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It's about finding a balance…exploring conscientious objection to abortion with UK midwives☆,☆☆

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ABSTRACT

Background: Despite the right for health professionals to abstain from providing abortion services existing for over 50 years, literature on conscientious objection to abortion scarcely mentions midwives. In addition, little empirical research has been carried out concerning midwives' views surrounding what constitutes participation in abortion and in turn, what areas of care they can withdraw from.
Aim: To explore midwives' beliefs regarding the extent of and limitations to the exercising of their legal right to objection to abortion on conscience grounds.
Design: Qualitative study with 17 midwives in Glasgow and Liverpool, UK.
Method: Face to face semi-structured interviews, transcribed verbatim and analysed using a thematic analysis and Human Rights framework for midwifery care.
Findings: The extent of and limitations to CO to abortion-related care was reflected in four themes: respecting and protecting, making informed decisions, providing non-discriminatory care and experience and culture. There was an overriding sense of support for midwives to be able to exercise their right to conscientious objection, how this is operationalised in practice however continues to be fraught with complexity, which in turn poses constant challenges to midwives who object, their colleagues and managers.
Conclusions: Midwives' beliefs regarding the exercising of their legal right to object to abortion-related care on conscience grounds can be summarized in the challenge of "finding a balance". A national picture of how to accommodate CO to abortion is needed, so that all midwives can continue to give optimal care to women and receive it themselves, within a human rights framework.

Introduction

Over the last decade, abortion provision has changed from a mainly surgical procedure to a primarily medical one whereby women can self-medicate early in pregnancy, under medical supervision or have labour induced after the first trimester (Fleming et al., 2020). Based upon this change, midwives globally have been designated by the World Health Organisation as key providers of abortion services (World Health Organisation, 2015). This is similarly reflected in the International Confederation of Midwives' latest version of their "Essential Competencies for Midwifery Practice" (International Confederation of Midwives, 2018). It is also repeatedly stressed as a major role for midwives by the authors of the United Nations Population Fund biennial 'State of the World's Midwifery" report (United Nations Population Fund, 2021)

In the United Kingdom, the Abortion Act (United Kingdom Government, 1967) contains four conditions, one of which must be fulfilled before an abortion can be legal. This includes a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped and often leads to second or even third trimester abortions. Midwives' involvement in abortion provision tends to come in regional maternity units which offer a foetal medical service when babies are diagnosed with conditions deemed incompatible with life. Such abortions involve inducing labour and, after several hours, the delivery of the foetus and placenta. All of this takes place under the guidance of a midwife.

Abbreviations: CO, Conscientious objection.

☆ Ethical approval was granted by Liverpool John Moores University (UREC 18/NAH032) and was ratified by the Health Research Authority (246,528).

☆☆ **Study aim**: To explore midwives' beliefs regarding the extent of and limitations to the exercising of their legal right to objection to abortion on conscience grounds

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However, just as the issue of abortion itself causes many conflicting views so too do the rights of midwives (and others) to abstain from providing abortion services although, according to the Act, they have this right if their consciences dictate it. This was a late amendment to the original Bill but one which smoothed the way for the enactment of the legislation. Despite such a right existing for over 50 years, the substantial literature on the topic scarcely mentions midwives and little empirical research has been carried out concerning them although conscientious objection (CO) is hotly debated from a number of theoretical disciplines and can crucially impact on midwifery practice (Chavkin et al., 2013; Fleming et al., 2019; Neal and Fovargue, 2019).

A systematic review of reasons for nurses and midwives objecting (Fleming et al., 2018) to abortion provision showed only 10 articles in which they were even mentioned, publications by lawyers or philosophers focusing exclusively on the medical profession.

However, legal and professional consequences for midwives who have chosen to exercise a CO to participation in abortion services, have been documented throughout Europe (Fleming et al., 2017), including a prominent legal cases that reached the highest court in the UK (UK Supreme Court, 2014). This case, which concerned two senior midwives in a labour ward, saw the midwives lose as the judges ruled that they operated mainly in a supervisory nature which they deemed was not the intention of the Abortion Act. Similar cases affecting midwives have also been reported in other European countries notably Croatia and Sweden, the latter of which does not have a legal position on CO.

