Interviewer: Let’s check it’s moving on. That’s brilliant. Just to start off with I’ll be asking you questions, hopefully not leading you too much. It’s about your views or opinions on conscientious objection as a whole.

Petra: What do you mean by that?

Interviewer: I was going to ask you what you thought about it.

Petra: Right, fine.

Interviewer: Start there, what do you think conscientious objection means?

Petra: You have a right to decline to be involved with that process, I think is probably the way of putting it. As a healthcare professional who may be involved with abortion in some way and there are many kinds of different ways, you have a right as a professional to take a step back and not be involved with that process.

Interviewer: When you say involved, because this is really the crux of what we’re trying to get to, what do you think constitutes being involved? You did say there were a number of processes.

Petra: From my point of view as a pharmacist, it would be to do with the supply of medication, the morning after pill or any other medication involved in the termination process and dispensing of it. The processing of prescriptions from a pharmacist’s point of view is what I would say.

Interviewer: Would you widen that out to maybe giving somebody advice in relation to the morning after pill?

Petra: Yes, definitely. Sorry, yes.

Interviewer: That’s okay because some people wouldn’t think that. They’d say it was actively dispensing.

Petra: Anything to do with that medication regarding advice about choice and actually the dispensing process, then not to get involved. Anything to do with it really. From my point of view as a pharmacist, it would predominantly be around the medication supply or advice to do with medication.

Interviewer: If someone asked you for information, say signposting to services in relation to this, would you also…?

Petra: I suppose, yes, you could. If I don’t want to be involved with that at all, then I suppose your role as a healthcare professional would also involve that signposting, showing them where to go and what services to be involved with, phone numbers to ring, websites to visit etc. Yes, that’s a good point.

Interviewer: It’s difficult, isn’t it? I don’t know if you know about the case there was in Glasgow, it was two midwives in the delivery unit who said it wasn’t just the active participation of giving the medication to a woman. It was caring for her, it was caring for her relatives, it was taking phone calls etc. What do you think about that?

Petra: If you were to consider my involvement with any other patient with any other condition, there’s a wide spectrum you’d be involved with and you’d automatically do as part of your role as a pharmacist. I would agree if that patient is being admitted for that procedure, anything to do with that procedure you would say falls under the remit of that.

Your role as a healthcare professional in providing care for that patient may be, I don’t know, supplying the medication, chatting to the family members, friends, it could be to do with anything. I suppose that whole visit, in-patient stay, whatever you want to call it, treatment episode. Anything to do with that then as a healthcare professional you could be involved in all kinds.

Interviewer: Do you think somebody should have the right to refrain from taking part in that?

Petra: Do I think they should have the right to? I don’t necessarily disagree with that. If that’s their viewpoint, it’s not my viewpoint, but if that’s their viewpoint and they don’t want to be involved with that, fine. Whether they can pick and choose which parts they can be involved with, I don’t know. I don’t know how you’d get around that because that’s complicated. Maybe it’s easier to say yes or no rather than, “Yes, I’ll do this, this and this. No, I won’t do that, that and that.” That’s where it may get a little bit complicated.

Interviewer: That’s sort of the situation we’re at, at the moment, really. There’s no definitive guidance as to what you can refrain from doing or what you would be expected.

Petra: From a pharmacist’s point of view, this is going back a number of years. When we were educated about this, a lot of it was about the supply of the medication, the supply of the morning after pill. You had a right as a pharmacist to walk away from that potential consultation.

Everything I’ve known over the years is about the supply of medication, not necessarily everything else. If my view is I didn’t want to supply that medication, but someone asked me where they could go for it, I don’t know where I lie there. I’ve never really thought of that before. I don’t know how you would answer that one.

Interviewer: Have you ever worked in an environment or come across anyone who has objected?

Petra: Yes. When I was what we call a pre-registration pharmacist in training I worked in a chemist in [name of city] city centre. There was a pharmacist there who was very religious. Not that we had that many morning after pills, but chatting with colleagues and chatting with her there, she wouldn’t be involved in the supply of the morning after pill. She refused to do that.

Interviewer: Was that difficult from a practical perspective at times?

Petra: Not particularly because there were a number of pharmacists in the team. I’m not sure at the time if it was via a pharmacist. There were always two or three pharmacists on in that shop. If that was a pharmacist and they were on their own, then that would be difficult. At the time it was the pharmacist who had to authorise supply.

