Interviewer: Okay, so just to start, if you just tell me a bit about yourself and your role here.

Peter: Yes, so, I’m a [job title]. We rotate between three wards. Maternity, gynae, NICU. So, the babies. I only started in August. Before that, I worked at [pharmacy name]. Yes, I’m on gynae at the moment. I’ve been on it for a couple of weeks.

Interviewer: Okay. Are you enjoying it?

Peter: Yes, it’s good.

Interviewer: What made you make that change from community to the hospital?

Peter: Just a change really. I’d been in community for two- So, I qualified in 2017. It has been about two years. I just felt like having a change and a hospital… There’s a lot of variety in hospitals. A bit more than community. So, I thought I’d make the move.

Interviewer: Yes, very good. So, can you tell me your experience or you role in relation to prescribing or dispensing medication for terminations?

Peter: Yes. So, in community, I never saw anything. In hospital, we sometimes… The medication for the abortion, we sometimes just have to accuracy check- So, the ward will send down an order and we will just accuracy check it. That’s really all we really see in terms of the prescribing and dispensing of it. Then we might see prescriptions for patients who have had an abortion and have been to the clinic. They might then prescribe something afterwards, like an antibiotic or pain killers. Something like that. In terms of the abortion medication, in my time here I’ve only checked, to check what we’re sending up is the right thing.

Interviewer: Okay. You just brought up a very good point. I’m just going to make a little point there. Post-abortion. Have you ever been involved in issuing emergency contraction? So, the morning after pill.

Peter: Yes, in community, where I worked on [City / Town name], they have got the free scheme where I was- Yes, the emergency contractive I did, yes.

Interviewer: What did you think about prescribing that, dispensing it?

Peter: Yes, you needed to ask a lot of questions before dispensing it, just to check it was suitable. Just to check the medical conditions and any medication. I think if you’d asked the questions and then you have to trust what the patient is telling you. That what they’re telling you is true and that’s their medication, and those are their medication conditions.

We could always double-check the Summary Care Record if they wanted to. So, we could check what they were saying they were on. But, yes, you had to trust that when they said the event happened, that it happened. So, a lot of it was on trust of what the patient was saying. But I always thought being able to provide it for free was a good thing. Instead of- It’s quite expensive to buy.

Interviewer: Were there any occasions you ever felt you didn’t want to give it?

Peter: There have been cases where I’ve refused it, but more on medical- So, one of them under the free scheme was if there’s a possibility of them being pregnant you couldn’t supply the EHC. They had to have a pregnancy test. So, it was quite late. The pregnancy test would come back and I felt it was a bit inconclusive. So, I did ring the out of hours. I was quite near the hospital. So, we booked one of the appointments and they had that. I said, “If that’s fine, then they can supply that for you and there is a pharmacy attached.” So, they could’ve provided it.

If they’ve been on medication that interacts, which meant I couldn’t provide it under the scheme and you had to refer, then I have referred them. But, yes, if I ever was unsure on what they were telling me, I always referred them to another healthcare professional.

Interviewer: So, that was usually on medical grounds?

Peter: Yes, on medical grounds. Just if it went outside the PGD on medical grounds, where you had the possibility that you couldn’t give it, I always referred them but made sure that they saw someone. So, I wouldn’t leave. I wouldn’t say you had to go- I’d ring their GP, ring out of hours, or ring the sexual health centre and get an appointment for them. I never wanted to just leave them and say, “Go.”

Interviewer: No, and were there any occasions where ethically maybe you thought somebody was getting it for a holiday or…?

Peter: In my time, I never had that. I know I’ve had a pharmacist who has rang me before, just because someone wanted to have it as an advance supply. There is guidance on the Royal Pharmaceutical website on what you can do in terms of that. So, I referred them to that. But I’ve never personally had any kind of ethical or safeguarding reason not to supply it.

Interviewer: Okay, and what does the term conscientious objection mean to you if you think about it?