Beside these practical and legal aspects related to CO mentioned above, the literature reflects a number of conflicting views from different theory based disciplines. Wicclair who has been working in the area of conscientious objection for two decades, has consistently stated that respect for moral integrity of each health professional is the best way forward (Wicclair, 2000). Similarly, Curlin (2007) notes that acting conscientiously must be the heart of ethical life and suggest that if this is forfeited, practitioners no longer have the capacity to make or act in accordance with their moral judgments.

The authors of one article, however, urge European countries to reassess their laws governing CO as this has the potential to affect women's legal rights to abortion (Heino et al., 2013). Other authors have supported this call suggesting that permitting CO has compromised women's human right to abortions (Zampas and Andión-Ibañez, 2012). However, a report based on evidence from a number of Ministries of Health in Europe concludes that there should be no problem in balancing the rights of midwives who object to providing abortion-related care with those of women have access to abortion (Chavkin et al., 2017; Fleming et al., 2020). This is supported by another study which used in-depth case studies to assess four European countries' positions (Chavkin et al., 2017).

The UK's regulatory body for midwives, the Nursing and Midwifery Council, has a recently revised Code of Practice in which midwives who have a CO,

> "must tell colleagues, their manager and the person receiving care that they have a CO to a particular procedure. They must arrange for a suitably qualified colleague to take over responsibility for that person's care"(Nursing and Midwifery Council, 2020)

Summarising the situation throughout Europe, it becomes obvious that inconsistency in practice and a lack of clarity exists in the literature as to the extent to which CO should be permitted. Because of this lack of any focus on midwives' perspectives of participation in abortion and the extent to which they can legally object, we undertook a study with UK midwives to explore and subsequently give voice to their views and beliefs.

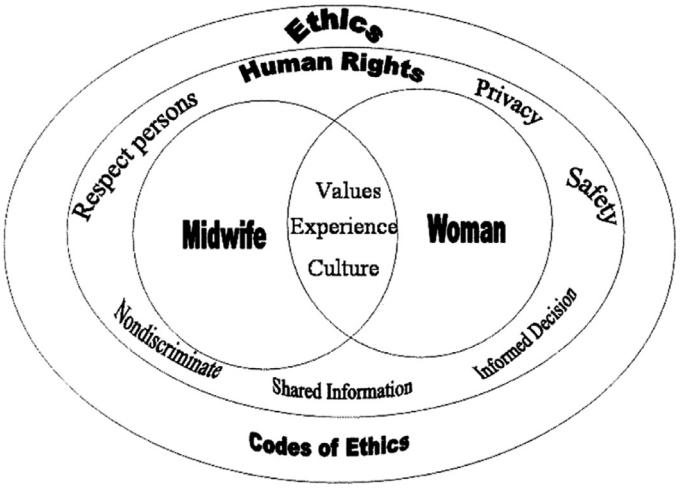

Fig. 1. Human rights framework for midwifery care (Thomson 2004) (with permission).

Method

As the aim of the study is to explore midwives' beliefs regarding the extent of and limitations to the exercising of their legal right to objection to abortion on conscience grounds, the 'human rights' framework (Thompson, 2004) has been applied (Fig. 1). Human rights are founded on universal ethical principles of justice (equity) and respect for human dignity. Embedded into these should be the moral behaviour associated with being a professional embodied in codes of ethics including duties, obligations, rights, and responsibilities. Consequently, ethics and human rights are closely linked (Fatho, 2015). This framework depicts how midwife and woman can form a partnership based upon valuing their own and others' experiences within a culture and society. The framework is rooted in ethical principles and as the present study deals with sensitive topics, its use assisted in ensuring confidentiality, respect and anonymity were maintained as well as those concepts in the middle circle of the model. The framework is underpinned by the three elements of ethics, values and human rights, recognising the link between health and human rights (WHO 2002). In order to work within this framework, a qualitative design was employed to capture in-depth data on CO to abortion.

The research team consisted of two research assistants and two midwives working within Higher Education. All of the team had experience of qualitative research design and implementation. They were based across the two research sites and met regularly throughout the study both online and face to face.

The study target sample was 20 (NMC) registered midwives currently working in one of two Trusts in England or Scotland. No limits were set regarding years of midwifery experience, role, grade band or area of practice within the Trust. In addition, the midwives did not have to identify as an objector or non-objector or have been directly involved in CO to abortion. This broad inclusion criteria were developed to give voice to as diverse a group of midwives as possible. Recruitment took a multi-method approach. Firstly, gatekeepers within the Trusts disseminated information pertaining to the study and midwives were asked to contact the research team if they would be willing to take part. In addition, the study was presented at meetings in the two hospitals in order to reach as many midwives as possible. Furthermore, snowballing took place, whereby midwives who had been interviewed 'recruited' interested colleagues. Twenty midwives were recruited from two NHS Trusts in England and Scotland, with seventeen eventually undertaking the interviews.