I don’t know the legality of it now because I’ve been predominantly in hospitals. You could obviously get it over the counter and the pharmacist could go through that process. If that pharmacist objected to that, I don’t know what they would do then. That would be awkward.

Interviewer: We have heard cases where somebody has been the only pharmacist on at the weekend.

Petra: Yes, I can believe that happens.

Interviewer: It’s not unheard of. They’ve not wanted to participate at all.

Petra: What then happens, I don’t know. Whether the pharmacist is obliged or… I don’t know if it’s unethical not to signpost them, if that makes sense. I don’t know if that’s the case, I don’t really know how it works. Whether they can just turn around say, “No, I’m not doing supply here, but you may be able to go to Boots around the corner who’ll do it for you.” I don’t know.

Interviewer: It’s difficult, isn’t it? If signposting is considered to be participating.

Petra: I suppose is that then up to the individual as to how much they want to be involved with it? I’m sure there are people who will strongly disagree and won’t signpost. Then it gets down to what are your obligations as a healthcare professional for someone who’s wanting some kind of healthcare treatment.

Interviewer: That’s what came up in a few of the other interviews in relation to the duty of care you have to your patient versus your own right to object. Would you say it was a duty of care?

Petra: Yes, I would. Definitely. It’s fine to say, “I’ve got my personal views and I won’t supply this medication.” However, as you said my view is as a duty of care you should be then at least ensuring that person can access that treatment, that service in some way, be that signposting or something like that. I think there should be an obligation there.

Interviewer: Would you say in relation to the signposting, do you think the person could give minimal information? Is there a standard?

Petra: There should be a standard. It would probably be quite easy for people who have a viewpoint if they want to not be involved in this process. There’s a standard of leaflet patient information or whatever that they should be able to meet, which gives the patient enough information to go elsewhere or find the service available.

Rather than say, “Go and Google it.” You could say, “Here’s a website. Here’s a leaflet that we keep because we know that I as a pharmacist won’t supply this or as a healthcare professional won’t be involved with this. Therefore, if you go to this service you should be able to find what you need.”

Interviewer: There should still be a minimum standard you’d say.

Petra: Yes. I’d say so, definitely.

Interviewer: I presume you’ve got a managerial role.

Petra: Yes. Very much I’m strategic in the [are of work] and managerial rather than operational day to day work, if that makes sense.

Interviewer: Do you have a policy here for conscientious objection, do you know?

Petra: In the [area of work] itself I’m not aware of it, no. I’m not sure what the trust’s position is, to be honest with you. I suppose the nature of the how we work and where we work, it would be difficult to work in this environment and object to it, if that makes sense. I’m sure there are people who work in women’s health who do object to it.

There are places in women’s health where you don’t have to be involved in termination of pregnancy, abortion, whatever. We don’t have a policy here. I’m sure the trust probably do have a policy, but I couldn’t tell you where it is. I’d have to look on our policies website and have a look.

Interviewer: When you employ people, is it something you’d ask them?

Petra: No, it isn’t. Not at all. It’s not something that’s involved in the recruitment process. They ask a lot of questions, occy health potentially and all of those types of things. Questionnaires that you complete. I’m not aware that’s listed as a potential question or anything like that, some information you’d get from potential employees. I don’t know.

Interviewer: Some locums where they’ve worked, they have been asked that. Do you think it should be explored at that stage?

Petra: Probably, yes. I suppose as part of the recruitment process, if there are barriers to what you can do on a day to day basis then it would make sense for the employer to be aware of those. Then they can tailor the service or department to their needs. It shouldn’t influence the recruitment process, so maybe that’s why the questions aren’t asked. I don’t know. I really don’t know.

I think here, to want to work in women’s health, it would feel odd to me that you wanted to work here, but you have an objectional view to potential termination. That doesn’t make sense to me, there’s a difference there. In a community pharmacy where you’ve got an array of different things and you don’t know what’s going to walk through the door, I kind of get that because you’ve got to provide a multitude of different services.

Here, we’re very much [area for women’s health]. It would feel odd that someone came here with that opinion that they don’t want to be involved. They might have an opinion on it, but it wouldn’t stop them doing their job.

Interviewer: In relation to that, what do you think about countries? In Sweden and Iceland as a health professional you can’t conscientiously object.

Petra: A difficult one.

Interviewer: Testing you now.

Petra: If that’s the way they want to do it, fine. It’s difficult because I’m not that bothered, do you know what I mean? If they want to do that, it wouldn’t affect me. That’s fine. I think as part of being a healthcare professional you have a duty of care to look after whatever walks through the door, whatever their opinion is, within certain reason. If that’s what they want to do, then you’re signing up as being a healthcare professional then that’s part and parcel of it.