Peter: I don’t know what the exact term, I’m going to be honest, is.

Interviewer: It’s okay. It’s just what it means to you. It’s fine.

Peter: It’s kind of, I would say, what your personal belief is. What your conscience- I’m not entirely, I’m going to be honest, sure what the exact term is.

Interviewer: No, it’s fine. I think it’s difficult to pin down.

Peter: Yes. What are the objections to not give it in terms of personal belief or ethically? I’m not sure if that is what it is. I’m going to be honest. I’m not really sure.

Interviewer: Yes, that is the crux of it and it is a very grey area. That’s why we’re researching it. Because even the actually termination that’s used, the terms are difficult. Have you ever come across anybody who has conscientiously objected in your career?

Peter: In terms of abortion?

Interviewer: Yes.

Peter: No. I know, or I have- I know of some pharmacists, in terms of EHC, they won’t supply it. More kind of religious grounds. But in terms of abortion, no.

Interviewer: So, going back to the EHC, have you worked with those people?

Peter: No. It was only purely I was off one day and they’d come in. They weren’t able to supply it, so they referred it to a pharmacist who would supply it. Then I had just been told the next day that it had happened. Obviously, I never heard it first-hand.

Interviewer: Yes, and what did your pharmacy think about that?

Peter: They’re accepting, I think. We were always told, “If you’re not going to supply it for personal or religious reasons, then you need to let the manager know.” So, I think my manager was always happy that if you’d told them at the start of the day, “Look, I’m not providing it,” and then you referred them to somebody, then they felt okay. I think it was just making the team aware you couldn’t supply it in advance. Just so they knew who to refer to. Just so they know where to send the person. But, yes, my team seemed okay with it.

Interviewer: Did you have a lot of discussions in your training surrounding conscientious objection to supply EHC or termination?

Peter: Not- In terms of EHC, a little bit. So, to supply it, the CPPE had to do a declaration of competence. So, you had to do emergency contraceptive training, contraceptive training, and one of them was safeguarding. So, in terms of safeguarding, there is a lot of training on it. In terms of ethical, a little bit but not a lot, no.

Interviewer: What do you think constitutes conscientious objection? So, do you think it’s the actual physical dispensing? Or referring to that pharmacist who covered you, I presume that person did refer onto somebody. Could that be part of active participation?

Peter: I think in terms of EHC or abortion, if you did both, I think any stage where you refuse to do it, I would say is probably conscientious objection. So, I either, in terms of EHC, if you’re not happy to supply it, then I’d say that you probably- Yes, if you’re going to object in any way of not supplying it or not doing the abortion, then I’d say that probably…

Interviewer: Do you think people should be able to object to maybe referring someone on, or giving them a leaflet, or maybe taking a referral call?

Peter: I think if you're going to refer… I think everyone has their own choice on it and if it’s your religious or ethical choice, then that is their choice. I think if you’re going to refuse it, then you always make sure that you always put the patient first and that’s the most important. So, if you’re not going to do it, then how are you going to solve that for them?

So, if you’re not going to do it, then who are you going to refer to? I think, don’t leave them. Ring them, book an appointment, get them in. In terms of EHC, let the pharmacist know in the other store, or for the abortion, get that all sorted for them. But always make sure the patient is your first- That’s your first concern, and how are you going to help that person if you’re not going to do it?

Interviewer: Yes. So, really, you’re saying that they could object to maybe the physical handing over of the job etc, but they can’t leave somebody.

Peter: Yes, I think they have the right- If they don’t want to do it on ethical or religious grounds, then that’s their choice. But I think you have to weigh-up that verses the patient. When you look at what your standards are in terms of being a doctor, or a midwife, or a pharmacist, always patients being your first concern is a big one in patient care. So, I think you have to take that into account. If you’re not going to do it, how are you going to help them? You’re referring them on, so I think, yes, at least then you’ve helped them in some way.