An interview schedule, aligned to the study aims and based on published literature was developed by the research team. Open-ended questions and prompts were included to explore this complex and potentially emotive subject, and to capture rich data. Examples included: *What do you think of as participating in abortion? What do you think are the limitations to participating in abortion? What has helped to form your views?*

Face to face semi-structured interviews were undertaken by the research team between November 2019 - March 2020 in a place convenient to the participants (workplace, neutral venue, home). Interviews lasted between 35 and 68 min, were digitally recorded and transcribed verbatim. All participants were randomly assigned non-gender related pseudonyms to protect anonymity. To add further protection, a decision was made not to provide any specific details about the participants such as how long they had been in practice or which Trust they worked at.

Processes were employed to ensure rigour throughout the study. These included: the individual interviews being carried out by three members of the research team who had extensive experience of undertaking qualitative data collection. The research team meeting at regular intervals to discuss and reflect on emergent findings in order to inform next steps reflexively. All transcripts being independently coded and themed twice by two members of the research team who then compared their findings, with a high similarity index being found. A third member of the team, not involved in the data collection, independently reviewing the themes and checking them for alignment with codes and interview data. Agreement across the research team that data saturation had been achieved, with no new themes being generated.

Data analysis

Initial data analysis was undertaken using the six stage thematic analysis of Braun and Clarke (2013). During this process and in order to facilitate a wider and deeper understanding of the data collected, it became evident that simple themes could neither describe the complexity of positions held by the midwives nor answer the research question on its own. Thus, we chose to draw directly from Thompson's (2004) framework, to gain a more nuanced understanding of the midwives' views and experiences relating to CO.

Findings

The participants consisted of seventeen midwives practising in a community or hospital settings across one of two trusts in England and Scotland. Years of experience ranged from 3 to 35 years, across varying levels of seniority. Although not asked directly regarding their position on CO to abortion, all of the midwives interviewed did openly disclose this of their own accord. Seven midwives identified themselves as 'objectors' to abortion and ten identified as 'non-objectors'. The extent of and limitations to CO to abortion-related care was reflected by four themes that emerged from the data analysis and derive directly from Thompson's (2004) model: respecting and protecting, making informed decisions, providing non-discriminatory care and experience and culture.

Respecting and protecting

The theme reflects the midwives' desires to respect and protect the rights of women to choose to terminate a pregnancy whilst also respecting and protecting the rights of midwives to CO to abortion, with one midwife describing this as *'finding a balance'*. All of the midwives believed women had the right to choose an abortion and the majority believed CO to abortion should be accommodated,

> *So I think it is an individual's right as a human being, even though you are still a health professional, that you should still have your own choice and decision-making process whether you do or don't want to be involved in something. (Megan)*

One midwife disagreed with any right to CO to abortion, appearing to contextualise abortion within the holistic role of the midwife as being with woman and respecting the woman's decision with no regard to her own values,

> *…midwife means being with woman and that goes from preconception up to postnatal and everything in between, whatever her journey is…whatever her loss or termination, whatever her story is…I just don't think it [Co to abortion] should be a thing. (Melanie)*

Although the midwives voiced their support of both the women's and midwives' rights, the rights of both parties were not always viewed as being on an equal footing. Many of the midwives stated that a duty of care to the woman should be paramount, which was contrary to some believing their own human rights took precedence. A 'hierarchy' of rights was evident and discussed from both sides,

> *If you are a conscientious objector then I think you need to be placed somewhere where you are at a less risk of having to care for somebody who is in that position [a woman having an abortion]. That might feel like you're being, kind of, singled out a bit, but, at the end of the day, it's about the woman, not about you as a practitioner.(Michelle)*

> *So I don't think duty of care should outrank the importance of your own human rights. (Megan)*

While it was recognised that religion could underpin a midwives' decision to object, midwives also described other reasons such as personal experience and underlying values that could be the foundations for objecting,

> *I think …., most of them were religion. I'd say the majority were, but not all of them. Some of them just felt that, personally, their own values, their own beliefs, that they just didn't agree with it. (Mille)*