 In this day and age now everyone has a choice, be it the patient or the employee, the healthcare professional. Maybe it’s easier to have that choice, but then it can be a little bit grey and not black and white, so it would be difficult. I’m not against that, I’m not against that at all.

Interviewer: Other countries, like Italy, they’ll have a whole institution that conscientiously objects. They’ll have a whole institution where they don’t conscientiously object. What do you think about…?

Petra: As in a whole organisation?

Interviewer: Yes, like a whole hospital.

Petra: Again, that’s whether you want to go and work for that employer or not. It’s difficult really, for a women’s health organisation to object to something like that wouldn’t feel right. You wouldn’t feel like you’re offering all the services you could do for women’s health. If everything is well advertised and well known about and you don’t particularly want to go or you can’t go there for that service then…

You can’t go to the [name of local hospital] to have fertility treatment or childbirth, there are services available. To say you couldn’t go to the [name of local hospital] or something for that would feel a little bit ridiculous really. We’re trying to provide a healthcare service, so you’d like to think we could offer as much as possible. A difficult one.

Interviewer: Just going back to the morning after pill. Probably your pervious experiences, not in this role. How do you feel about giving that out? I don’t feel you have any issues with that.

Petra: I don’t particularly, no. I think we have strict guidance, strict policies, standard operation policies and procedures about how to give it out, when to give it out. I’ve not personally done it for a long, long time, just because of the nature of where I’ve worked. I’ve not really ever locumed in community pharmacy or anything like that.

I think the situation then arises when you need to give it out. I think you have that policy, that infrastructure to make that supply and you’re doing it for the best interests of the patient. I think because it’s that regimented, that black and white from a supply point of view, it helps that process a little bit. It’s a shame that process isn’t available for other drugs that would make it easier for you as a healthcare professional to undertake your role. That helps.

Interviewer: That’s really interesting. In relation to that, are there any times you think maybe it shouldn’t be given out? Somebody who’s using it constantly. I know there has to be a gap in-between.

Petra: It does. Again, that’s where your guidance helps you a little bit. I’m sure there are times when you’ve got to use your expertise, experience and you don’t quite feel it’s the right thing to do. I don’t know what those circumstances may be. I’m sure there’s still a responsibility as a healthcare professional or pharmacist where you need to feel that what you’re doing is in the best interest of the patient.

I think the way the guidance is written and the policies are developed, it helps you make that decision. As far as I know it will have different scenarios about what could happen and will help you. “When did you last have it?” That type of thing. That kind of helps.

Interviewer: That’s covered.

Petra: It does, yes. At the end of the day, you’re still making that supply as a professional, so you need to be reassured that what you’re doing is correct.

Interviewer: I think we’ve talked about what you think constitutes or anything that contributes to the whole episode of termination constitutes, anything that you would say constitutes.

Petra: I think so. I’ve never thought of it like that before. As you’ve stated, the signposting bit, the counselling of the best friend who may be with them or the family member as well as the patient goes with it. It’s the whole episode of that patient’s care.

Interviewer: Would you say if there were guidelines that would be a clearer guideline or do you still think that could be quite difficult?

Petra: It would help. I think it would help. I’m sure there are situations you couldn’t cover in the guideline, but the more detail, the more helpful that guideline would be for both the patient and the healthcare professional, the better. Potentially giving example scenarios within it to say, “This is what you’re expected to do. This is what you’re not expected to do.” Then that would help.

Interviewer: In a managerial role you may come across somebody who maybe would participate in parts of that guideline, who would be willing to give information, but wouldn’t be willing to dispense physically. Would you say that’s realistic?

Petra: Yes, I do. Probably in this day and age people will be on one side or the other. “No, I’m not being involved full-stop.” Or, “Yes, I’m more than happy to do anything.” There may be people who want to get involved and be selective. Again, within the guidance, if you stated that, then that would be helpful for people. It allows you to employ people with views. It gives them guidance on what they can help with and run a service.

Interviewer: What do you think about people who maybe cover up their conscientious objection? We’ve heard of a few cases where somebody just didn’t sign, is it the yellow form? Just putting them to one side, they seem to be mounting up.

Petra: What do you mean? Is that to do with the procedure itself?