Interviewer: Yes, that’s quite an interesting way of looking at it.

Peter: I think it’s a very difficult thing really. I think, yes, it’s very, very difficult if they might not want to and they might not want to refer.

Interviewer: Yes. We have heard or cases where people have just refused to refer somebody. They’ve been the only pharmacist on call at the weekend somewhere. How do you feel about that?

Peter: I think it’s very difficult. You can understand from the side that they don’t want to do it, which you can understand. Kind of the two sides, I think it’s a very difficult on what’s right and what’s wrong really. Because I think there are no guidelines really. It doesn’t state how far they can object. If they can just object to do it, but they still have to refer. Or they can object completely. I think without guidance it’s always going to be a grey area.

Interviewer: Yes, that’s why we’re doing this.

Peter: It’s very difficult, I think. Yes, I think you can understand both sides, but, yes, it’s a difficult one.

Interviewer: In relation to guidelines, what do you think should be in there then if we had some sort of overarching guidelines? Say in relation to your role.

Peter: I think in general, if you’re not going to do it then refer to somebody who is. I think that should be the underlying thing. I think obviously there are always going to be people who are going to fully object to it and I think that’s the difficult one. I think that’s the bit which is the hardest. Well, if they object, you have to accept that. But how can you take that into account? But I’d say probably the overarching thing is, if you’re going to refuse it then if you’re happy, refer them to somewhere. Yes, it’s a very difficult one.

Interviewer: It is. It’s really hard, isn’t it? There was a case, I don’t know if you remember, in Scotland and it was two midwives on the delivery unit.

Peter: Yes.

Interviewer: Yes, and they objected to taking phone calls and looking after the women’s families and partners. So, every aspect really that was contributing to that episode of a termination. What do you think about taking a phone call or…? There was a receptionist who didn’t want to type letters in relation to it.

Peter: I think it’s a difficult one. I think it always comes down really to your belief verses what’s best for the patient and patient care. Yes, I think it’s a difficult one. Yes. I think personally if you aren’t going to do it then at least refer to someone who is happy to do it. But you can- Just because of what is- If you’re going to object, what constitutes that? Is that taking a phone call or dispensing the medication, administering the medication? I suppose it’s that grey area of what it is and if you’re going to take part in a bit of it, have you objected fully or have you participated? It’s very difficult.

Interviewer: Yes. Do you think that taking a phone call is actively participating?

Peter: I think if you’re taking a phone call and passing a message along… I suppose it depends what the phone call is about. If you’re just passing a message along and you’re not taking part in the dispensing or administering of it, then personally, no.

Interviewer: That’s fine. We want to know what you personally think.

Peter: Yes, it’s difficult.

Interviewer: You’ve opened up a really interesting area for me about post-abortion, which really we haven’t thought about. But do you think somebody- I’m going to take you out of your comfort zone now. Say it’s a midwife and they’ve looked after- Or they haven’t looked after a woman. They didn’t want to look after a woman who was having a termination. Say a late termination. Or maybe a nurse. Then post-event, they were asked to care for them. What do you think about that? You’re the first person I’ve asked this to, but you did bring it up and it’s really interesting.

Peter: I’d say post it, really I think their duty of care, what they are, I personally see as more important than what they’re in for. I think you need to treat everybody the same, whatever they’re in for. Whether they’re in for an abortion or they’re in to deliver the baby, that’s your standard and that’s what you work towards. Your work is patient care is the first. So, yes, I think in those times they need to care for the person.

Obviously, if they’ve had an abortion, there aren’t any physical thing they’re going through. But there is all the mental and emotional thing. I think if then a healthcare professional refuses to work for them on those reasons, I don’t think that helps the patient in any way.

Interviewer: So, that really is- Would you say that’s being more judgemental than based on ethics? If they were saying, “I don’t want to care for that woman because of what she has done.” Because I suppose that’s what it would be.