> *I didn't participate because she was having selective reduction of twins, I don't know why she was getting a selective reduction of twins. Personally, as well, I found that very difficult. ….(Margaret)*

There was also a recognition from one midwife of the conflict some midwives must have felt within their professional role as a midwife and their personally held values and beliefs,

> *But it must be something really strong, underpinning that, [CO to abortion] because these weren't people who didn't care about women. They were very caring people; it was just that was the point that they couldn't go to.* (Melody)

Defining participation: making informed decisions

In this theme, midwives reflected on the challenges surrounding what constitutes 'participation' in abortion and participating in abortion care *per se,* so that they could make an informed decision as to whether to participate or not. One midwife highlighted the difficulties that led to some of them exhibiting moral dilemmas,

> *It's a grey area…What part of it do you actually call the pre and the post [abortion]? It's different if somebody's going for a suction termination of pregnancy. That's very clear-cut, but in a labour ward situation, it's not black and white. (Mila)*

For others, although not clear cut, actual participation in abortion was generally thought to be the giving of medication to induce labour,

.. to me, the process would be if you actually handed over the pills, that's participating….So, to me, the only bit you can object to is the giving of medication. (Mila)

…administering drugs. That's the actual act isn't it? It's not a transaction but that's the moment when there's going to be a change and you've administered a drug that's caused the change then I can understand if someone did want to object. (Meya)

Post abortion care appeared to be more straightforward, in that this was overwhelmingly viewed by midwives as not being part of the abortion procedure,

But the actual care post, once that has happened, the delivery and the postnatal support is something I would happily provide to women. (Megan)

For some midwives, 'pre-abortion care' was viewed as more difficult to separate from being an active element of the abortion procedure,

When you are bringing someone in and you're inducing labour, where do you define what's pre-care….(Millie)

Of interest are the midwives who defined participation as 'everything', not from an objector's perspective, but more from a care perspective, seeing midwifery practice as being at risk of fragmentation if objectors were allowed to opt out of any aspect of it,

Well, I think if somebody was objecting to it, I think I've got to object to the whole thing because you can't take care of the person. (Millie)

It was evident from the present study that participating in abortion care could impact negatively upon all midwives, regardless of their views. Advancing gestation appeared to heighten both the negative impact and, in some cases, midwives' decisions to object,

I don't think that I could look after a lady having a termination for social reasons at that gestation [22 weeks]. *(Mila)*

Providing non-discriminatory care

In this theme, analysis demonstrated the nuances surrounding participation and objection, which were not always seen as being reciprocal, with the midwives not always able to articulate clearly what care they felt able or unable to provide,

Participant: Directing women to a service that will provide an abortion. That's contributing to the process, isn't it? Basically any advice from the point of, "I want an abortion." Any help that you give the woman.

Interviewer: So would you see those elements as part of the abortion procedure?

Participant: I would, but I don't think that you should be entitled to object to them. (Mila)

However, there was a recognition that midwife objectors had rights, and exhibited differing beliefs and interpretations,

I think people should have the right themselves to decide what level of involvement they want. Something that I deem acceptable to be involved while someone else might think, "I wouldn't even want to be involved in that level, and I wouldn't want to care for them post-procedure. (Megan)

All of the midwives understood that in an emergency situation that they had a legal duty to provide safe care to a woman undergoing an abortion,

..if a woman starts bleeding I wouldn't just walk away and leave her, I would be there trying to save her life in my role as a midwife. (Maeve)

'Overriding' conscience however, was not always limited to an emergency situation, with one participant describing a scenario where a colleague did so in recognition of the needs of other colleagues,

I had a nun that worked on the rota, and I never ever would have asked her in a million years…but there was one particular day and the place, it was just like an explosion, the number of women that were in labour. We were covering between rooms, and she realised that I hadn't cover for that woman to let the midwife out for a break, and she actually volunteered… That was her duty of care as well, and obviously thinking of her colleagues. (Mila)

The majority of midwives were aware of the law pertaining to CO to abortion, however operationalising this, in relation to everyday practice, was not always easy, mainly due to the 'spectrum of objection' that appeared to exist. To accommodate this, some of the midwives discussed the need for clinical guidelines that allowed for an 'individualised approach' in order to accommodate personal perceptions,

I think it would simply be as clear as 'You can be involved with as much of the decision-making process, the care or as little or none, if you deem that matches your rights as an individual.' (Megan)

This suggestion is countered however, by the midwives who described the need for 'limitations',

I think there should be a limitation. I mean to take a phone call or look after a patient after the event, if my colleague didn't want to do that I'd find that really difficult to accept because I feel that's not being involved in the act. (Melanie)

and a clearer definition of CO,

I think for a lot of midwives and nurses, they lack clarity as to what their role actually is and what the definition of conscientious objection is in the law, not their definition, because at the end of the day, their definition has got no place.(Millie)

Of note, Millie's comment highlights a further misperception and in turn complexity surrounding CO to abortion, in that there is no actual definition of it in law.