Interviewer: Yes, they just let them mount up. I think the person didn’t feel they could expose their…

Petra: You’ve got to wonder why that person is in that role in the first place really to be that heavily involved but have such an opinion they don’t want to be involved with it. They should be telling their employer about things like that or their line manager and letting them be aware. You’ve still got a service to run. If you can’t run that service, that would be difficult to undertake.

If I had a member of staff now who I employed in a dispensing role, but didn’t like dispensing, that would be a difficult thing to undertake. Surely, there’s some kind of capability thing there that you need to have a chat with. I’m sure their job description, their job plan would detail, “You need to be involved in this process.” For them to then say no or almost do it in a way that is walking away, but not telling anyone. That’s not good.

Interviewer: Would you say that possibly has happened because…? I presume you don’t talk about.

Petra: Not really, no. Obviously, there’s the [name of abortion service] here. We’re a little bit removed from it, if that makes sense. Our patients don’t come here for any medication supply. They don’t come to the hatch where you guys have just been or anything.

A lot of it is to do with we supply the ward area. We’ll go up there and we’ll have our role as pharmacy up there to do with medication. Then we can walk away from it and come back to the department, so we’re a little bit removed from it. We can get involved with it, but not in a day to day way that the nurses up there are involved or the staff up there are involved.

Interviewer: Would you say if one of your members of staff did suddenly say, “Actually, I do object.” Obviously, people change their views. Would you say it was…? I can’t say an open environment because… How do you think you would manage that?

Petra: We’d probably have to discuss it as a senior team and try and accommodate their wishes, I think. We’ve probably got enough in the team to still quite easily maintain that service, even if all of a sudden we started getting prescriptions at the hatch that we had to process. There are probably enough of us in the team to understand that person’s viewpoint and accommodate it.

If we get back to the locum pharmacist who works on their own and tries to run that service, then that’s completely different. We would try and accommodate, but again I’d have to look at what our trust policy was on that. We may have a policy where we don’t accommodate, I don’t know. Probably not in the NHS now where you can accommodate these things. I’d like to think we were able to do that and therefore accommodate that person’s wishes.

Interviewer: Going back to your education, did you have much training on conscientious objection?

Petra: A little bit. It was about the supply of the morning after pill and the ethics around it. As a pharmacist, I’m going back and you’re testing me now, if a patient presents with a prescription there’s almost an ethical and legal thing you have to do as a pharmacist to make a supply of that medication. The only situation where you can walk away and say no is this.

We were told a lot about it. Again, this is 20 or 25 years ago when I was back at uni. It’s never really cropped up in my career. Things could have changed for all I know in that time. We were educated on it, I would say. Yes, definitely. Because it was different to everything else, the one thing that stood out a lot with our role as a pharmacist. Again, relating to the supply of medication and dispensing of medication.

Interviewer: I know you haven’t given it loads of thought over the years. Would you say your view has changed in relation to conscientious objection to abortion or would you say it’s always been the same?

Petra: It’s always been the same.

Interviewer: Nothing has happened that’s changed it.

Petra: No, nothing at all. I think from a pharmacist’s point of view just looking back, we used to have to do it on a prescription and now you have the potential to be able to sell it over the counter, I think. I’m sure my lack of knowledge here, it could be…

Interviewer: It’s conscientious objection that we’re…

Petra: No, my view hasn’t changed on that.

Interviewer: It’s always been the same. I suppose it’s quite interesting here because it is a hospital that’s [for women’s health], so it’s very different from the other…

Petra: It is. I’ve only been here about six months myself, so everything is kind of new to me still. Actually, working with [name of abortion service] and we’re trying to do a couple of different things to do with the supply of medication. I’ve never once thought, “I don’t agree with this.” Or, “Does anyone object to this?” “What are my views on objection?” It’s part and parcel of what we do. It’s just the nature of it. I’ve never actually thought there could be people who don’t agree with it. There could be people in the pharmacy who don’t agree with it. Anything like that.

What I’m trying to do is improve the patient experience. We’re trying to do things like with supply of medication, so that when patients do come to [name of abortion service] from a medication point of view their experience is good through what is a very, very emotional thing that they’re going to go through. We need to try and make sure there are no bumps in the road for them. That’s how I’ve been involved with it. Again, that’s just a service development thing I’m involved with, not necessarily any kind of thoughts about objection or anything like that.

Interviewer: I presume from what you’re saying it would surprise you if there was an objector in this service.