Peter: Yes, I think there’s probably a bit of a judgemental thing on it really. Yes, I think if they’ve been told to look after somebody, then you look after them really.

Interviewer: Because they wouldn’t be actively participating in the events.

Peter: Yes, because obviously the event has happened, but all they’re doing now is caring for that patient. I’d say whether they’ve participated in the activity is less important really. Because that activity has happened. They’ve had the abortion. They’ve not participated in that and now the person is in because they need care post whatever it was. I think in those terms, they need to treat them like they would treat any other person, whatever it is.

Interviewer: \_\_\_[0:18:29]. You said before you thought about the emergency contraception the fact that on [city / town name] it was free and that’s a good thing.

Peter: Yes.

Interviewer: I think what you’re saying to me is you support giving it. You don’t have an issue giving out emergency contraception.

Peter: No. In terms of myself, no, I don’t have an issue administering it. Pharmacists who don’t want to give that, I respect that. That’s their personal belief. But personally, I am quite happy to give it really. But I think that comes down to that person and whether they’re happy to. But I’m happy to administer it. In terms of it being free, I thought it was a good thing. It’s not cheap to buy it.

Interviewer: No, I know.

Peter: So, I think if you can [train 0:19:27] to supply it for free, then that’s always the best way.

Interviewer: Would you say the same for- I know you’re checking for accuracy, the drugs that are going \_\_\_, but obviously they will be used in terminations. Would you say again that you’re comfortable with that? You don’t have a-

Peter: Yes, I’d say in terms of myself, I’m comfortable. I think I’m happy to dispense it, yes. I’m happy. I’m all right giving it.

Interviewer: When you came here, were you asked at all about whether you objected?

Peter: No, but I was- Prior to coming to the hospital, I was aware of the services the hospital provided and I was aware that there is the abortion clinic. It being kind of [an area for women’s health]. So, yes, I was aware that it happened prior to coming. I haven’t been asked, no.

Interviewer: Are you aware of any trust policy in relation to it?

Peter: I know on the hospital intranet I think there is guidance. I personally haven’t read any guidance, just because we only really participate in terms of sending the medication up when they’re low on stock. So, I felt like I didn’t need to know the ins and outs of what happened really. Just in terms of a bit of privacy for the patients really. But I’m sure there is guidance on the intranet on what to do.

Interviewer: I presume as well because you don’t object, you’re not looking for that guidance, would you say?

Peter: I think in terms of because we only dispense the medication, I didn’t feel personally I needed to- I’m kind of aware of what drugs are used and what the doses are. That there can sometimes be multiple medications. I’m aware of how they do it. Kind of which drug is first and which is next. But in terms of the details of what happens, I felt, just because it’s not in my job remit, that I didn’t really need to know. Yes, I don’t think if it’s in your job remit then you really need to know the ins and outs. Just because it is such a sensitive thing really, I think.

Interviewer: Is it something you’ve given thought throughout your career, conscientious objection in your role?

Peter: Not really. Yes, probably not really. I always think your personal belief- You can have your personal belief, but you always think about what your personal belief in patient care is. I think I was always [growing up] with, you don’t know the reason that they’re coming in for EHC or an abortion. It may not be what you think it is. It could be something happens and you can have your belief, but you don’t know why they’re in for that. There might be something horrible that has happened.

So, yes, I think I’ve always grown up with the idea of not judging anyone for what they’ve done, or what has happened to them. But in terms of conscientious objection, no. I probably subconsciously have, but I’ve never thought until you said.

Interviewer: Well, now you’ll probably be talking about it. It does open up views and things. I think lots of people work through their feelings as we’re interviewing you really. In relation to particularly here, I suppose, because it is [an area for women’s health], do you think people who do conscientiously object have a role here, a legitimate role?

Peter: I think it’s very dependent on what your job is. So, I think if your job entails you supplying it, then I think maybe there could be an issue. If you’re not happy and that’s what’s in your job, what you call it.

