitate to use it – this analogy, but they prosecuted at Nuremburg – the accounts from like the cleaners from the concentration camps, they didn’t have anything to do with things directly. They weren’t involved in the killings and things like that – they were morally seen as culpable in part of a regime and involved and from a societal point of view they are the baddies. When the [name of hospital] case was going on, I struggled – even as somebody who objects to the procedure itself – I do still recognise the autonomy of women to seek this service and this service has been approved for things as a recognised thing and I did struggle to see their role within it. But, if you can draw parallels with what happened in the concentration camps, maybe for them, morally they felt themselves as culpable.

I: Yeah, I know the case so I completely understand your viewpoint on that. Can you tell me, you know your belief system you have as professional, taking that to more down a personal route now….did you have particular views on abortion prior to becoming the professional that you are today?

D: I do reconcile my professional career through Catholic education – you know born and raised a Catholic and I think it starts with like high school – though very simplified view of abortion in as much as it seems wrong and that’s….we were taught it was wrong. In the same token, I grew up in a house where my mum was both pro-abortion and then become anti-abortion – my mum was a ballet dancer in the 1960s and 1 of her close friends nearly died from a back street abortion, so she can remember seeing the original – when the Steele Bill came through, despite being a Catholic and being married in to an Irish Catholic family, she was very much in favour of abortion as she had seen what happened….

I: Yeah, personally, yeah….

D: When abortion was not available….you know doing intensive care and anaesthetics, there’s a pragmatic part of me that says people will do what they’ve got to do and you’ve got to try minimise that harm that can come from it. I think it’s difficult as-well as a man to have this idea because essentially there’s no question about the autonomy over my own being in body, whereas with women, some people feel they lose a degree of their autonomy when it comes down to when they are with child and pregnant. So the idea that 1 person should have more right to autonomy than another is difficult when you’re dealing with 2 adults….like 1 person’s life is worth more than another and then when you take that to the level of an unborn child or a collection of cells, it does seem quite strange. That being said, is it maybe an argument to personhood? Is that the most important thing….actually could I justify to myself – thinking in terms of abortion….backtracking a second….if you think of the way abortion is at the moment, there’s an time limit and that in itself is the best thing that we can come up with at the moment, but the time limit thing will be subject to changes in technology anyway because as we push neonatology and neonatal intensive care forward, viability moves back and back further and you’ve also got artificial wombs that have been used in sheep and things, so to have a time based thing might work just now but it doesn’t seem a philosophically sound way of looking at things. So the idea then that a woman would have control of her own body and the autonomy to make decisions is then the idea how you would define personhood….if you go down that route saying abortion is OK as its only killing if it’s a person….the trouble for me then is trying to come up with a useful definition of what is and is not a person. I can quite easily then try to apply a criteria and come up with lots of scenario in neonatal intensive care where something is already born even up to the age of 2 or 3 that isn’t really a person, but I feel would have rights and should be protected and things. I definitely couldn’t bring myself to perform infanticide as such and therefore I would struggle to find a simple point in the foetal part of things and I think you couldn’t really run a service where I can look at each individual case and go I can do your abortion but can’t do your abortion, I can’t be making judgements so maybe in some ways it becomes easier to default to this system, but it is something in some ways I struggle with overall because I can see the reasons a woman would choose to have an abortion and why I should not have any say in that but by the same token in respecting that woman’s autonomy, I think she has to in some ways respect my autonomy in that I’ve given things a lot of thought and unfortunately, this is the best way at present that I can reconcile my moral stances and moral difficulties. I wouldn’t make any judgement as such in that women’s abortion rights should be curtailed or that. I wouldn’t go out protesting and try to stop things like that – I can recognise someone’s right to autonomy but they should also be able to recognise mine and understand the matter as-well.

I: Yeah, that’s really interesting. Have you ever came up against any like barriers to you putting across your point of view as to how you feel? You know you said before that some anaesthetists would step in and the list would be split – so that person wouldn’t conscientiously object. Have you ever had an instance where it’s been a problem at all?

D: No as such as it’s very much procedural we do have in general 2 day surgery theatres and 9 general theatres and abortion where there may lots of grey areas and difficulties from a law point, but from an anaesthetic point of view it’s pretty straight forward. We have always managed to swap lists.

I: Would it be fair to say then – I was just wondering if a commonality thing is then that there’s a sort of team ethic? Your views are known and respected? Would you agree with that?

D: I would certainly say yeah your views are known and most people either don’t have an issue with it and do it - or have an issue with it and don’t do it. I don’t know of anyone who would not wish to do it but feels overall pressure or obliged to. Certainly from the anaesthetic side of things as it is very much come in and give it and leave. We’re not involved in the scheduling of things in the procedure you know – it tends to be as a rule it’s young healthy women who go for abortions, it’s not difficult challenging medical cases that need [crosstalk]….

I: Thinking about that, sorry go on…..as you’re talking it’s just come to mind there that if a woman was experiencing a loss, due to complications – you know she had no choice but to have a termination - have you come across that at all?

D: Do you mean as in she’s already miscarried?

I: Well, yeah that and also if there is something wrong with the baby and it’s been advised that the pregnancy shouldn’t continue….

D: From that point of view, as anaesthetists we don’t actually go in to the reasons for the abortion it’s just taken as a very procedural thing. As a system stands currently, by having CO/opt out it’s a blanket and it means we don’t go in to these things so it almost allows you not to – you’re making a moral decision on your own part – not a decision about what the woman is doing you know like the correct thing or not….we just say like there’s 2 coming on to the end of the list and we don’t do any more about that and the anaesthetist that is assessing the woman may ask about her medical history, as that would affect the anaesthetic but they won’t actually enquire as to the reason she’s having an abortion.