Balancing experience and culture

The theme 'balancing experience and culture' encompasses how objectors were identified, chose to identify themselves in the 'undertaking' of CO to abortion and the potential impact of CO on the culture of the institution in which they worked. It was evident that there was no 'official' system for identifying objectors. No midwives stated being under any obligation to declare that they objected, with their decision being afforded a certain level of privacy to the extent that is was almost 'invisible',

Interviewer: Have you been ever asked what your position is on whether you'd object or not object?

Respondent: Not directly, no. I've just been asked, "Are you okay to look after that woman?" But I don't think they ask you those questions. (Meya)

It's [CO to abortion] *not something that gets talked about really. (Margaret)*

The subject of 'disclosure' of a CO was multifaceted, with the sharing of information being debated by the participants in terms of the impact on the woman and midwife. The right to privacy for both parties was highlighted and was recognised as 'an impossible situation'.

> *…although you were very much aware that staff couldn't really refuse to provide care before and after the procedure, you knew if they had an objection. You wouldn't want to even put them in that situation, unless you actually had to. (Millie)*

> *..isn't it a breach of somebody's human rights to tell every single person working in a hospital, "This woman's having an abortion, so do you want to be involved in her care or not?" It's just an impossible situation, isn't it? (Melody)*

One participant described the challenges of 'protecting' an objector suggesting this would be better enabled by the midwife being overt in their objection,

> *…realistically… when you look at an off-duty, are you going to write 'conscientious objector'?…Who has the right to that information? …to protect a conscientious objector, they are probably best to have to put their head above the parapet. (Marion)*

Some of the midwives who identified as objectors also described concerns regarding being offered employment if their CO to abortion was 'known' and therefore did not mention it,

> *..you're not guaranteed a job at the end of the 3 years, so it makes it easier if you agree with what they want you to do to get that job, you know?(Megan)*

However, the majority of midwives in this study who had exercised their right to CO to abortion were accommodated 'problem free', with no descriptions of any 'resistance' to their decision to object or feelings of coercion in terms of participation,

> *No, I wouldn't have been forced. I'm trying to think if I probably made my feelings known. I probably did, but there was never an issue…. Always accommodated and I think I probably knew other people in the same boat and yes, it was accommodated. (Millie)*

However, what denotes 'participation' and the ensuing nuances of what care midwives believed they could withdraw from led to one midwife being asked to undertake a procedure which they had designated as 'active participation' in abortion and as such did not undertake,

> *The first thing, when she came in, I said I didn't want to participate and I didn't want to look after her and then I was asked would I site a cannula. (Margaret)*

The same midwife discussed her role working on delivery unit as becoming increasingly untenable due to her position on CO to abortion.

In line with this, the impact of midwives exercising their right to CO to abortion was discussed by midwives as having a negative impact on colleagues, with a link to staffing being made in a number of instances,

> *You're talking small numbers though, aren't you? But I guess why should it always fall to the same people then who decide that they think that they're happy to provide that care? (Melanie)*

> *I would say things have changed so much these days and staffing levels are just so awful that you can see managers' points of view…'one of my best midwives or nurses is not going to be here to A, B and C'…(Millie)*

From this, it is conceivable that managers may have to ask midwives to participate in care to which they object, placing both parties in an untenable position. In addition, it highlights the current shortage of midwives as impacting all aspects of care.