Interviewer: Description, yes.

Peter: Yes. If it’s in your job description to supply it then there could be an issue. But I think if you’re not going to supply it and you’ve made that aware to your senior, your line manager, that, “No, I’m not happy to do that. I’m happy to provide all the other services,” I think if you’re going to object then you need to let people know prior- So they can always make sure that there is somebody who is happy to do it. But, yes, I think it’s very dependent on what your job is I would say, in the hospital.

Interviewer: Yes, because we have heard of instances of people just not telling anyone they object, but just not doing-

Peter: Yes, I’d say if you’re going to object, I think it’s part of… It’s just- I don’t know. The common sense thing to do or sensible thing to do, I don’t know if that’s the right word, is to let somebody know in advance. I think maybe when you start the job. “Look, I’m not happy to do this for religious or ethical reasons. I just wanted to make you aware of it.” I think it’s just part of your job role. If you’re not going to do it, then let somebody know in advance.

I think keeping quiet and not telling anyone until they ask you to do it, then that raises the issue. Because you can upset the patient, you can make their time longer. Yes, you can cause an inconvenience if you don’t tell someone and then they have to do it, and then they can’t do it. Then who is going to do it? So, yes, I think they need to tell them in advance.

Interviewer: Yes, and I think probably you’re saying to me your views have always been the same on administering emergency contraception.

Peter: Yes.

Interviewer: If you think about other people’s views, what would you say is the underpinning- If somebody says they conscientiously object, what do you think usually informs that in your experience or your knowledge? What’s underpinning that?

Peter: I’d say it’s always… In terms of abortion, I think how far the woman is along can be a major factor.

Interviewer: Yes, that’s a good point.

Peter: Yes, with the foetus, how far along in the pregnancy journey does the foetus become a baby and then you’re killing a baby? I think that whole ethical thing of, yes, when is it a human being and when is it…? Yes. It can be an underlying thing and I think in terms of emergency contraception that is a factor. Yes. I’m guessing there probably are a lot of other factors, but I’d say I think that is a big one.

Interviewer: Yes, and when would you say or when would you draw the line there? Or is it something you’ve never really considered?

Peter: I’ve never really considered it. I’ve never really considered it in terms of abortion really. I’ve never really thought about it until- Well, until coming here, I never really thought about abortion. I never saw it in my job or in day to day life. When I came here, I was aware that it happened. But I’ve never really thought about it, I’m going to be honest, on what my kind of personal belief is in terms of EHC.

I think I always took the view of- Well, you can have your own view, but the patients come and you just dispense it like a regular medication really. The patient needs it. You don’t know what their scenario is. Yes, it might not be just the- You could be very stereotypical and just say, “Well, it’s their own fault.” But you don’t know what has happened. Yes, but I’ve never really thought about it. I’m going to be honest.

Interviewer: No, that’s fine. I suppose because what we’re thinking is scenarios midwives might face if somebody who is having a termination at 38 weeks pregnant, because something has happened-

Peter: Yes, of course.

Interviewer: Do you think there’s a difference or do you think that would affect somebody- Maybe you would not conscientiously object to giving out emergency contraception, but you may conscientiously object to physically caring for somebody \_\_\_[0:28:39].

Peter: I’d say how far they’re along does play a big factor in it. Yes, because at that stage, they’re fully formed. Yes, I think that is a very difficult one. I can understand it, I would say, from both sides at that stage of- The reasons for it. But then there’s the- Yes. At that stage, that’s 38 weeks, the baby is…

Interviewer: It almost legitimises it, I suppose, the objection but-

Peter: Yes, I think it’s very difficult. I’ve never thought. I’m going to be honest. I’ve never thought of it, but I can understand the views, I’d say, of both sides. Especially I think- There is the law on how far along you can have the abortion. I think post that, there is the question of the baby is either nearly fully formed or formed, and the question of, “Are you killing a person or are you not?” But I think it’s a very difficult one that I’ve never thought about.