Petra: A little bit, yes. I’m not saying it doesn’t happen, but if you’re working in this type of environment, then why are you here if you really object to that? There are other hospitals you can work in or other healthcare environments you can work in. For you to feel that strongly about something and then work in [an area for women’s health] where this is going to happen, that doesn’t quite feel right.

Interviewer: Particularly [name of abortion service], that would be really \_\_\_[0:28:09].

Petra: Exactly. Even if you’re a midwife on delivery suite, you would know what went on at [name of abortion service]. Fair enough, you might disagree with it. I don’t know, there are all kinds of different parts of the women’s health and childbirth pathway for you to disagree and agree. I’d find that odd, I don’t know.

Interviewer: I suppose with the midwives it could be participating in third trimester very late termination. Do you supply the delivery unit with that medication if that’s required?

Petra: I’m lacking clinical knowledge here on what that medication is. As far as I know, we supply medication for all parts. Do they do medication in the third trimester?

Interviewer: They can do. Usually they do a… Yes, because they’d do a KCL.

Petra: Yes, that’s what they do in the [name of department] unit.

Interviewer: Yes, they do.

Petra: Again, it’s just my experience. I’ve only been here six months, so it’s kind of like you’re picking things up and your knowledge is expanding all the time. Yes, we are involved in that.

Interviewer: Could you imagine people objecting to that versus the morning after pill?

Petra: Potentially. I think so, yes. I don’t know why.

Interviewer: Why would you say you don’t know why?

Petra: I don’t know. I suppose the baby is more developed. You can almost relate to the foetus a little bit more than something that’s a few weeks old. I can imagine they’re about… They’re not full term or whatever. You can understand why people may object there compared to here. A late termination compared to an earlier one. Yes, I can imagine that.

Interviewer: Here, you’re not sure whether someone is under obligation to declare they’re an objector.

Petra: I don’t think we have to declare that. No, I’m not aware. I’d have to check policy. No one has ever said that.

Interviewer: We’ve talked about a guideline, you were saying you’d probably want a lot of detail in that to try to cover as many scenarios as possible.

Petra: Yes. You don’t want it ‘War and Peace’ at the same time because you want a guideline policy to be helpful. Especially the grey areas, if you can aid the user of that policy then that would be good. There has to be enough detail.

Interviewer: Yes and some scenarios as well, I presume.

Petra: I think so. That would help.

Interviewer: I’ll just have a little look. I think we’ve covered most things. I’ll just double check that’s still going. You’ve talked about the morning after pill. Your views have always been the same, they’ve always been quite static.

Petra: I’d say so, yes.

Interviewer: Have you ever refused or considered refusing yourself giving out emergency contraception or have you never been in that situation?

Petra: You could probably count it on one hand when I’ve done it over the years. I’ve never considered I’m not going to do this. It’s part and parcel of my role as a pharmacist. When a person comes in requesting it that you do your duty and make that supply according to whatever the guidance is. No, I’ve never considered not.

Interviewer: Would you say that’s because you’ve signed up to that role?

Petra: I think so, yes. I’ve been made aware of the situations where I don’t have to do it. I don’t necessarily agree with that. I’m quite happy to fulfil my role fully, completely, nothing has changed over the years. I’m quite happy to do that. Even now I’d quite happily do that.

Interviewer: There’s no conflict there.

Petra: No, not at all. I don’t think there ever really has been at all. I don’t know what would change for there to be conflict. I can’t think of any situation.

Interviewer: Finally, most of the literature looks at conscientious objection, and you’ve alluded to it yourself, from a religious perspective. Research that’s looked into health professionals, they’ve given all sorts of reasons, like a personal reason, just the fact you can object ethically. What do you think the underlying reasons are, in your experience, knowledge or even thoughts about conscientious objection? When somebody says that to you, what do you think the reason for that is?

Petra: Religion. For me it’s probably 99% of the time. I can’t really think of any other situation. There probably is, but nothing that springs to mind for me for you to conscientiously object. Why are you working in healthcare and you object to that? I don’t get that. I really don’t get that.

The spectrum of healthcare is vast. For you to object to that one thing not on religious grounds, I just feel a lot of people who object to it are doing it for religious reasons. Then we could get into religion. (Laughter) I don’t want to go down that road. I can’t think of any other situation. I’d find that really hard to understand. I would, yes.

Interviewer: I think we’ve asked everything. Is there anything you want to add?

Petra: Not really, no. I think that’s probably about it.

Interviewer: Thank you very much.

Petra: No, it’s okay. No worries.

END AUDIO

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