Discussion

Comparable with a small but growing number of studies (Chavkin et al., 2017; Fleming et al., 2020; Fullerton et al., 2018), this study illustrates midwives' respect for and support of another midwife's right to CO to abortion. However, it is also clear that this right to object is interspersed with complexities, particularly when operationalising it in clinical practice

The midwife's right to exercise CO to abortion was found to 'compete' with their duty of care to the woman, with the latter often being viewed by participants as the priority. This illustrates to some extent what has been labelled an 'incompatibility thesis' in that the health professional's obligation is to the welfare of their patient, with CO to abortion being viewed as incompatible with this concept (Bluetow and Gauld 2018, Wicclair 2017). However, this prioritising of rights is indicative of what Czarnecki et al. (2019) describe as a form of 'subordination' being experienced by the clinician in relation to the patient. The 'hierarchy of rights', which was evident in the current study, can be assimilated with what Keogh et al., 2019) describe as '*different weights*' being attributed to the values of personal moral integrity and obligation to patient care. In recognition of this, Buetow and Gauld (2018) propose a more 'person centred approach' to CO to abortion, which firmly places the rights of both the woman and midwife as being central to care, rather than being in 'competition' with each other (Minerva 2015), precisely as Thompson's framework proposed 15 years earlier. To do this, Ramsayer and Fleming (2020) describe the need for respect and acknowledgement of various arguments for and against CO to abortion, which provide understanding surrounding a midwife's right to object, whilst respecting women's autonomy. This is in effect encapsulated in one of the participants' comments who stated '*it's about finding a balance*'.

Recognition of midwives' values and experiences as shaping their decision making in terms of CO to abortion was evident in this study, widening the current narrative, which often depicts religion as the main driver for CO to abortion (Biggs et al., 2020, Fila and Arthur 2017). In a post-Christian UK, the narrative of CO to abortion being exclusively religiously motivated is not wholly representative and has the potential to obscure understanding of the context surrounding midwives' decisions to object within practice.

What participants constituted as participation in abortion was not clear from this study, with a 'spectrum' of participation being described ranging from 'everything' to 'just the giving of medication'. These polar opposites are somewhat indicative of the narrow versus broad interpretation of participation debated within the Dougan case (Supreme Court 2014), with 'hands on' care eventually being ruled as a definition of participation, although the meaning of hands on care in that ruling was far from clear. It is also apparent from the present study that definitions of participation exist between the extremities of the spectrum, validating Czaenecki et al's (2019) discussion around participation as a dichotomous yes or no as not being realistic. This is further illustrated by Ramsayer and Fleming's (2020) who describe CO as remaining '*an individual decision that can vary according to different situations as the topic is complex and controversial*'.

Midwives are not alone in their differing interpretations of what constitutes participation in abortion, with doctors (de Costa et al. 2010; Keogh et al., 2019) medical and midwifery students (Biggs et al., 2020) pharmacists (Maxwell et al. 2021) and nurses (Lamb et al. 2018) all recording differing interpretations. However, when compared with other health professionals, midwives hold a unique position during abortion care within the labour ward environment. Czarnecki et al. (2019) describe how abortions can 'un-

fold over days' and include 'multiple care moments' and it is these care moments that add a layer of complexity to what constitutes participation, which within the present study appear to constitute the 'grey areas' that can blur informed decision making.

Of interest are the midwives who defined participation as 'everything', not from an objector's perspective, but more from a care perspective, seeing midwifery care as being disjointed if midwives were allowed to opt out of an aspect of it. From this, one could question how the UK midwifery continuity of care model (NHS 2017) will adapt to ensure the right to CO to abortion is accommodated. This will also pose challenges for maternity services globally, were the World Health Organisation and International Confederation of Midwives call for Midwife-led continuity of care (ICM 2021), whilst supporting the midwives' role in providing abortion-related care (Fullerton et al., 2018).

UK midwives' potential exposure to 'late' abortion cases is low, with Fleming et al. (2020) finding a ratio of 0.56 late abortions to 24.74 births. However, despite such a small proportion, due to the acute shift from surgical to medical abortions (GOV.UK, 2022), midwives are more likely to be involved in the abortion process than they were previously. With this, comes the potential for all midwives', regardless of their views, to experience a level of 'moral distress' in caring for women undergoing abortions, something that been highlighted previously (Mizuno 2011; Zolala et al., 2019) and which was alluded to in this study. This is also echoed in findings from a recent systematic integrative review by Carvajal et al. (2022), which found that midwives experienced challenges in providing abortion care while holding differing beliefs concerning the subject.

Unlike previous assertions (Finer and Fine 2013, Keogh et al., 2019; Autorino et al., 2020), the present study did not find the exercising of CO to abortion as impeding women's choices and access to abortion. Nor did it find that women's care was negatively impacted. In addition, the NMC's (2021) requirement that midwives can object except in circumstances where the woman's life or health is in grave danger was recognised by all, with safe care remaining a priority.