Interviewer: Sorry, I’m just [Crosstalk 0:29:59].

Peter: No, it’s okay.

Interviewer: So, you weren’t asked to declare if you object. When you worked at [pharmacy name], were you asked to declare there?

Peter: I can’t remember. I don’t think so. I was never forced to deliver it. It was always, “If you’re not happy to deliver the service, then let us know.” Obviously, not everybody provided the service for free if they hadn’t done the training, but they could buy it. But, yes, I think I was never asked, but if I had an issue then I was told to just let them know.

Interviewer: So, it was sort of facilitative of maybe you objecting if you wanted to.

Peter: Yes, I think it was just, “If you’re not happy to, then just let us know.”

Interviewer: Yes, and what do you think about countries, say like Sweden or Iceland, where you can’t be a health professional if you conscientiously object?

Peter: I think it’s a very difficult situation. I think I can understand both sides. Because when you’re doing your job, you’re following the standards that patient care comes first, the patient always comes first. But then there is the ethical. It’s very difficult. I’d say I couldn’t say a definitive, “Yes,” or, “No, I agree.” Yes, I can understand both sides, I think.

Interviewer: It’s a conflict, isn’t it?

Peter: It’s a conflict, yes. People have their religious beliefs, they have the right to have that religious belief, but then there is that right to have that religious beliefs first [as 0:31:57] their duty of care. I don’t think I could come out with a definitive- I think I’d have to think about it for a long time and then say. Yes, I can understand both sides.

Interviewer: Yes, and then in Italy you’ll have a whole institution, say a whole hospital, where they can’t conscientiously object.

Peter: I think patients should always have the chance or the opportunity to have either EHC or an abortion, and be living within a suitable distance to be able to have that. I think if a patient has to travel 200 miles to have an abortion, then that can cause them added stress. Mental issues or physical issues that maybe they don’t need. So, I think there always should be a place within a suitable distance for that person to have it. I think that’s a duty of care really. That they should be able to have the opportunity, or be within a suitable distance.

Interviewer: Yes, that’s really interesting. So, you’ve talked about what you think might constitute abortion. You’ve talked about the guideline, your training. We talked about countries where you can’t object. Just finally really, would you say the main reason you have heard or you think about when someone conscientiously objects, would you say that’s usually based on religion? Because you’ve mentioned about ethics per se. Some people object because they have the right to object, but-

Peter: I don’t know. I’d say overarching I’d probably… Probably my main one if someone asked me immediately what could be the main reason for people objecting, I probably would say on like religious grounds than the grounds of, “Well, everyone has the choice, everyone has the right to object.” Yes, I’d say religious is probably the one. The big one that I’d say is a reason. But there are probably loads more reasons.

Interviewer: Well, some research was done and sometimes it was someone’s personal experience of something that had happened.

Peter: Yes, I can understand. I’m going to be honest. I’ve never thought of it. I think because I’ve never really thought about abortion and had a really long conversation, or because I don’t do it in my day to day job, I’ve never thought about it in depth. I’ve never really thought about every single possible reason for someone to object. I think just the main one is religious.

Interviewer: It’s overwhelming \_\_\_[0:34:55].

Peter: But, yes, I think it’s very difficult. It is what constitutes which part of taking part in the process can you object to? Is it taking a telephone call, or administering the medication? I think it’s very difficult. I think without guidance or guidelines on, “You need to do this,” or, “You need to do that. If you object, you need to do this.” Without guidelines, I think it is always going to be a grey area.

Interviewer: Yes, it is. Well, thank you very much. Is there anything you want to add?

Peter: No, it’s okay. I’ll be honest, I’ll be going home and thinking about this now. But, no, I think it’s a good thing. Obviously, it’s a really good thing.

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