I: Yeah, I understand.

D: The only way that would come up is if she’s having the abortion because she’s been advised for her own medical reasons – she’s maybe got congenital cardiac disease and is ill with it – something physiological that would actually affect how the anaesthetic was given. Other than that you wouldn’t go in to the reason for that….for the abortion from a foetal point of view….

I: Do you think all this said that within the 1967 Abortion Act, the clause within that CO – do you think that we need more clarity on that?

D: Yes and no [laughs] I think medicine works really well sometimes because for these things there isn’t clarity and when you produce a sort of legal standard of clarity, things become very black and white. If we move away from abortions just now and talk about end of life care, say intensive care at end of life, when I have had discussions with lawyers and things – they get very frightened about the amount of grey area and uncertainty that’s in things and sometimes for medicine to actually work, you’ve got to have that slight grey area because if you over clarify things, from my point of view, in a non-emergency situation….if someone said to me this woman is dying and she’s going to die unless she has an abortion, that would be a rare case – I wouldn’t be able to justify my own moral stance there – you would be working towards trying to make an awful situation….if the woman dies the baby dies so it’s trying to make 2 awful things only 1 and a bit….but for the other things, the way things stand at the moment it allows me to think I don’t need to make a judgement from a moral point of view on someone’s reasons for abortion. It keeps centred to me morally what I’m happy to do and not to do….it doesn’t make me judge what the other person is doing if it’s right or wrong.

I: OK. That makes sense. Your chat has been great and I really appreciate you sharing your views with me. Finally – is there anything you think we haven’t covered and might be relevant or do you think your views have come across?

D: I’m trying to convey that I ultimately don’t really know what the right answer is here….

I: It’s so complex….

D: It’s huge….I’m trying to elude to the whole idea of personhood and things like that – I can justify – I could justify from an autonomy point of view, you know….or from the woman’s - doing an abortion if you had this argument to personhood, what she’s carrying isn’t a person and therefore doesn’t have the same rights and/or experience, but the it’s relating that to the rest of my practice….like dealing with severely brain injured children and you know….to the far end of the scale to my older demented patients….it’s a question of if you’re going to take things from a personhood point of view as to what make things right or wrong….it could be a sort of involuntary euthanasia for people who are demented and may not be classed as a person as such and that maybe – maybe my CO within these areas is a bit of a cop out for me because I don’t have to….take the logical view and put my personal stance out to [inaudible]….at the end of the day, it’s something that makes….it gives me some uncertainty and a lot of moral anguish and while again, I can ultimately respect somebody’s decision to have an abortion, I can….they should be able to respect my decision not to participate on the matter particularly when I genuinely have given this quite a bit of thought….

I: Absolutely….

D: I think that’s where I am and also this idea of what would I count as direct involvement….maybe that’s different to with what someone with militant strict kinda views – like the argument with concentration camps and things….it’s very difficult to see where the line of responsibility ends and for me it might be 1 thing but for someone else it can be different. The other thing I wondered if you were going to ask is if a soldier can’t kill can he be a soldier?

I: Well yeah….I think with this subject matter, what we want to get across is that it is very personal and whether it be your own pre-understandings or your own experiences….just like what you were saying about your mum. There are so many different things to take in to the mix here….and this is what makes it such a complex thing….people should be allowed their views regardless as to what profession they’re in. Those views should be respected, shouldn’t they?

D: Uhu….I think that’s it. I didn’t go in to medicine to be a sorta A-moralist procedurist you know….the whole idea of a medic has to behave ethically; you know we have autonomy, malevolence, non-malevolence, injustice….and things and everyone sorta trumps autonomy but if the only important thing was the patients’ autonomy then there would be no need for medical ethics….you would just do what other people told you to do and that’s getting back to the idea of there has to be grey areas and there has to be a meeting of autonomy – can’t remember if it’s Mills, the idea of autonomy….this is where a woman has her autonomy to make these decisions but as an ethical person, an ethical Dr, I can acknowledge her autonomy to make that decision but she has to acknowledge my autonomy to say that this is something I can’t do. I am fine with the idea of I can find you a colleague who will do this and that is essentially what we do….but I can’t do this myself. I mean I talked about my mum with her friend’s experience and she was pro-abortion when it came to the Steel Bill, but when my mum was pregnant with my youngest brother, she developed a breast lump and had categorically stated….it all worked out OK in the end….but she stated that she was not having chemo until the baby was delivered as she’s felt this grow inside her and seen the result of that, she knew that life was of equal value from the start of that….or of more value to her’s and she was willing to risk her’s for that. It is very difficult [crosstalk]….

I: Things can change and it can be down to 1 situation….

D: Yeah. My views have gone from a Catholic absolutist at high school level to a recognition that this can be a very grey area….to an acceptance that I can’t come up with a decent definition outside of when there’s a physiological threat to the lady as to what would and wouldn’t constitute me harming a person or a potential person….if I accept 1 definition of what a person is then that has knock on effects to other areas in my practice. I would definitely feel a great deal of moral anguish when it comes to saying demented people or infants are not people….and at the end of the day, the way things stand at the moment does work for me personally….

I: Yeah. Thank you so much, the way you have expressed your views has been really valuable here.