Because agreement between the midwives on which elements of care a midwife could withdraw from is not wholly apparent in this study, there did appear to be a case for having an 'individualised approach' to this. Dobrowolska et al. (2020) describe CO as 'dynamic' in nature, endorsing suggestions that midwives should be able to 'choose' what they want to object to, with guidelines developed to reflect this. This approach responds to Ramsayer and Fleming's (2020) view that a midwife's decision making around CO to abortion *'may change or may be situationally dependant'* and resonates again, albeit within a different context, with the need to *'find a balance'*.

The NMC states that objectors who have a CO *'must tell colleagues, their manager and the person receiving care that they have a conscientious objection to a particular procedure'* (NMC, 2021), however, it is clear from the present study that this was not readily undertaken. The problems of undertaking disclosure 'neutrally' have been debated previously (Shahvisi, 2018) and the 'risks' for health professionals associated with disclosure have been highlighted (Fleming et al., 2018). Such risks were reflected in the present study were objectors believed their human rights were being eroded as they could be discriminated against if they made their views on CO to abortion known, which is of concern. Apprehension regarding employment prospects of objectors have been voiced previously (Maxwell et al., 2020, Maclure and Dumont, 2017) and although not verbalised in this study, it could lead to midwives not being offered posts, which, given the current shortage of midwives in the UK (Bonar, 2021), is problematic. Additionally, the process of disclosing CO to abortion exposed potential contravention of women's rights to privacy surrounding their decision to have an abortion. In essence, the identification and disclosure of a midwife's CO to abortion is infinitely more complex than the NMC's requirement to do so.

Although the majority of midwife objectors in this study were able to exercise decision-making, one midwife did describe how her position on labour ward was becoming untenable in terms of being asked to participate. One could argue that in order to eliminate such situations being faced by midwives, UK law should emulate countries such as Sweden, which does not legislate on the topic of CO to abortion (Munthe, 2016), leaving it up to individual organisations to develop their own policies. However, this can be viewed as opposing a UK midwife's human rights and dismisses the advantages of employing staff who object, described by Dobrowolska et al. 2020 as enabling 'ethically sensitive' individuals to enter the profession, whilst promoting diversity in the workplace.

The legacy of CO to abortion creating 'burnout' of staff undertaking abortion care is potentially a legitimate concern. Although this was not seen in the present study, in smaller maternity units that carry out abortions this may pose a problem. There are no national data on the numbers of midwives who are conscientious objectors and thus no modelling can be done to support or refute this. Nevertheless, it is clear from the present study that the UK shortage of midwives permeates every aspect of care, including that of midwives' rights concerning CO to abortion.

Limitations

This study is not without its limitations. Due to the self-selected nature of the participants, midwives who wished to hear their voices heard on the subject of CO may be overrepresented, thus the data could reflect this. In addition, the participants were not required to have direct experience of CO to abortion, which may have impacted their discussions, although it should be noted, the study focuses on midwives' views rather than their experiences. Finally, the study centres may have exhibited certain cultures and practices, reducing the transferability of the findings to other areas.

Conclusion

This study aimed to explore midwives' beliefs regarding the extent of and limitations to the exercising of their legal right to objection to abortion on conscience grounds, and we conclude that this can be summarised in the challenge of 'finding a balance'. By applying a human rights framework (Thompson, 2004) during the analysis stage, we have been able to give credence to the voices of midwives and contribute to a much-needed understanding of their views and experiences surrounding this contentious topic. Despite the intricacies presented, there was an overriding sense of support for midwives to be able to exercise their right to conscientious objection. How this is operationalised in practice however, continues to be fraught with complexity, which in turn poses constant challenges to midwives who object, their colleagues and managers. A national picture of how to accommodate CO to abortion is needed so that all midwives can continue to give optimal care and receive it themselves, within a human rights framework. We recommend further study to intensify the debate in this complex field of research, continuing to explore it together with midwives.

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Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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CRediT authorship contribution statement

Clare Maxwell: Conceptualization, Methodology, Formal analysis, Writing – original draft. **Beate Ramsayer:** Writing – review & editing. **Valerie Fleming:** Conceptualization, Methodology, Formal analysis, Writing – original draft, Funding acquisition.

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